NHS
Countess of Chester Hospital
NHS Foundation Trust

Public meeting of the Board of Directors Agenda
(published items)
Tuesday 25th November 2025, 08.30 – 12.00
Boardroom, 1829 Building

Chair	Mr N Large, Trust Chair
Apologies	
In attendance	Ms L Ates, Named Nurse for Safeguarding Children (Item 3.), Mr M Woodward, Head of Nursing - Infection Prevent & Control and team (Item 4.), Dr S Brigham, Associate Medical Director (Item 13.) and Ms C Davies, Head of Midwifery (Item 14a.)

Time	Agenda No.	Agenda item	Lead	Page No.	Decision Required
08.30	1.	Welcome, apologies and Chair's opening remarks (verbal)	Trust Chair		For noting
08.33	2.	Declarations of Conflicts of Interest with agenda items (verbal)	Trust Chair		For noting
08.35	3.	Patient Story (to be presented on the day)			
08.45	4.	Service Showcase (to be presented on the day)			
09.00	5.	Minutes of the previous meeting held on 30th September 2025 (attached)	Trust Chair	5 - 28	For approval
09.05	6.	To consider any matters arising and action log (attached)	Trust Chair	29 - 32	For noting
09.10	7.	Chief Executive Officer's Report (attached)	Chief Executive Officer	33 - 38	For noting
09.20	8.	Chair's Update (verbal)	Trust Chair		For noting
09.30	9.	a) Board Assurance Framework – 2025/26 Q2 Update (attached)	Director of Governance, Risk & Improvement	39 - 59	For decision & assurance
		b) High Risks Report (attached)	Director of Governance, Risk & Improvement	60 - 70	For noting
Quality of Care					
09.40	10.	General Medical Council (GMC) National Training Survey 2025 Report (attached)	Medical Director	71 - 72	For assurance
09.45	11.	Quality & Safety Committee Chair's Report – 6th November 2025 (attached)	Chair Quality & Safety Committee	73 - 74	For assurance

09.50	12.	Care Quality Commission (CQC) Improvement Plan including Well Led (attached)	Director of Nursing & Quality / Deputy Chief Executive	75 - 76	For assurance
09.55	13.	Perinatal Services Quarterly Update (Quarter 2) (attached)	Associate Medical Director	77 - 87	For assurance
10.05	14.	a) Maternity and Neonatal Bi-annual Safer Staffing Report January to July 2025 (attached) b) Bi-annual Safer Nurse Staffing Report (mid-year establishment review 1 January to 30 June 2025) (attached)	Head of Midwifery Director of Nursing & Quality / Deputy Chief Executive	88 - 94 95 - 101	For assurance For assurance
Comfort Break (10.15 – 10.25)					
10.25	15.	Safety Surveillance and Learning Report – Quarter 2 2025/26 (attached)	Director of Nursing & Quality / Deputy Chief Executive & Medical Director	102 - 111	For assurance & noting
10.35	16.	Quarter 2 2025-2026 Mortality Surveillance Report (Learning from Deaths) (attached)	Medical Director	112 - 119	For assurance
Operational Performance					
10.45	17.	Integrated Performance Report (IPR) (to follow) Operational Performance Quality Safety People Finance	 Chief Operating Officer Director of Nursing & Quality Medical Director Chief People Officer Chief Finance Officer		For assurance
11.00	18.	Operational Management Board Chair's Report – 25th September 2025 and 23rd October 2025 (attached)	Chief Executive Officer	120 - 122	For assurance

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Finance, Use of Resource and Performance					
11.05	19.	Finance & Performance Committee Chair's Report – 4th November 2025 (attached) and 18th November 2025 (verbal)	Chair Finance & Performance Committee	123 - 124	For assurance
11.10	20.	Audit Committee Chair's Report – 7th October 2025 (attached)	Chair Audit Committee	125 - 126	For assurance
Strategic Change					
11.15	21.	Emergency Planning & Resilience (EPRR) Core Standards Self-Assessment and Annual Report (attached)	Chief Operating Officer	127 - 141	For assurance
11.25	22.	People Strategy – 2025 – 2028 (attached)	Chief People Officer	142 - 182	For approval
Leadership, Improvement Capability, Organisation Development and People					
11.35	23.	People Committee Chair's Report – 14th October 2025 (attached)	Chair People Committee	163 - 164	For assurance
11.40	24.*	Council of Governors Report – October 2025 (attached)	Director of Governance, Risk, and Improvement	165 - 167	For noting
Items for noting					
11.42	25.*	Items for noting and receipt (attached): ***Sent under separate cover*:** **Minutes of Committee Meetings:** a) Approved minutes of the Quality & Safety Committee – 8th September 2025 (attached) b) Approved minutes of the People Committee – 12th August 2025 (attached) c) Approved minutes of the Finance & Performance Committee – 27th August 2025 and 23rd September 2025 (attached) d) Approved minutes of the Audit Committee – 15th July 2025 (attached) e) Approved minutes of the Operational Management Board – 24th July 2025 and 25th September 2025 (attached) **Other items:** f) Board of Directors Workplan 2025/26 (attached)	Trust Chair		For noting
Other items					
11.45	26.	Any Other Business (verbal)	Trust Chair		For noting
11.50	27.	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:***	Trust Chair		For noting

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		coch.membershipenquiriescoch@nhs.net ***by Thursday 20th November 2025*** **Future Dates:** 27th January 2026 31st March 2026			
12.00	28.	Closing remarks (verbal)	Trust Chair		For noting

Next Meeting: Tuesday 27th January 2026

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

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MINUTES OF THE PUBLIC BOARD OF DIRECTORS

Tuesday 30th September 2025, 08.30 – 12.30
Boardroom, 1829 Building

Members	20/05/25	29/07/25	30/09/25			
Trust Chair, Mr N Large MBE	☑	☑	☑			
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, Mrs 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	☑	☑	☑			
Chief People Officer, Ms V Wilson	☑	☒	☑			

In attendance	20/05/25	29/07/25	30/09/25			
Head of Corporate Governance, Mrs N Cleuvenot	☑	☑	☑			
Consultant Dermatologist/Skin Cancer Lead, Dr E Domanne	☑ (item 3)	n/a	n/a			
Healthcare Assistant, Ms M Facer	☑ (item 3)	n/a	n/a			
Director of Midwifery, Ms N Macdonald	☑ (item 11 and 12a)	☑ (item 4)	☑ (item 11)			
Director of Clinical Research, Mr P Bamford	☑ (item 23)	n/a	n/a			
Deputy Medical Director, Dr I Benton	n/a	☑	n/a			
Maternity and Neonatal Voices Partnership Lead, Ms R El Boukili	n/a	☑ (item 4)	n/a			
Director of Pharmacy and Medicines Optimisation and Controlled Drugs Accountable Officer (CDAO), Ms K Adams	n/a	☑ (item 15)	n/a			
Intensive Care Consultant and Organ Donation Clinical Lead, Mr D Zeinali	n/a	n/a	☑ (item 4)			
Safeguarding Lead, Ms J Cooper,	n/a	n/a	☑ (item 10)			
Deputy Chief Operating Officer, Mr S Brown	n/a	n/a	☑			
Freedom to Speak Up Guardian, Ms H Ellis	n/a	n/a	☑ (item 13)			

Agenda No.	Agenda item	Lead
1.	**Welcome, apologies and Chair's opening remarks** Mr N large (NL), Trust Chair opened the meeting. Apologies were noted from Non-Executive Directors, Mr M Guymer and Mrs P Williams; and Ms C Chadwick, Chief Operating Officer. The Chair introduced a new approach for the meeting today following feedback regarding papers. After each report the Board will be asked to comment on the format and content of the paper and to identify any areas where additional assurance is needed.	

2.	**Declarations of Conflicts of Interest with agenda items** There were no declarations of interest to note.	
3.	**Patient Story** Mrs S Pemberton (SP), Deputy CEO/ Director of Nursing & Quality read a patient story relating to gynaecology services. The patient described a highly positive experience, highlighting the compassion and professionalism of the clinical team, particularly Jade Edwards and the other nurses, as well as the efficiency of the administrative team. The patient felt reassured and well cared for throughout, and their faith in the Trust had been restored. The Board **noted** the patient story.	
4.	**Organ Donation Service Showcase and Organ Donation Annual Report** Darius Ali (DA), Intensive Care Consultant and Clinical Lead for Organ Donation, presented an overview of the organ donation service at the Trust. The presentation included: • Introduction of the Organ Donation Committee members. • Highlights from the annual report: In 2024–2025, there were 2 organ donors at the Trust, resulting in 6 lifesaving transplants and 10 corneas donated. • Explanation of the organ donation process, noting that donation is only possible in very specific circumstances. • Ongoing education for junior doctors and ward staff to ensure organ and tissue donation is considered as part of end-of-life care. • Plans to expand awareness and referral rates for tissue donation. • A patient story was shared about Jamie Griffiths, who died in intensive care and had expressed his wish to be an organ donor. Jamie's donation of kidney, liver, pancreas, and intestine resulted in multiple life-saving transplants. • Update on Organ Donation Week: The Trust is performing well but recognises there is always room for improvement. **b) Organ Donation Annual Report** The Annual Organ Donation Plan 2025–2026 had been circulated to the Board. Key points presented included: • The Trust continues to benchmark well for early referral and consent rates. • In 2024–2025, 2 deceased donors led to 6 organ transplants; 10 corneas were also donated. • The referral rate to the organ donation team was 94%, with a 55% approach rate to families and a 50% consent rate. • The committee aims to maintain high referral rates, improve family approach and consent rates, and further promote tissue donation and community awareness in 2025–2026.	

	The Trust Chair described the presentation as humbling and highlighted the importance of registering as a donor, noting the common misconception that everyone is automatically registered. DA clarified that it is essential for individuals to actively register as donors and to share this decision with their families. The Chair thanked DA and the team for their work and also thanked Jan Chillery, Public Governor for volunteering to Chair the Committee. Prof A Hassell (AH), Non-Executive Director praised the presentation and asked if there was anything further the Board could do to support organ donation success. DA responded that while organ donation is progressing well, there is still significant work to do in raising awareness and referral rates for tissue donation. He suggested including tissue donation awareness in staff induction and committing to other ways of raising awareness. AH noted that the publication of organ donation information on the intranet and recent communications campaign had been very positive. The Board commended the team's achievements and thanked DA for the presentation. The Board **noted** the service showcase and Organ Donation Annual Report 2024/25. *DA exited the meeting at 8:45.*	
5.	**Minutes of the previous meeting held on 29th July 2025** The minutes of the previous meeting held on 29th July 2025 were reviewed and **approved** as a true and accurate record of the meeting.	
6.	**To consider any matters arising and action log** **Action 1 -** update provided on action log and nothing further to add at this point. **Action 2** – update provided on Private Board agenda and closed. **Action 3** – it was noted that Value for Money assessment feedback had been chased from the CQC and it was confirmed that this would not be shared. Action closed. **Action 4** – IPR updates are being tested with hope to implement this for September data. The Chair commented that this would useful to implement for the 6 month stocktake and to perhaps share a draft at the October Strategy Day. The Board **noted** the action log updates.	
7.	**Chief Executive Officer's Report**	

	The CEO's report was taken as read. Ms J Tomkinson (JT), Chief Executive Officer highlighted several key points, many of which have been discussed in other forums. • Cheshire & Merseyside Provider Collaborative (CMPC) - The collaborative now incorporates mental health and community elements. Recent Leadership Board meetings focused on commercial opportunities, efficiency at scale, and a reset of provider priorities, including planned care, community services, and fragile clinical pathways. • The Board will devote time to Trust sustainability and related issues at the next strategy day. The Chair queried whether there is guidance on a five-year medium-term strategy. Mrs K Edge (KE), Chief Finance Officer confirmed that while some broad detail exists, further discussion will take place at the development day. JT continued with the following updates: • Obstetrics and Gynaecology has been recognised as one of the most improved areas for training, with national commendation from the Royal College of Obstetricians and Gynaecologists. • Significant investment has been made through charitable funds and the Ursula Keyes Trust, particularly in lifesaving skills training. The Board discussed opportunities to further engage with the community around these initiatives. • The recent resident doctors' strike was discussed, with an update provided in the written report. Robust plans were in place to minimise service disruption. • The Countess of Chester Country Park received its eighth consecutive Green Flag award and the Land Trust's Health Park of the Year Award, highlighting the value of this asset for staff and the community. • The Celebration of Excellence Awards Night was well attended and fully sponsored. A wide range of teams and individuals were recognised for their contributions. • The new corporate offence of 'failure to prevent fraud' is now in force. The Trust has published a statement outlining responsibilities and expectations. The Trust Chair invited feedback on the report's format and content. Prof A Hassell (AH), Non-Executive Director asked about current concerns and areas on track. JT identified finance, waiting times, and urgent and emergency care (UEC) as the key ongoing challenges. Despite difficulties, there is a clear trajectory for improvement, with plans in place for finance, waiting lists and UEC. The Board's ability to balance quality, savings, staff morale, and partnership working was acknowledged as an important focus. Discussion focused on hospital flow, discharge processes, and the need for adaptive action plans. Collaboration with partners is ongoing, though	

	fluctuations remain. Ms S Pemberton (SP), Deputy CEO/ Director of Nursing and Quality emphasised that flow is the Trust's biggest operational issue, impacting patient experience and survey results. Leadership, culture change, and accountability were all highlighted as priorities. The Chair noted that medical workforce issues, while significant, represent only a small proportion of the overall workforce. Ms V Wilson (VW), Chief People Officer reported ongoing work to improve culture and communication in the Emergency Department (ED) and across triumvirates, with early feedback indicating a desire for improvement. AH suggested more public recognition of positive achievements. Mrs S Corcoran (SC), Non-Executive Director asked about staff willingness for change; JT confirmed strong desire for improvement amongst staff. The Board discussed the importance of the work that has been done and is ongoing to build governance foundations, ownership, and accountability, while providing support. Mrs W Williams (WW), Non-Executive Director raised the lengthy discharge process she had observed at a recent walkabout. There was discussion around the need to modernise discharge processes, including nurse-led discharge and weekend/ out-of-hours arrangements. Barriers such as nursing home admissions at weekends were noted. The Trust Chair reiterated urgent care, referral to treatment (RTT), finance and CQC as key challenges, all of which have approved plans in place. The Board agreed on the importance of tracking progress against plans and maintaining transparency about the direction of travel. The Board **noted** the contents of the CEO's report.	
8.	**Chair's Update** The Trust Chair noted that challenges will continue into next year, highlighting the need for improved infrastructure and system efficiency. The Board should consider how it can support and gain assurance through Committees. Thanks were extended to David Williamson, Mick Guymer, and Pam Williams, Non-Executive Directors who are leaving the Trust on 31st October 2025, and to Lucy Liang, who is stepping down as a Governor. Appreciation was also given to Governors whose terms end at the Annual Members Meeting (AMM), with a welcome to the 11 new Governors. The Celebration of Excellence Awards were a success, noting the need for positivity for staff in a time of difficult decisions and change. The Annual Members Meeting is on 1st October 2025 and a Governor Induction Session is taking place on 22nd October 2025 from 10am to 1pm, focusing on Governor and Board roles. All NEDs, including newly appointed ones (pending COG approval), are invited to attend.	

	The Board **noted** the Chair's update.	
9.	**a) Board Assurance Framework 2025/26** Mrs K Wheatcroft (KW), Director of Governance, Risk and Improvement shared that the BAF was presented for triangulation with the Board agenda. The Q2 update is in progress and will be ready for the next meeting. Triangulation remains a key focus, ensuring that Committees review and debate their respective BAF extracts. The Chair queried whether the assurance Committees are satisfied with the information presented to them and this was confirmed. The Board **noted** the alignment of the BAF with the Board agenda and the ongoing process of assurance triangulation. **b) High Risks Report** In terms of the High Risk Report, Prof A Hassell (AH), Non-Executive Director highlighted that many risks overlap between committees, indicating the need for continued cross-committee visibility. KW noted that the report is not yet at the desired standard. The Risk Management Committee will meet in October and will look at addressing the articulation of risk, consistency of scoring, and appropriateness of risks included. Good discussions have taken place at Operational Management Board, and divisions have undertaken risk maturity work. Reports are currently manually driven but efforts are being made to develop automated reports and aim to link risks more closely with the BAF. Ms N Cleuvenot, Head of Corporate Governance noted that where risks were deemed relevant to multiple committees, these would be included in the high-risk report for those committees to ensure cross-committee scrutiny. Mr P Jones (PJ), Non-Executive Director requested a target date for closure be added to risk 3255. The Board **noted** the high-risk report.	
10.	**Safeguarding Annual Report** Ms J Cooper (JC), Safeguarding Lead attended to present the Safeguarding and Complex Care Annual Report for 2024/25. It was noted that the length of the report is due to a requirement from external bodies, but a concise and effective executive summary was provided. Mrs S Corcoran (SC), Non-Executive praised the executive summary, stating it captured all key messages from the full report and was exactly what the Board needed.	

	Prof A Hassell (AH), Non-Executive Director queried the completion rate of the safeguarding screening tool. JC reported that completion is progressing well, particularly in the Acute Medical Unit (AMU) where the rate is 78%. However, there is a need to investigate why completion is not higher and to target surgical wards for improvement. The biggest challenge remains embedding the tool in the Emergency Department (ED), which is a priority. AH raised concerns about the availability of child protection information sharing in Flintshire. JC confirmed this has been a persistent issue, with communication ongoing to improve the situation. The national CPIS infrastructure exists, but Flintshire's lack of access has been escalated, particularly through child protection practice reviews. This has been highlighted as a risk. However, all children presenting are subject to a mandatory screening tool, with 100% uptake. AH noted an increase in high-risk domestic abuse cases and asked about resource implications. JC responded that routine enquiry is being embedded, and the Trust has a full-time midwife (part-funded by the Trust) supporting this area. There is a need to upskill staff to complete risk identification checklists. Ms S Pemberton (SP), Deputy CEO/ Director of Nursing and Quality, commended the significant work undertaken in respect of safeguarding, noting the report reflects the dedication and impact of JC and the team. Ms J Tomkinson (JT) emphasised the importance of front door assessments in identifying safeguarding issues and recognised that this has led to a recent increase in complaints about the nature of some safeguarding questions, especially in child safeguarding. JC stressed the vigilance of the team, particularly in identifying fabricated illness cases. SC enquired whether the increase in safeguarding cases was due to better identification or a genuine rise in incidents, and whether the team had capacity to cope. JC explained that the team's visibility and reputation across the organisation encourages staff to consider safeguarding. Training has been a key asset, with Level 3 safeguarding compliance for clinical staff now at 90%. AH highlighted that the high level of training compliance reflects both the team's efforts and a positive cultural shift within the organisation. The Board thanked JC and the team for their enthusiasm and commitment. *JC exited the meeting at 9.37am.* AH commented positively on JC's approach and the quality of the report, querying whether it is reviewed by the Quality and Safety Committee (Q&S). SP clarified that the report goes to the Quality Governance Group (QGG), which feeds into Q&S through an assurance report. Mr D Williamson (DW), Non-Executive Director asked whether all such reports must come to the Board. Mrs K Whearcroft, Director of Governance, Risk and Improvement confirmed this is a statutory	

	requirement and that the Board workplan has been reviewed and reset to ensure compliance, even where it may appear there is duplication with assurance Committees. Ther Board **noted** the update.	
11.	**Perinatal Services Quarterly Update Quarter 1** Natasha Macdonald (NM), Director of Midwifery presented the Perinatal Services Quarterly Update for Quarter 1, confirming that the Trust continues to meet national standards for maternity and neonatal safety, with all Maternity Incentive Scheme (MIS) safety actions on track. The collaboration with the Maternity and Neonatal Voices Partnership (MNVP) has been strengthened, but under Year 7 requirements, MNVP representatives are expected to be part of the perinatal mortality review process. NM explained that, while this review is sensitive and MNVP involvement is important, the Trust is currently awaiting Local Maternity and Neonatal System (LMNS) training for MNVP members. She made the Board aware that, until this training is completed, the Trust is not fully compliant with this requirement. Mrs K Edge (KE), Chief Finance Officer asked if there was any financial risk associated with Year 7 requirements, and NM clarified that as long as the Board is aware and concerns about MNVP attendance and training are escalated, compliance can be declared and there are no immediate financial risks. The Board confirmed that they understood that MMNVP representatives would not be present in the perinatal review process until they had received appropriate training. There were no immediate risks to escalate, and all Maternity and Newborn Safety Investigations (MNSI) reports have been completed and are awaiting Integrated Care Board (ICB) sign-off. The Trust achieved 96% compliance with the Saving Babies' Lives Care Bundle, with ongoing focus on protected handover and escalation protocols. Actions around the EPR freeze have been delayed, but ward accreditation has been achieved on some wards. Mrs W Williams (WW), Non-Executive Director asked, given the information coming into the public arena and recurring incidents, whether any new areas of concern had been flagged. NM responded that the team is monitoring where the national review will take place and maintains strong relationships with the MMNVP. She highlighted a focus on ethnicity data and workforce, and governance oversight, with both executive and non-executive leads in place, and noted the need to see the outcome of the Thirlwall report. Mrs S Corcoran (SC), Non-Executive Director raised the topic of the perinatal mortality rate, which now includes contextual data, and noted that this was discussed at the last safety champion meeting. She confirmed satisfaction with the trajectory for training compliance, which remains high for both midwives and obstetricians. SC also commented on the value of having an MMNP who is a midwife, as many trusts have lay	

	representatives, and the detailed clinical discussions benefit from this expertise. Mr D Williamson (DW), Non- Executive Director suggested that the executive summary should highlight key issues and risks, such as training compliance, to ensure clarity for the Board. The Chair asked about the new Women and Children's building, and NM reported excellent feedback from both patients and staff. *NM exited the meeting at 9:56am.* The Board **noted** the update.	
12.	**Care Quality Commission (CQC) Improvement Plan including Well Led** Ms S Pemberton (SP), Deputy CEO/ Director of Nursing and Quality confirmed the CQC Improvement Plan is also reviewed by the Quality Governance Group (QGG), with several areas now moved to business as usual, such as the Quality and Safety Strategy and risk management improvements. The stroke service was specifically referenced, with ongoing discussions about affordability and increasing service provision, which has also been discussed at the Executive Directors Group. Prof A Hassell (AH), Non-Executive Director questioned whether some actions marked as complete are truly at the required standard and asked about the value of Board review. It was acknowledged that while actions may be marked as complete, underlying issues like patient flow may persist, and it's important to ensure changes are embedded as part of BAU before fully closing actions. It was agreed some areas may need caveats, and SP noted the CQC may scrutinise if issues are not brought to the Board. Mr D Williamson (DW), Non- Executive Director raised concerns about overpromising on improvement timelines and highlighted the need for realistic prioritisation given the improvement team's focus on the Cost Improvement Programme. Ms J Tomkinson (JT), Chief Executive Officer pointed out that much of the quality improvement work is led by SP's team, not just the improvement team. Mr P Jones (PJ), Non-Executive Director questioned whether the improvement strategy timeframe is realistic. It was agreed to reconsider the format in which the Board received assurance that CQC action plan was progressing. The Board was assured that the details of the progress was monitored by QGG and in turn reported to the Quality and Safety Committee. **ACTION:** Review how CQC action plan is monitored and reported to Board. The Board **noted** the update.	**SP**

13.	**Freedom to Speak Up (FTSU) Guardian Report** Ms H Ellis (HE), FTSU Guardian presented the FTSU report, highlighting that the number of concerns raised by staff continues to increase year-on-year, though there was a decrease in the last quarter. Bullying and harassment concerns have reduced significantly, but poor attitudes and behaviours remain a recurring theme. HE noted the expansion of the FTSU Champion network, with over sixty champions now in place and plans to develop more localised champion hubs to support new champions. The first meetings for these hubs are scheduled for October, with bi-monthly meetings for all guardians continuing as usual. Mandatory training compliance for FTSU is strong across most staff groups, though Estates and Ancillary staff remain below the 90% target. There is ongoing work to improve compliance, particularly among doctors who are not patient-facing and the facilities teams. Dr N Scawn (NS), Medical Director explained that for medical staff, revalidation is now linked to achieving at least 80% mandatory training compliance. Ms V Wilson (VW), Chief People Officer added that while overall compliance has improved, some staff groups and topics have been slower to progress, often due to leadership and clarity issues. The Chair asked about national changes to mandatory training, and VW confirmed that oversight groups are reviewing the programme, with any changes to be approached cautiously. Mrs S Corcoran (SC), Non- Executive Director asked whether the reduction in bullying and harassment concerns aligns with other data. VW confirmed that historically high numbers are now decreasing, possibly due to earlier intervention and a shift towards addressing poor behaviours before they escalate to disciplinary cases. HE and VW emphasised the importance of supporting staff to have appropriate conversations and providing resources to address issues proactively. Mr P Jones (PJ), Non-Executive Director asked about staffing concerns, and HE responded that issues raised stemmed from skill mix, communication, and staff wellbeing, which are closely linked to staffing levels. VW suggested the report should include more detail on the specific concerns raised and the actions taken, as well as how feedback is communicated to staff. HE noted that case studies are shared at the People Committee to illustrate common issues and learning. Ms S Pemberton (SP), Deputy CEO/Director of Nursing and Quality shared positive feedback about safe staffing and leadership visibility, noting that while there are compliments, there are also concerns when staffing levels are not adequate. She highlighted the importance of balancing agency and bank controls and ensuring staff feel listened to. The Chair asked HE about her six years in the role and the impact made; HE reflected that staff are now more willing to speak up and that Board support has been crucial.	

	The Board discussed the importance of FTSU feeding into the People Committee, with Ms W Williams (WW), Non-Executive Director suggesting that future reports should include the impact of interventions and follow-up actions. Prof A Hassell (AH), Non-Executive Director asked if feedback is sought on the FTSU process. VW confirmed this is asked following every speak up and that feedback on the process has been positive. The Board agree that the detail should continue to be monitored by the People Committee to ensure assurance and appropriate reporting to the Board. The Board **noted** the update.	
14.	**Quality & Safety Committee Chair's Report – 8th September 2025** The Board received the Quality and Safety 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. Prof A Hassell (AH), Non-Executive Director highlighted the following: • The Committee noted ongoing improvements in palliative care, but challenges remain, especially the lack of an internal 24/7 service and reliance on local hospice support, which may affect CQC assessment. • The quarterly safeguarding report was received, with actions progressing on domestic abuse enquiry, hospital passport completion, and restraint. • Reports were also received on cancer services, breast surgery (workforce pressures), and the skin service (large increase in referrals). • Assurance was received on the medical devices report, improvements in clinical audit management, and the medicines optimisation annual report. The Board **noted** the Chair's report.	
15.	**National Inpatient Survey Results** Ms S Pemberton (SP), Deputy CEO/Director of Nursing and Quality presented the results of the 2024 National Inpatient Survey, stating: • Four hundred and seventy-seven people completed the survey (response rate: 41.88%), with 94% of respondents coming through the urgent care pathway. • The Trust's overall experience score is 1% higher than last year, with 78% of patients rating their experience as 7/10 or above, the highest since 2021. • 99% of patients reported being treated with kindness and compassion; 97% felt treated with respect and dignity. • The Trust is benchmarked by CQC against all trusts and by Picker against sixty-one organisations. Links to both reports were shared.	

	• The "Leaving Hospital" section was identified as an area performing worse than others, accounting for 58% of all worse/somewhat worse scores. Of fourteen sections, only this area declined; all others remained stable or improved. • Discharge data and processes require significant improvement. SP has met with colleagues, and Fiona Altintas, Deputy Director of Nursing and Governance is leading work on this. • Key issues include patients not knowing their discharge date or length of stay. The aim is to start discharge planning on admission and ensure all specialties are engaged. • Positive feedback was received regarding staff kindness. Mrs W Williams queried average ideal discharge rates and the impact of proposed changes. Mr S Brown (SB), Deputy Chief Operating Officer suggested a target of seventy discharges per day; SP agreed this would significantly improve flow. SP asked Mr N Scawn (NS), Medical Director if this discharge rate was feasible over the weekend. NS confirmed that ward round for discharge is considered additional activity but is well covered with discharge lists prepared on Friday. It was recognised that the weekend service would not reflect the weekday service and that the primary challenge to overcome was discharging patients that needed to move into the care of another provider. Mrs S Corcoran suggested increasing the weekday target discharge rate to overcome the decreased discharges over the weekend. She reiterated the importance of planning Estimated Discharge Date (EDD) upon admission and greater clinical engagement. NL noted the Trust's length of stay (LOS) is two days longer than peers and questioned when improvements would be evident. **Action:** It was agreed to add an update on the discharge pathway to the November Board agenda. Prof A Hassell (AH), Non-Executive Director suggested process mapping, especially for patients needing specialty input. NS highlighted challenges with co-morbid and frail patients. SB referenced community capacity and a commissioned deep dive into the acute model with ECIST, aiming for a root-and-branch review. SC asked if clinicians would be involved in service redesign; SB confirmed clinical leads are engaged. **Action:** An update on the ECIST review of the acute model and service redesign to be bought to the Board. The Board **noted** the update.	**NS/SP** **SB/CC**
16.	**Integrated Performance Report (IPR) – August 2025**	

	Mr S Brown (SB), Deputy Chief Operating Officer provided an update on operational performance. In summary: • Improvement in 4-hour standard, primarily due to Type 1 ED performance • Ambulance handover times improved, with August average below 20 minutes. • 2-hour targets remain stubbornly high. • Multiple senior meetings are ongoing to identify further improvements for ED. • Corridor care was virtually eliminated in August, with only two instances recorded. • Performance has deteriorated, mainly due to echocardiography waiting times. • Action plan for echo is in place but not delivering; being revisited. • Mutual aid with Wirral approved, but technical issues with software integration have delayed progress. SB provided an additional update on RTT (Referral to Treatment) position: • Waitlist gradually rising; currently 34,479 incomplete pathways • Pathways fully validated; participating in a validation sprint, resulting in 18% more RTT clocks stopped than last year. • ENT, dermatology, and vascular surgery account for half the backlog. • 48.3% of patients treated within 18 weeks. 9% of pathways are over 52 weeks and two hundred and eight patients waiting over 65 weeks • ERS/Cerner integration launching 3rd November. • Revised guidelines for varicose vein referrals now allow more appropriate triage. • Consultant Connect triage in place for ENT, dermatology, and vascular (21–42% triaged back to GP) The Chair sked for clarification on “stopping RTT clocks.” SB explained that stopping the clock means the patient has been treated, and would be removed from the waiting list. Prof A Hassell (AH), Non-Executive Director queried why initial consultant triage is not more effective. SB responded that advice and guidance to GPs is improving and learning from Consultant Connect will be shared internally to enhance triage. Mrs W Williams suggested that verbal explanations be provided for areas of concern in future reports and asked if there are stretch targets in planning. SB confirmed stretch targets exist for cancer and RTT (60% delivery is the stretch target). The Chair sought clarity on RTT trajectory from September 2025 to March 2026, emphasising the need for a clear plan even if demand and delivery is uncertain.	

	Mr D Williamson (DW), Non-Executive Director requested more regular reporting to Finance & Performance (F&P) Committee for assurance. It was noted that SB had attended the last F&P meeting. Ms S Pemberton (SP), Deputy CEO/Director of Nursing and Quality presented the Quality update: • C. difficile (CDIFF) cases remain within threshold, though 6 cases were reported in August. • Ongoing Trust-wide focus on patient flow and infection prevention. • Compliance with Braden, MUST, and falls risk assessments is below the 90% target but showing improvement. • The Trust's position on NOF metrics for certain bacteria was shared, with a request for annual and more regular assessments, and for a trajectory for the year for C. difficile, E. coli, etc • Overall falls remain high, but the number of falls with harm is low. • There is a continued reduction in falls with harm, with 0.06 per 1,000 bed days in August • 6–7 wards have reported no pressure ulcers for the last 6 months. • No never events or STeIS reportable incidents were recorded in August. • Consistent incident reporting and a reduction in moderate and above harm incidents were noted. The Chair requested clarity on which assurance committee would take the lead for each NOF item. The need for clear trajectories and regular review of infection metrics was discussed. SC asked if positive changes are being tracked. SP confirmed weekly pressure ulcer group meetings and wider learning dissemination. Dr N Scawn (NS), Medical Director presented the Safety update: • E-discharge performance remains below target though there has been improvement. Efforts led by Fiona Altintas and Ian Benton are ongoing, with a current focus on Planned Care. • Sepsis data has improved, and further discussion is scheduled for the private agenda. The report notes ongoing work to align sepsis metrics with national guidance, with improvements expected in future reporting. • There was discussion about the potential use of AI to support discharge processes, with recognition of confidentiality and data protection concerns. Ms V Wilson (VW), Chief People Officer presented the People update: • Notable reduction in agency shifts, especially in nursing. Agency spend is significantly down year-to-date. • The Trust planned a reduction of 182 WTE (whole-time equivalent) posts; 108 have been achieved, mainly by releasing vacancies. Workforce CIP (Cost Improvement Programme) plans are	

	progressing, with external auditors (PwC) advising adherence to the 182 target. • The Trust is making good progress on workforce targets, with turnover below 10% and sickness absence at 4.89% in August. Mrs K Edge (KE), Chief Finance Officer presented the Finance Update: • The Trust is £3.5m off plan year-to-date, primarily due to £3.3m withheld deficit support funding and costs related to industrial action. The reported year-to-date deficit is £14.3m against a planned £10.8m. • There is slippage on CIP delivery, with £4.3m undelivered at month 5, mitigated by non-recurrent benefits (e.g., vacancies, VAT rebate • The forward look projects a deficit of £39.8m (excluding deficit support funding), with further details to be discussed on the Private agenda. The Board **noted** the Integrated Performance Report.	
17.	**Operational Management Board Chair's Report – 24th July 2025** The Board received the Operational Management Board 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. Ms J Tomkinson (JT), Chief Executive Officer raised the ongoing challenges with finance and CIP but recognised these have been addressed in depth through other agenda items. There were no further questions raised. The Board **noted** the Chair's report.	
18.	**National Oversight Framework (NOF)** Mr J Bradley (JB), Chief Digital and Data Officer, presented the latest NOF update. The NOF was published in September 2025 and is now integrated into the Trust's Integrated Performance Report (IPR). Further validation is ongoing for community waiting times data, with a deep dive underway in collaboration with service leads. Community waiting times currently focus on Community Paediatrics, an area historically lacking robust data quality checks. Mr S Brown (SB), Deputy Chief Operating Officer had previously referenced the importance of accurate referral data; the next data cut will be at the end of September, which is critical for next quarter's reporting accuracy The Trust is prioritising delivery of existing improvement plans, especially for RTT and the System UEC Improvement Plan. There is an ongoing effort to align IPR metrics with the NOF, with enhanced narrative and weekly updates to improve visibility and accountability.	

	The Board **noted** the NOF update.	
19.	**Winter Planning and Board Assurance Statement** The Board was asked to review the Winter Plan against the Board Assurance Statement. Key points were summarised in a presentation. If approved, the Chair and Chief Executive will sign off the plan for submission to the ICB (Integrated Care Board). Information was shared regarding winter capacity. The Trust has minimal resources for additional winter capacity options. Discussions have taken place with NHSE colleagues about potential solutions, including the possible use of elective surgical wards if required. The Board noted that the lack of ward G&A (General & Acute) bed capacity is the biggest risk for winter. Options under review include keeping Ward 33 open and utilising additional spaces in ESSU, which could increase capacity by 39 beds. Ms J Tomkinson (JT), Chief Executive Officer highlighted that the opening of Ward 33 has not yet been discussed in detail, and the implications of keeping it open will need to be further considered by the Executive Team. Prof A Hassell (AH), Non-Executive Director asked for figures on peak bed usage in winter and how this compares to previous years. SB Confirmed that the modelling matches previous months, with approximately twenty additional spaces available last year. This winter, six hundred and ten patients are projected to need beds, with only five hundred and eighty available, highlighting a shortfall that should be included in the plan Mrs W Williams (WW), Non-Executive Director raised concerns about the impact on frailty patients awaiting discharge with an expected increase over the winter. SB shared that the plan is to concentrate on one ward to improve turnaround time, which should also increase geriatric consultant capacity. AH queried the approach to elective activity over winter. SB explained that elective capacity is note being decreased, elective beds are consolidated into one ward, with agreements in place with Clatterbridge and Wirral to use their capacity if needed. Currently, twenty patients per week are already sent externally, with additional capacity available if required. Mr D Nash (DN), Director of Delivery explained that a deterioration in the annual elective footprint is forecast and has been accommodated in the annual plan. Mrs S Corcoran (SC), Non-Executive Director questioned the confidence in plans, especially as previous discussions did not demonstrate high assurance. SB responded that improvements have been made but sustained rigour and challenge are needed from senior leaders. The Chair and AH emphasised the importance of clearly articulating risks, including the challenge of achieving 78% 4-hour A&E performance and the	

	limitations in surge and bed capacity. The Board agreed these risks should be documented in the plan. The Board acknowledged the significant financial challenges and the difficulty in matching resources and beds to potential surges. The Chair stated that, despite these constraints, the Trust is preparing as best as possible under the circumstances. Mr D Williamson asked about the inclusion of 4-hour and 12-hour A&E trajectories and their interdependencies. SB and JT confirmed these were included in the planning stage and have been reviewed by the Board and Assurance Committee earlier in the year. JT emphasised that the plan has been curated as best as possible within the restraints, we are aware of the risks and will ensure updates are appropriately monitored by the assurance committees. The Chair reiterated the importance of regular updates through the winter months. SC noted that the statement should clarify that rotas will be reviewed (not have been reviewed), and the risk of not doing so is acknowledged. The Board agreed this clarification should be included. **Action:** Winter plan and assurance statement to be updated to reflect the Board discussion and risks prior to submission. With the above caveats and clarifications, the Winter Plan and Board Assurance Statement were **approved** for submission.	**SB**
20.	**Finance & Performance Committee Chair's - 27th August 2025 and 23rd September 2025** The Board received the Finance and Performance 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. Mr P Jones (PJ), Non-Executive Director presented the highlights of the report. The Trust's financial position was broadly on track except for the non-receipt of Deficit Support Funding (DSF), which is adversely affecting the reported deficit. Year-to-date CIP delivery is £4.3m behind plan at Month 5, with under-delivery being mitigated by non-recurrent benefits. There are particular challenges in Urgent Care and Planned Care Divisions, and a deep dive on CIP and urgent care is scheduled for the next meeting. Mrs K Edge (KE), Chief Finance Officer confirmed that an action plan for CIP delivery is in place and will be continue to be reviewed by the Committee. The Board **noted** the Finance and Performance Committee Chair's report.	
21.	**Research Update**	

	Dr P Bamford (PB), Director of Clinical Research provided an update on research activity, emphasising alignment with both Trust and national priorities. Strategic goals: • **Make Research Accessible:** Focus on inclusion, visibility, and equity. Key delivery methods include embedding research in everyday care, promoting engagement, and strengthening patient and public involvement, especially for underserved groups. • **Build Capacity:** Investment in workforce training, mentorship, and career pathways. Expansion of research across specialties and into the community, supported by modern facilities and digital systems • **Strengthen Partnerships:** Agreements and collaborative work with the University of Chester and other higher education institutions. Progress towards Teaching Hospital status and the establishment of the West Cheshire Research Collaborative. Ongoing work with regional research communities • **Work with Life Sciences & the Future:** Building infrastructure for commercial research, engaging with CROs, pharma, biotech, and MedTech firms. Alignment with NIHR Commercial Research Delivery Centre, with the aim to generate income for reinvestment and provide early access to new therapies for patients. Mrs W Williams (WW), Non-Executive Director asked about aligning commercial research interests with community needs. PB explained that research hubs can facilitate patient access and that community-based studies can be delivered through GP services and local hubs, such as Ellesmere Port. The Clinical Research Unit (CRU) is available for studies requiring hospital-based facilities. When asked about future trial numbers, PB noted that trial sizes vary, but the aim is to reach around 1,000 patients per year, with a focus on increasing commercial trials to boost funding. The Commercial Delivery Network is expected to support this ambition. Mr J Bradley (JB), Chief Digital and Data Officer highlighted the importance of technology and collaboration with the Health Innovation Network and neighbouring trusts. PB agreed, noting the agility of smaller trusts and the need for a dedicated focus on research funding opportunities. **Action:** Research Strategy to be brought to the Board in November 2025. The Chair thanked PB for his work and presentation today. The Board **noted** the research update and looked forward to receiving the Strategy. *PB exited at 11.52am.*	**PB**
22.	**Green Plan**	

	Mr J Develing (JD), Director of Strategy and Partnerships provided a summary of the Green Plan. This sets out a refreshed and robust strategy to improve health outcomes, reduce costs, and minimise waste across the Trust. Building on the previous Green Plan, this new strategy prioritises interventions that support world-leading patient care, population health, and the reduction of health inequalities, while tackling climate change and broader sustainability issues. The plan reinforces the Trust's commitment as an Anchor Institution to manage resources and operations in ways that benefit the local community, and aligns with the NHS-wide ambition to achieve net zero carbon emissions. The Board **ratified** the Green Plan 2025-28.	
23.	**Communities and Partnerships** Mr J Develing (JD), Director of Strategy and Partnerships, presented an update on the Trust's communities and partnerships work. The report described a wide range of partnership activities, including engagement with local communities, voluntary and social enterprise sectors, and anchor institutions. The Trust is actively involved in initiatives to improve patient and family experience, population health, and service integration. Assurance was provided to the Board that the Trust is engaged and making progress, despite limited resources to further extend its reach Ms J Tomkinson (JT), Chief Executive Officer noted that JD is progressing this agenda alone and making significant progress, but additional resources will be needed to expand the work and as other priorities become business as usual. The Board **noted** the update.	
24.	**People Committee Chair's Report – 12th August 2025** The Board received 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. Mrs W Williams (WW), Non-Executive Director, presented the following highlights: • The Committee heard a staff story describing the impact of racism and bystander apathy, highlighting the need for deeper cultural change. While HR interventions were noted, it was recognised that culture change requires more than individual action and must be organisation-wide. • The Committee discussed the importance of accountability and the need for a structured approach to culture and leadership. • The Committee noted that some key risks (e.g., culture, staffing in Microbiology and Obstetrics & Gynaecology) have been on the risk register for a long time and further assurance is needed on the actions.	

	The Chair suggested that culture should be considered at the next Board development day. **Action:** Culture to be considered at the October Board development day. The Board **noted** the update.	**VW**
25.	**Annual submission to NHS England North West: Medical Appraisal, Revalidation and Medical Governance** Dr N Scawn (NS), Medical Director, presented the annual update on medical appraisal, revalidation, and medical governance, as required for submission to NHS England North West. The report provides assurance on compliance with the Responsible Officer Regulations and outlines the Trust's commitment to continual quality improvement in professional standards. The submission has already been reviewed by the People Committee (12th August 2025) and is now presented for Board sign-off prior to submission by 31st October 2025. The main change this year is the establishment of a peer support review group with neighbouring trusts to strengthen the appraisal and revalidation process. Mrs S Corcoran (SC), Non-Executive Director requested a clearer executive summary in future submissions. She also queried the monthly governance meeting to discuss concerns raised by doctors (referenced on page 359). NS confirmed that this is the Responsible Officer Advisory Group (ROAG) meeting where concerns about doctors are discussed and actions are agreed. The Board **noted** the assurance provided within the report and approved the Framework and the Statement of Compliance prior to submission.	
26.	**Application of Trust Seal** The Board were asked to approve the application of the Trust seal in retrospect for the Women and Children's build sub-contractor collateral warranties. The Board **approved** the use of the Trust Seal in retrospect.	
27.	**Fit & Proper Persons Policy** Mrs K Wheatcroft (KW), Director of Governance, Risk & Improvement outlined the key changes to the Fit & Proper Persons Policy following recommendation from a recent internal audit. Prof A Hassell (AH), Non-Executive Director raised a concern that the dispute resolution section currently reads more like guidance than a policy. In response, KW agreed to update this section to make it more specific and	

	policy-driven but confirmed it had been approved by Mersey Internal Audit Agency (MIAA). **Action:** Review wording regarding dispute resolution process. There was a question of whether the policy needs to go to the Board for approval. It was suggested that while it could be considered by the Audit Committee, it is important for the Board to have sight of this policy. The Board **approved** the Fit and Proper Person Policy subject to the above amendment.	**NC/KW**
28.	**Operational Management Board Terms Reference** The Operational Management Board Terms of Reference were presented. These had been updated and approved at the last meeting of the OMB and now required Board approval. The Board **approved** the revised Terms of reference for the Operational Management Board.	
29.	**Proposal to amend the Trust's Constitution** Mrs K Wheatcroft (KW), Director of Governance, Risk & Improvement, presented the proposed amendments to the Trust's Constitution, as summarised in the supporting paper. The amendments included: • updating the Board composition to reflect the number of Executive and Non-Executive Directors, • introducing a University-appointed Non-Executive Director to support the Trust's ambition for teaching and university hospital status, • simplifying Governor membership of the Nominations Committee, and • making minor updates for accuracy and regulatory compliance. The Chair highlighted the caveat regarding the inclusion of the University Non-Executive Director appointment and that there was flexibility as to whether we would have a university NED and that any proposed appointment would be considered by the Trust and not automatically accepted The Board reviewed and **approved** the proposed amendments to the Constitution. The changes will also be submitted to the Council of Governors for approval, as required by the Constitution.	
30.*	Items for noting and receipt (attached):	

	***Sent under separate cover*:** **Minutes of Committee Meetings:** a) Approved minutes of the Quality & Safety Committee – 3rd July 2025 (attached) b) Approved minutes of the People Committee – 10th June 2025 (attached) c) Approved minutes of the Finance & Performance Committee – 25th June 2025 (attached) d) Approved minutes of the Operational Management Board – 22nd May 2025 (attached) e) Research and Innovation Committee Chair's report – 5th September 2025 and Approved minutes - 16th July 2025 (attached) Mr P Jones (PJ), Non-Executive Director highlighted the alerts and risks detailed in the research chair's report and questioned whether this information should be included in the noting pack or in the main body of the agenda. In response, Karan stated that the reporting structure for the Research and Innovation Committee needs to be clarified. **Action:** To confirm the reporting structure of the Research and Innovation Committee. **Other items:** f) Board of Directors Workplan 2025/26 (attached).	**KW/ PB**
31.	**Any Other Business** There was no other business to raise. The Chair reiterated the need to improve the executive summaries and length of the reports received. The Chair thanked everyone for their contributions and closed the meeting.	
32.	Questions from Governors and members of the Public relating to items on the meeting agenda - ***Questions to be submitted in writing in advance of the meeting to:*** coch.membershipenquiriescoch@nhs.net ***by Thursday 25th September 2025*** **Visa Sponsorship** Ms V Wilson(VW), Chief People Officer updated the Board that Unison leads and healthcare assistants (HCAs) had submitted questions in advance and are attending the meeting to present their concerns to the Board. Approximately ten Unison and HCA staff were in attendance. HCA's present explained the impact of recent new government sponsorship salary threshold. They asked the Board to consider options, highlighting implications for recruitment and retention. Personal testimonies were shared. The Board discussed arrangements for Band 3 and Band 4 staff in relation to the visa sponsorship threshold. VW clarified that the Trust sponsors over four hundred staff, mostly in unskilled roles, and that the government's	

	£25,000 threshold applies to contractual hours. The Trust has not considered increasing contractual hours and cannot artificially adjust contracts to meet the threshold. The Trust will continue to use sponsorship where appropriate but must operate within legal and contractual requirements. It was confirmed that only one current staff member is directly affected, but around eighty-five staff are on different visa types and may be impacted. HR are working through the information to clarify the position for all affected staff. Ms J Tomkinson (JT), Chief Executive Officer thanked the HCAs in attendance, reiterating the value of overseas staff. JT reinforced that she was committed to exploring all lawful options to support and retain them, while recognising the legal and financial constraints. The Board recognised the impact these decisions have on people's lives and that options should be explored on a case-by-case basis and with legal and financial parameters. Unison representatives expressed disappointment at the lack of earlier resolution and shared that a petition with two hundred and eighty signatures has been collated. **Action:** the impact of the national thresholds for visa sponsorship to be clarified for all affected staff and all options to be explored, recognising the legal and financial constraints. The Board thanked staff for attending and sharing their experiences. The importance of timely action and clear communication was acknowledged. **Future Board Dates:** 25th November 2025 27th January 2026 31st March 2026	**VW**
33.	Closing remarks	

Next Meeting: Tuesday 25th November 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 November 2025

Action No.	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 an increase in the number of concerns raised and a deep	Sept-25	**Closed**

Action No.	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/ Outcome	Due Date	Status
						dive of concerns has been completed and presented.		
2	29th July 2025	Chief Digital and Data Officer	16.	Integrated Performance Report (IPR) – June 2025	Mr J Bradley, will develop mock-ups and consult with the Executive team and Committees, aiming for implementation by September 2025.	Draft to be shared at October Strategy Day. **Update 10th November 2025** - J Bradley presented on the development of trajectories at the October 2025 Board Development Day. First set of trajectories to be added to IPR for the November 2025 Trust Board Meeting.	Sept -25	**Open**
3	30th September 2025	Director of Nursing & Quality / Deputy Chief Executive	12.	Care Quality Commission (CQC) Improvement Plan including Well Led	Review how CQC action plan is monitored and reported to Board.	Deferred to January 2026 to incorporate all aspects.	Jan-26	**Open**
4	30th September 2025	Medical Director/ Director of Nursing & Quality	15.	National Inpatient Survey Results	It was agreed to add an update on the discharge pathway to the November Board agenda.	**Update 17th November 2025** – Deep Dive to be included alongside NCTR at the December 2025 Board Development Day.	Nov-25	**Open**
5	30th September 2025	Chief Operating Officer/Deputy Chief Operating Officer	15.	National Inpatient Survey Results	An update on the ECIST review of the acute model and service redesign to be bought to the Board.	**Update 21st October 2025** – ECIST review not due to take place until November. This will be reported as part of patient flow/ED plan to Finance and Performance	Nov-25	**Closed**

Action No.	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/ Outcome	Due Date	Status
						and Quality and Safety Committees.		
6	30th September 2025	Deputy Chief Operating Officer	19.	Winter Planning and Board Assurance Statement	Winter plan and assurance statement to be updated to reflect the Board discussion and risks prior to submission.	**Update 31st October 2025** – Confirmed this has been updated and submitted.	Oct-25	**Closed**
7	30th September 2025	Director of Clinical Research	21.	Research Update	Research Strategy to be brought to the Board in November 2025.	**Update 17th November 2025** – Research Strategy deferred to the January 2026 Board of Directors for the Strategy to go through Research & Innovation Committee.	~~Nov-25~~ Jan-26	**Open**
8	30th September 2025	Chief People Officer	24.	People Committee Chair's Report – 12th August 2025	Culture to be considered at the October Board development day.	A culture session took place at the Board Development Day 22nd October 2025.	Oct-25	**Closed**
9	30th September 2025	Director of Clinical Research/ Director of Governance, Risk & Improvement	30.	Minutes of Committee Meetings: Research and Innovation Committee Chair's report – 5th September 2025 and Approved	To confirm the reporting structure of the Research and Innovation Committee.	**Update 17th November 2025** – Research & Innovation Committee reports through Operational Management Board	Nov-25	**Closed**

Action No.	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/ Outcome	Due Date	Status
				minutes - 16th July 2025				
10	30th September 2025	Director of Governance, Risk & Improvement/ Head of Corporate Governance	27.	Fit & Proper Persons Policy	Review wording regarding dispute resolution process.	**Update 18th November 2025** – Section amended to remove NHSE appointed roles with options aligned to COCH as a Foundation Trust.	Nov-25	**Closed**
11	30th September 2025	Chief People Officer	32.	Questions from Public: Visa Sponsorship	The impact of the national thresholds for visa sponsorship to be clarified for all affected staff and all options to be explored, recognising the legal and financial constraints.	**Update 18th November 2025** – verbal update to be shared at the November 2025 Board.	Nov-25	**Open**

(PUBLIC) Board of Directors
25th November 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** **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 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	Contributes to 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

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

1. National

Earlier this year NHSE published the operating model for regions, describing core functions and the transition of duties that will transfer from Regions to Integrated Care Boards (ICBs).

In turn, the model ICB Blueprint has now been published describing `strategic commissioning` as the central purpose for integrated care boards going forward. Strategic commissioning being defined as 'a continuous evidence-based process to plan, purchase, monitor and evaluate services over the longer term and with this improve population health, reduce health inequalities and improve equitable access to consistently high-quality healthcare.'

The strategic framework outlines an updated commissioning cycle, which ICBs are expected to deliver for all NHS services. ICBs are expected to work with local government in using this approach.

2. Regional Updates

The Cheshire and Merseyside ICB continues to focus on recovery priorities and has written to providers setting out the challenges and delivery expectations.

Cheshire & Merseyside priorities to ensure winter preparedness including provider operating plans as well as vaccinations campaigns, use of 111 services and joint pharmaceutical needs assessments.

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

October 2025

The CMPC Leadership Board met on the 3rd October discussed the need and opportunities that derive from developing an evidenced-based approach to provider action that is framed by what patients need and want and not dictated or shaped by NHS structures or institutions. Discussions included the potential to partner with suppliers in this space. Consideration would be given to system resource that could support development of this approach which was considered essential but equally the need for an aligned implementation plan on how services could or should be delivered in the most efficient, productive and safe way going forward.

The second half of the meeting focussed on discussion and agreement of the priorities for CMPC:

- Planned care
- Community and Patient Flow
- Blueprint
- Clinical Pathways / Fragile Services
- Efficiency at Scale including Corporate Services

- In year delivery

With subject matter leads also being identified for cancer, mental health and CYP.

The way the Leadership Board works with, connects and uses Trust leadership capacity was also discussed with the need for CEO link officers with the following groupings agreed:

- Chief Operating Officers
- Strategy Directors and Company Secretaries, Communications & Engagement
- Clinical forum – Medical Directors / Directors of Nursing
- Directors of Finance
- Chief Digital Officers
- Chief People Officers

The Board also explored the current ask of providers and coordination of actions in respect of system recovery.

4. Cheshire, Warrington and Wirral

The development of the provider blueprint – part of the CMPC priorities, will shift the focus from the Cheshire, Warrington and Wirral footprint to ensuring that all future partnerships are built on the foundation of the Cheshire and Merseyside Blueprint.

5. Cheshire West

Cheshire West system held a workshop with regards to neighbourhood health with voluntary, community and faith-based groups in attendance. This is part of embedding the contribution of all partners in neighbour health and wellbeing.

6. National Cost Collection

On 6 November 2025, NHS England published the 2024/25 National Cost Collection (NCC) data, including the national schedule of NHS costs, the NCCI index, and organisation-level cost files (both MFF-adjusted and unadjusted). The Countess of Chester's NCCI score for 2024/25 is 96 unadjusted and 98 when adjusted for Market Forces Factor, placing the Trust below the national average cost benchmark.

Finance and Performance Committee will receive a full report on the outcome of the NCC at their next full meeting.

7. Future Workforce Solution (New ESR) Contract

On 14th October, NHS Business Services Authority (NHSBSA) announced it has awarded a £1.2 billion contract to Infosys to deliver a new and enhanced workforce management solution for the NHS. The Future NHS Workforce Solution will succeed the Electronic Staff Record (ESR) and implementation is expected to be completed by 2030.

8. Care Quality Commission Consultation

On 16th October the Care Quality Commission (CQC) launched a consultation on 'Better regulation, better care: consultation on improving how we assess and rate providers'. The consultation has 2 key areas of focus which are proposals for developing the framework and guidance for assessing providers; and proposal on changes to the methods for inspecting, assessing and awarding ratings to health and care services.

The Trust is currently reviewing the consultation with a response to be developed and submitted in line with the deadline of the 11th December 2025.

9. Annual NHS Staff Survey 2025

The 2025 NHS Staff Survey launched in September, providing all colleagues with a critical opportunity to contribute their views on workplace experience and service delivery. The survey, which takes approximately 15 minutes to complete, is a key instrument for shaping both national NHS transformation and local Trust improvements. Staff participation is actively encouraged, with managers supporting protected time for completion. At the time of writing 35% of staff had completed the survey. Insights gathered will guide visible and timely changes, helping leadership identify strengths and areas requiring further attention to strengthen care quality and staff support. The feedback from this survey will underpin future planning and inform our commitment to being a better employer.

10. Women and Children's Building leading the way on Net Zero

Our Women's and Children's building was announced as the first NHS Net Zero building in England – fully electric, powered by renewables, and built to get greener as the UK grid decarbonizes. It is in the top 10% most energy-efficient buildings in the UK. Thoughtfully designed: sensory rooms, tranquil gardens, light-filled wards. This was a proud moment for Chester and COCH – leading the way as an anchor institution. A huge thank you to our staff, community and partners for their hard work.

Clinical teams planned, tested and rehearsed for months ahead of the opening to ensure patients were moved seamlessly into the new facility.

Demolition of the old building, which was constructed in the 1970s, will begin in the coming weeks and be completed by the end of the current financial year. Clearly there are sensitivities around the deconstruction of the original Neonatal unit and this is recognised via the nature of the contractors to undertake the work. Subsequent discussions with the families and staff regarding a suitable memorial will be undertaken.

11. Opening of double maternity Theatre Suites at Countess of Chester Hospital

In September 2025, the Countess of Chester Hospital's new Women and Children's Building became one of the few NHS sites nationwide to offer two purpose-built maternity theatre suites dedicated exclusively to maternity care. This significant enhancement enables the hospital to provide uninterrupted, timely access to theatre services for planned and emergency caesarean sections, eliminating delays and improving patient safety and choice.

Feedback from patients has been overwhelmingly positive, highlighting the modern facilities, calm environment, and the reassurance provided by accessible, dedicated care. The Director of Midwifery reports that the dual-theatre provision is already making a tangible difference, particularly for those planning caesarean births.

12. New Stroke Ward

A newly refurbished stroke ward has opened at the Countess of Chester Hospital, marking a significant improvement in patient care and recovery. The ward offers enhanced facilities including increased bed capacity, a brighter and more therapeutic environment, and improved infection control measures. Wider corridors, ceiling-mounted heat panels, and carefully designed lighting contribute to patient safety and comfort, while a refurbished garden supports rehabilitation and family visits. Sustainability has been integrated through the re-use of materials from other hospital buildings. Staff within the stroke team contributed to the ward's design to ensure it meets the real needs of patients and carers.

13. Faster diagnosis in bowel cancer services

The Countess of Chester Hospital has been recognised as the leading hospital in England for rapid bowel cancer diagnosis for four consecutive months. Nearly all patients with suspected bowel cancer now receive a diagnosis or all-clear within four weeks of GP referral, meeting and often exceeding the NHS Faster Diagnosis Standard. Endoscopy procedures are typically booked within two weeks, further supporting timely care.

Performance has improved significantly, with the proportion of patients diagnosed within four weeks rising from 31% in April 2023 to 93% by July 2025. This achievement is particularly beneficial for communities at higher risk of late diagnosis, contributing to fairer and more equitable cancer care.

This success has been made possible through the dedication of diagnostics, gastroenterology, and cancer care teams, despite ongoing financial challenges and historical changes in leadership. While the Trust continues to address broader organisational issues reflected in the National Oversight Framework, this milestone demonstrates the delivery of excellent patient outcomes in a critical area.

The Trust remains committed to further improvements, ensuring high-quality cancer care for Chester and the surrounding areas.

14. Hospital Sterilisation Decontamination Unit Accreditation

Following the conclusion of an annual external audit of our HSDU department for compliance with ISO 13485:2016, we achieved a pass in every area under review – something we have not accomplished in over 20 years. The auditors were highly complimentary, noting the professionalism, knowledge and diligence consistently demonstrated by our staff

15. Caring for Patients with Additional Needs Strategy

We have launched a new Caring for patients with additional needs strategy. This strategy outlines how the Trust supports patients with learning disabilities, autism, and dementia across

their hospital journey — from admission to discharge. It focuses on ensuring equitable access to care, personalised support, and legal compliance through reasonable adjustments and staff training

The strategy is available on the Safeguarding and Complex Care Team intranet page along with a 7 minute brief.

16. Virtual Tour

The Trust has launched an innovative, fully interactive virtual hospital tour designed to support patients and carers, particularly those with additional needs. Developed in partnership with the Safeguarding and Complex Care Team and Bartex Design, and funded by NHS Cheshire and Merseyside, the tool offers 360° navigation, clickable hotspots, and access to key hospital areas. This initiative directly addresses feedback from individuals with additional needs, aiming to reduce anxiety and improve familiarity with the hospital environment. The tour aligns with the Trust's Additional Needs Strategy and Patient and Family Experience Strategy, reinforcing the organisation's commitment to inclusivity, transparency, and enhancing patient experience. The virtual tour is freely accessible via the Trust's website and is intended to benefit all patients and families by making hospital visits more manageable and reassuring.

17. Winter Plans and Trust Flu vaccination programme

The Trust has submitted its winter plan to the Cheshire and Merseyside Integrated Care Board. We have already seen increasing demand through our Accident and Emergency Department in October and November with escalation areas already in use. Wider patient flow improvement plans are progressing and we are working closely with partners and have sought external support to help improve our services.

The Trust continues to deliver the flu vaccination programme with **1,600** vaccinations given in October 2025, and **197** planned and drop in visits across **55** different work areas. The vaccination campaign will continue throughout November.

18. Industrial Action: Resident Doctors Strikes

The British Medical Association (BMA) formally announced intentions for their junior doctor members to conduct a continuous period of strike action beginning 6.59am on 14th November until 6.59am on 19th November 2025. The Trust developed robust plans to manage services during this time, with a clear focus on emergency services, patients safety and minimizing disruption to elective treatment.

The BMA has a six-month mandate for industrial action, covering the period from 21st July 2025 to 7th January 2026.

19. Board Leadership update

We are delighted to welcome Hasintha Gunawickrema and Peter Williams as new Non-Executive Directors to our Board. They bring a wealth of experience in financial management, risk, and technology transformation.

We also thank Mick Guymer, Pam Williams, and David Williamson, who have contributed significantly to the Trust during their terms of office as Non-Executive Directors.

(PUBLIC) Board of Directors
25th November 2025

Report	**Agenda Item 9a.**	**Board Assurance Framework – 2025/26 Q2 Update**						
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 at Q2 2025/26. This paper provides an update to the Board of Directors along with the full BAF, 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. Strategic objectives have been updated following review at Q2. The report demonstrates the progress being made against key actions aligned to BAF risks and strategic objectives including: • Delivery of Referral to Treatment (RTT) plans to drive delivery of NHS planning standards • Delivery of integrated Urgent and Emergency Care (UEC) and patient flow action plan with partners • Ward accreditation programmes and harm reduction • Continued focus on leadership development and culture • Partnership governance (including Cheshire and Wirral Partnership/ Countess of Chester Hospital Joint Committee formally established) and collaboration models • Governance organogram developed • Risk management improvements continuing to progress with a current focus on development and roll out of guidance and training • Medium term finance strategy development • Digital and Data Strategy refresh and delivery of digital priorities • Green plan refresh and approval by Board
Recommendations	The Board of Directors is asked to: (i) **approve** the updates to the 2025/26 Board Assurance Framework at Q2 (ii) **note** the update on progress in delivering strategic objectives

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

Board Assurance Framework (BAF) 2025/26 Q2 Update

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 with both approved by the Board in July 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 update of the 2025/26 BAF, including actions to mitigate and manage strategic risks, and delivery of the 2025/26 strategic objectives.

2. BAF RISKS ALIGNED TO STRATEGIC GOALS

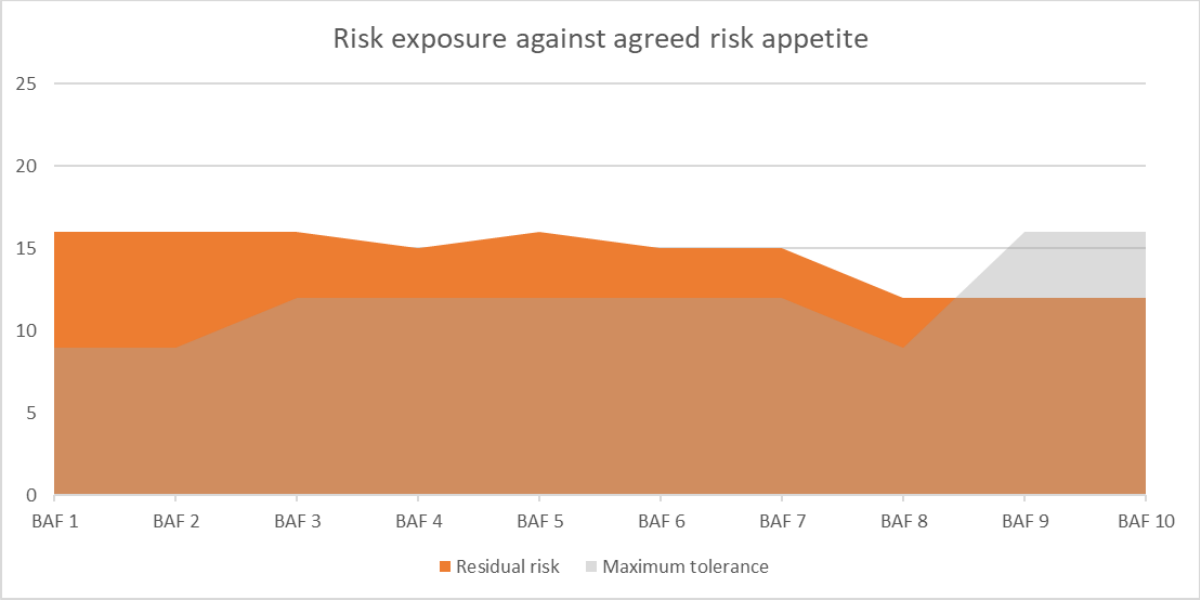
Alignment to strategic goals and objectives has been included within the BAF, with strategic objectives shaded within the key controls. The current risk exposure against the strategic goals is summarised below.

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

Strategic objectives have been reviewed and updated at Q2. Progress against strategic objectives has been aligned to the BAF. Key updates include:

- Delivery of RTT plans to drive delivery of NHS planning standards
- Delivery of integrated UEC and patient flow action plan with partners
- Ward accreditation programmes and harm reduction
- Continued focus on leadership development and culture
- Partnership governance (including CWP/ COCH Joint Committee formally established) and collaboration models
- Governance organogram developed
- Risk management improvements continuing to progress with a current focus on development and roll out of guidance and training

- Medium term finance strategy development
- Digital and Data Strategy refresh and delivery of digital priorities
- Green plan refresh and approval by Board

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

5. RECOMMENDATIONS:

The Board of Directors is asked to:

(i) **approve** the updates to the 2025/26 Q2 Board Assurance Framework

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

Appendix A – Summary of strategic risks above risk appetite

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

Principal Risk	Current Risk Score	Target Risk Score	Assurance Level	Key Actions progressing
BAF1. Failure to maintain **quality of care** would result in poorer patient & family experience	**16**	**9**	Partial	• Continued focus on consistency of application of standards • IPC compliance • UEC CQC action plan progress and embedding
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 delivery • Mental health steering group
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	• RTT recovery plan delivery • Delivery or the integrated patient 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 • 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 • Planning framework and guidance • Delivery of CIP schemes and PDO support • Cash management
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 2025/26 • Capital planning to commence for 2026/27 (3 year plan) • Continued RAAC failsafe and inspections continuing until final decant
BAF7. Failure to deliver transformative **digital and data** solutions and performant, secure and resilient infrastructure could impact on patient and staff experience	**15**	**12**	Partial	• Digital and data strategy refresh and audit • Cyber assessment framework and cyber security protection plans • Infrastructure developments

Principal Risk	Current Risk Score	Target Risk Score	Assurance Level	Key Actions progressing
and organisational productivity.				• 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 • Regulatory compliance and assurance map • 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 have been reviewed and updated for 2025/26 in Q2.

Strategic Objectives	Lead	Progress
SG1 Patients and Family		
Ensure consistent application of quality and safety standards	SP	Continuing to drive improvement through harm reduction programmes and bi-monthly review of progress with leads. Accreditations are demonstrating improvements with the majority of areas now accredited at Silver and some at Gold.
Develop and deliver a robust plan to deliver 2025/26 operational planning targets, both in aggregate and at specialty level.	CC	The Trust continues to meet the elective long waiting targets, the reduction in suspected long and long waiting cancer patients. From September 2025, as per the recovery trajectory, the Trust returned to to RTT compliance levels that were in line with the annual plan and made significant improvements in compliance. Access to UEC services remains 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 continues to work with the wider systems and local authorities to enable an improved number of complex discharges. The Trust has extended the UTC opening hours to 10pm for minor illness and injuries. The flow improvement plan is being re- aligned with a new meeting, chaired by the Medical Director, with each area identifying priorities and a taking a focus on assessing the impact of the actions taken.
Develop a programme of patient and family engagement.	SP	Patient and family engagement events held across some services. A structured programme is currently being developed.
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 to be circulated to stakeholders prior to approval.
SG2 People and Culture		
Develop staff experience, engagement, wellbeing, morale and culture	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. Staff survey action plans being monitored at sub committee level. 2025 staff survey in progress.
Develop fit for the future workforce plan	VW	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.
SG3 Leadership		
Deliver the clinical strategy	NS	Clinical Strategy approved and launched. External engagement events held by the Director of Strategy and Partnerships (July 2025). Discussions progressing on delivery priorities and approach to updates. Review of fragile services alongside collaboration agenda.

Develop our leadership capability	VW	Leadership framework established and programmes rolled out for clinical leaders, aspiring leaders (band 2-4) and lead managers. Basic skills for manager training launched in Q1 2025/26. Training needs analysis progressing alongside the national work. NETS currently open until 2nd December and action plan will be developed for review and monitoring through the Education, Learning and OD Sub Committee.
Ensuring governance and risk management is in place across the organisation	KW	Committee organagram developed and including sub committee structures and Divisions. Work underway to support Divisions to ensure consistency and effectiveness of governance aligned to Accountability Framework. 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, significant Datix developments actioned and priorities agreed with Divisions including training roll out.

SG4 Adding Value		
Development of a new financial plan and medium term financial sustainability 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. Consideration of financial strategy approach Board strategy day (June 25). Planning framework published outlining requirements for 5 year plan. Awaiting further guidance.
Advance digital solutions in support of transforming care	JB	Strategy to be presented at December Finance & Performance Committee. MIAA strategy audit follow up - deferred to Q3. Digital Maturity Assessment 2025 and EPR usability survey reports to be presented at December 2025 Finance & Performance Committee.
Develop and deliver the refreshed Green Plan.	JD	Anchor Institution Accreditation received July 2025. National guidance published in February 2025. Trust Green strategy refreshed and approved by Board September 2025

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.
Take a leadership role within the new Cheshire and Merseyside Provider Collaborative and partnership with partners.	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. Cheshire and Merseyside Provider Collaborative now integrated with Mental Health Services, to be known as CMPC. TORs and joint working agreement approved by the Board September 2025). Cheshire and Merseyside Provider Blueprint being developed in response to Regional and ICB operating models.
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		
Embed the health inequalities framework within clinical services	JD	Board development session held in October - raising education and training awareness of health inequalities at a national, Core20plus5, regional (Marmot) and local level using CIPHA data. Roles and responsibilities of Board members discussed and self assessment undertaken.

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:** November 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.	(i) Bi monthly meeting with leads of improvement programmes within Q&S strategy to monitor progress. (ii) Programme of accreditation in place. **Action owner:** Director of Nursing and Quality **Due date:** Quarterly updates	Continuing to drive improvement through harm reduction programmes and bi-monthly review of progress with leads. Accreditations are demonstrating improvements with the majority of areas now accredited at Silver and some at Gold.	*9*	*Mar-26*
										Develop a programme of patient and family engagement events **Action owner:** Director of Nursing and Quality **Due date:** Quarterly updates	Patient and family engagement events held across some services. A structured programme is currently being developed.		
			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.	**ADD**	Trust is seeing reductions across most of the HCAI. IPC compliance has improved supported by audit outcomes.		
			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. Significant progress against the action plan with assurance provided to Q&S Committee and the Board.		
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:** November 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	*4 x 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 compliance. **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. Sepsis Lead attended Board to provide an update on actions. Improvements progressing and focus extended to wider Trust.		
			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 to be circulated to stakeholders prior to approval.		
			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:** Quarterly updates	Clinical Strategy approved and launched. External engagement events held by the Director of Strategy and Partnerships (July 2025). Discussions progressing on delivery priorities and approach to updates. Review of fragile services alongside collaboration agenda.		
			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. Task and finish group implemented immediately to look at remedial actions. CWP Director of Nursing walk around new Millbrook unit New BAU Steering Group in place led by respective execs from CWP and COCH (montlhy) this inlcudes external partners ie Cheshire Police. 136 protocal and action plan developed - New standards operating models in place for clinical practice and escalation. Governance of the steering group align with joint executive committe of CWP/ COCH which has agreed TORs.		

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:** November 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 improvement 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 and long waiting cancer patients. From September 2025, as per the recovery trajectory, the Trust returned to to RTT compliance levels that were in line with the annual plan and made significant improvements in compliance. Access to UEC services remains 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 continues to work with the wider systems and local authorities to enable an improved number of complex discharges. The Trust has extended the UTC opening hours to 10pm for minor illness and injuries. The flow improvement plan is being re- aligned with a new meeting, chaired by the Medical Director, with each area identifying priorities and a taking 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	North West performance report overseen by ICB. Contract review meetings. System Oversight Group.	*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. To ensure the whole Trust Board is aware of progress for UEC/RTT and Cancer there have been presentations at Board development sessions.		

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:** November 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 Pay Control Panel in place for authorisaton of vacancies and variable pay. Weekly monitoring of whole time equivalent against plan. Plan being developed to roll out e'rostering for AfC staff commenced feb 2025, with current focs on diagnostics, estates and facilities, and therapies. Medical e'rostering procurement underway with contract signed and implementation to commence mid November 2025.	*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 - People and Culture Sub Committee AAA report to 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:** Complete	Civility statement developed through wide engagement, approved by the Board (May 24) and rolled out. Current focus includes zero tolerance and tackling poor behaviours. Staff survey action plans being monitored at sub committee level. 2025 staff survey in progress.		
									Consistency of wellbeing support.	Improving the consistency of the Trust wellbeing offer. **Action Owner:** Chief People Officer **Due date:** Complete	Staff hub opened (2024/25) and wellbeing offer includes physical, mental and financial. Developed resources to support managers and staff with violence and aggression. Financial wellbeing support to be launched in December 2025.		
									improving staff experience, ensuring accountability and consistency of behaviours aligned to our values	Structured approach to improving culture and staff experience **Action Owner:** Chief People Officer **Due date:** Quarterly updates	NHSE and Kings Fund culture and leadership programme, currently in discovery phase.		
			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. Statutory reporting in place, positive improvements being made and review through established governance structures. Further focus on anti-racism framework progress.		
			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 launched in Q1 2025/26. Training needs analysis progressing alongside the national work. NETS currently open until 2nd December and action plan will be developed for review and monitoring through the Education, Learning and OD Sub Committee.		

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:** November 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 FPRM	*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. Consideration of financial strategy approach Board strategy day (June 25). Planning framework published outlining requirements for 5 year plan. Awaiting further guidance.	***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 - Finance & Performance 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 FPRM NHSE mid year review	*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	(i) Continue to work with the C&M ICB. (ii) Develop forecasting updates for Board complying with NHSE template approach. **Action Owner**: Chief Finance Officer **Due date**: Quarterly updates	Inquiry funding supported by NHSE for 2025/26. Pay award funding and impact assessment complete and not a pressure. System work continues on levels of NC2R and subsequent impact on escalation costs with little improvement acheived. PWC have completed a grip and control review and Trust leads have been assigned to the action plan as reported to Board.		
			C3) Cost Improvement Programme including Quality Impact Assessments **Control Owner**: Chief Finance Officer	- Weekly CIP delivery group reporting to F&P. - Finance & Performance Committee papers. - Programme Delivery Office report to Board.	Financial Plan NHSE Template Weekly returns to ICB and NHSE and provider benchmarking of progress FPRM	*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. 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. Director of Delivery seconded and PDO now in place supporting and accelerating delivery.		
			C4) Cash Management **Control Owner**: Chief Finance Officer	- Finance & Performance Committee papers. - PDO report to Board of Directors.	Financial Plan NHSE Template Weekly returns to ICB and NHSE FPRM	*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 Q3 application underway. Cash preservation plan developed. Monthly updates to Board and plans in place upto end of Q3.		
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:** November 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. Confirmed arrangements in place for 2025/26. Planning framework published with further detail awaited.	***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) but confirmation received this was unsuccessful. 25/26 capital planning complete and majority of business cases drawn up and approved following prioritisation meeting held Feb 25. Capital planning to commence for 2026/27 to include a 3 year plan.		
			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 - Estates report to Finance and Performance Committee - Estates and Facilities Committee reports via Finance and Performance 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. Majority of decant achieved with further discussions taking place regarding Ward 33. Procurement underway for demolition.		

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 (Jul 2025) and formal Trust Board (Aug 2025)	MIAA Digital strategy audit (Jan-Mar 25)	*Partial*	*5 x 3 = 15*	NO	Strategy refresh required 2025 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) and 10 year health plan for England. **Action Owner:** Chief Digital and Data Officer **Due date:** December 2025 (ii) MIAA to conduct audit of Digital and Data Strategy. **Action Owner:** Chief Digital and Data Officer **Due date:** Q1 25/26 awaiting final report. - Awaiting update from MIAA	Strategy to be presented at December Finance & Performance Committee. MIAA strategy audit follow up - deferred to Q3. Digital Maturity Assessment 2025 and EPR usability survey reports to be presented at December 2025 Finance & Performance Committee.	**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 - Microsoft D	*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 action plan is being worked through ahead of initial submission by end of December 2025. MIAA review of progress against DSPT action plan to be completed in November 2025.		
										(ii) Deliver plan to maintain infrastructure health **Action Owner:** Chief Digital and Data Officer **Due date:** Sep 2025 Phase 1 - Completed Mar 2026 Phase 2	MIAA will conduct an audit of the main data centres in November 2025. A programme of work is under way to replace legacy network hardware across the organisation following capital funding.		
										(iii) Deliver Cyber Security protection plan **Action Owner:** Chief Digital and Data Officer **Due date:** March 2026	The Trust is now fully onboarded for Microsoft Defender for Identity (MDI). Password management and hygiene software (SpecOps) has been configured and is currently being piloted within the trust. Work continues to isolate data backups and backup related network activity from the central network Due for completion in Q4 25/26.		
			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 - Successful EPR upgrade in Sept 2025	- 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 to August 2025 - complete EPR Upgrade September 2025 - complete EPR Optimisation phase 2 to Mar 2026 Ophthalmology EPR by Mar 2026 Business case for Chemotherapy Electronic Prescribing system by Mar 2026	EPR upgrade completed in Sept 2025 eRS integration due to be live in December 2025 . Tools deployed for sepsis, emergency procedures, medical take deployed. Business case being developed for procurement of new Ophthalmology system - Q2 25/26. Final business case to be agreed - target November 2025. Options for Chemotherapy Electronic Prescribing solution have been reviewed. Next step is to develop a business case for procurement.		
			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 and first indicators added to IPR. A review of the IPR has taken place with key leads and several updates have been made. Trajectories / plans to be added to key IPR metrics.		
										Adopt NCF Framework for internal service development **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 the Data and Analytics teams		
			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) DSDN Level 3 accreditation. (April 2025)	*Partial*			Fit for the future workforce plan.	Workforce plan review, including data scientist capabilities and "digital innovation team". Develop options for a clinical digital team alongside the CCIO and CNIO. **Action Owner:** Chief Digital and Data Officer **Due date:** Workforce plan September 2025 - has been delayed until December 2025 to allow alignment with new strategy.	Regional digital workforce plan in development. Local plan to be developed following changes in WTE's within service.		

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:** November 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 including sub committee structures and Divisions. Work underway to support Divisions to ensure consistency and effectiveness of governance aligned to Accountability Framework. 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, significant Datix developments actioned and priorities agreed with Divisions including training roll out.	***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	*Acceptable*			Clarity 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:** Complete (BAU)	CWP/COCH Joint Committee established. New CMPC Leadership Board TOR and Joint Working Agreement approved by the Board (September 2025). Support provided on discreet projects/ developments (e.g. Pathology South Hub). Further work through BAU 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 revised. We continue to understand, share and embed learning from the Inquiry, with the report anticipated in early 2026.		

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:** November 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**: Completed Sept 2025	Representation and engagement continues across a range of forums. New manadatory `Communities and Partnerships return develop, and approved by the Board as assurance of activities undertaken.	*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 framework. **Action Owner:** Director of Strategy & Partnerships **Due date:** Complete	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.		
										Embed population health tools into community services as a menas of managing those patients most at risk of hospital admission. **Action Owner:** Director of Strategy & Partnerships **Due date:** Quarterly updates	An outline approach to Health Inequalities has been developed and 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	*Acceptable*			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:** Complete.	Anchor Institution Accreditation received July 2025. National guidance published in February 2025. Trust Green strategy refreshed and approved by Board September 2025		
			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 include cabinet office approval, and tender documents. **Action Owner:** Director of Strategy & Partnerships **Due date:** Quartley 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. Further discussion are required in advancing the FBC taking into account the 2026/27 planning and opeartional guidance, deivery of RTT and new VAT rules. Clnical engagement and development of the clinical model will continue in the background.		
			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:** Quarterly updates	An exec to exec group was held 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. Joint committee now in place with agreed TORs and reporting to Board will commence.		
									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 and collaboration progressed. **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. Cheshire and Merseyside Provider Collaborative now integrated with Mental Health Services, to be known as CMPC. TORs and joint working agreement approved by the Board Sseptember 2025). Cheshire and Merseyside Provider Blueprint being developed in reponse to Regional and ICB operating models.		

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:** November 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**: Q4	Research ambitions to support strategy development being aligned to the clinical strategy. Research Strategy being drafted for Board in January 2026.	***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. Progress made 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	Continue to work 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. Operational innovation continues to be encourage including Trust wide engagement in system led Innovation fortnight (November 2025).		

Board Assurance Framework

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

5x5 risk scoring matrix:

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

Risk Appetite Levels

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

(PUBLIC) Board of Directors
25th November 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	Executive Directors Group – 12th November 2025						
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 13 risks with a residual score of 15 or over and these risks include: • Reinforced Autoclaved Aerated Concrete (RAAC) • Waiting lists and overdue follow ups • Equipment and assets • Staffing levels and gaps in resources						

	• Cyber Security • Estates and infrastructure • Finance (Cost Improvement Programme (CIP) Delivery and Cash Management) • Level of Non-Criteria Reside (NCTR) patients • Management of patients outside of bed base
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 13 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	6
16	7
Grand Total	**13**

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
- Staffing levels and gaps in resources
- Cyber Security
- Estates and infrastructure
- Finance (CIP Delivery and Cash Management)
- Level of Non-Criteria Reside (NCTR) patients
- Management of patients outside of bed base

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 November 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
24/01/2025	3398	Multiple factors that could result in a Cyber Attack- several separate areas of risk that could contribute to a Cyber attack. Separate risks have been raised for these areas and this risk is to hold the	Digital and Data Services	5x3	15	Data Security Protection Toolkit submission for 2026 is in progress, initial submission is due in December 26. MIAA are reviewing progress against action plan as part of annual review. Risk score remains at 15 whilst DSPT action plan is completed. Work continues to reduce our device exposure score (MDE), with current score 31 against a target of below 30. Windows 11 has now	March 2026 (in line with DSPT action plan)	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
		overarching risk of a Cyber attack.				been rolled out to 90% of devices and extended support has been purchased to protect any device that could not be upgraded. This ensures our devices continue to receive critical security updates.			
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.	March 2026	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. Asked to delay recruitment of the backfill until new financial year as need to agree funding for the backfill. The risk score can be reduced if post is recruited to but this won't be until 2026/27. Risk assessment shared	Q1 26/27 2025	Nigel Scawn	Quality & Safety 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
						across clinical divisions for review on 28/10/25 after discussion at OMB. Difficult to assess risk score from incidents logged, for example prolonged length of stay or patient contracting an infection may not be recorded as an incident.			
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).	December 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	Q4 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
						who should be transferred to ward areas. 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. Reduction in NCTR has been achieved through September to 20% against a 15% target by end of March 2026. Challenge is now being supported from C&M ICB Additional P1 and P2 community capacity funded through ICB discharge monies. Recruitment underway. Implementing actions form national discharge team assessment in September			
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 Executive led contributions.	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
						Secondment of band 9 into Director of Delivery role and standing up of PDO function to lead delivery and accelerate implementation of CIP.			
05/06/2025	3477	High number of medical patients being managed outside of the Urgent Care bed base.	Urgent Care	4x4	16	Additional funding to support the management of Day2 patients across ED, SDEC and corridor. This includes junior and senior input 7-days a week. Expanded bed base on respiratory. 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	March 2026	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
						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 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. Trust is also participating in ICB cash working group to look at cash preservation within the system and actions that will be required when cash distress funding is required	March 2026	Karen Edge	Finance & Performance Committee
20/01/2025	3395	CERNER ordering/reports - The telepath (I.T) systems in place at CWMS are obsolete and due to be replaced by	Diagnostics and Clinical Support	4x4	16	The mitigation would be to develop integration between the Microbiology Telepath system and the Cerner EPR. Division to consider the cost pressure. There is an underlying issue with technical support for Microbiology which is	December 2025	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
		the new Network wide LIMS implementation, due 2027. There is currently a risk around microbiology results whereby Telepath result reporting cannot file back to CERNER under certain circumstances.				being reviewed with WUTH. Long term solution is the move to the ICS wide single pathology system. Approval has been given for short term resource from WUTH to work with us to develop the microbiology integration between Telepath and our Cerner EPR. Awaiting a timescale from WUTH.			
01/01/2024	3255	Dialysis machine past the recommended life span resulting in more frequent repairs.	Urgent Care	3x5	15	Dialysis machines were included in the 2025/26 Divisional capital bids, though no funding was awarded. A new bid will be submitted for 2026/27, pending prioritisation by the Division and Trust. Discussions are ongoing with Deputy COO to explore a MSC model, similar to the WUTH hub, which leases machines and avoids asset ownership risk. The Trust is reviewing the Renal/Dialysis service positioning within its broader strategy, especially in light	March 2026	Cathy Chadwick /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
						of national discussions on home dialysis. The dialysis machines will be considered as part of capital planning for 2026/27.			
27/09/2024	3326	Risk to safe staffing levels and potential for reliance on premium cost temporary staffing as a result of medical workforce gaps.	Corporate Services (People – Medical Staffing)	4x4	16	Review of vacant posts and offer of additional support where hard to recruit vacancies exist. Improving attractiveness of roles to ensure issues don't prevent people from wanting to work at the Trust. SARD job planning work to review capacity and demand. Recruitment of clinical fellows has taken place and agreement given to obtain short term cover for 3 months until new recruits start. Further recruitment to fill gaps in rotations due to LTFT working.	March 2026	Vicki Wilson	People Committee

(PUBLIC) Board of Directors
25th November 2025

Report	**Agenda Item 10.**	**General Medical Council (GMC) National Training Survey 2025 Report**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Dr Nigel Scawn			Medical Director				
Author(s)	Dr Lyndsay Cheater Dr Nigel Scawn			Director of Medical Education 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** **X** **X**	BAF impact is the provision of safe and effective systems and processes to ensure education and supervision requirements are met for the resident doctors and our GMC accredited trainers.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X**
Previous considerations	Full survey results report received at the People Committee on the 14th October 2025.							
Executive summary	The purpose of this paper is to provide assurance to the Board that a full response, including Action Plans, has been put in place following the publication of General Medical Council (GMC) 2025 survey results as reported to the People Committee (October 2025). The GMC survey is the largest National Training Survey that is carried out annually to gain a comprehensive picture of the experiences of resident doctors, about the quality of their education and the environments in which they work, and to gain information about clinical and educational supervisor experiences across the UK. The paper identifies good practice and areas of concern. There is a trend of slight improvement in overall results over the past 4 years, most of which are in the interquartile range. We score lowest in the region for our induction process, and highest for 'having a supportive environment'.							

	There has been significant improvement in the trainee results in the Obstetrics and Gynaecology (O&G) department, and this improvement has been noted by the Specialty Education Advisory Committee at the Royal College of Obstetricians and Gynaecologists (RCOG) who have awarded the CoCH department as the most improved of 167 departments in the country. Despite this, the O&G department remain at a level 1 on the intensive support framework (ISF - increasing levels of intervention are introduced by NHS England) although this is an improvement having previously been on level 2. The only other department currently on the ISF is Emergency Medicine at level 2. There is a scheduled a multiprofessional quality intervention visit from NHSE on 25th November 2025 due to ongoing concerning results in their GMC survey (particularly in the trainer survey this year), and the CQC report. There have been significant improvements in the survey results for Respiratory Medicine, Cardiology, Anaesthetics, Intensive Care Medicine, and Trauma and Orthopaedics There are some specialties that have negative outlier or deteriorating scores. These are specifically endocrinology and diabetes mellitus, gastroenterology, geriatric medicine, GP – paediatrics and child health, and vascular surgery. All these specialties have provided an action plan to address the issues raised by the trainees in their specialties. The full Countess of Chester Hospital NHS Foundation Trust GMC National Training Survey 2025 Report compiled by the Director of Medical Education, Dr Lyndsay Cheater, was provided to the People Committee. This report will be submitted to NHS England. Progress against the action plans will be reported through the Medical Education Group which reports into the Education, Learning & Organisation Development Sub-Committee and subsequently to the People Committee.
Recommendations	The Board is asked to **note** the assurance in respect of the survey results and action plans to address the areas for improvement, with assurance being reported through to the People Committee.

Corporate Impact Assessment	
Statutory/regulatory requirements	Training contract requirements and regulatory compliance.
Risk	The risk is the provision of safe and effective systems and processes to ensure education and supervision requirements are met for the resident doctors and our GMC accredited trainers.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published as part of the agenda pack.

Committee Chair's Report

6th November 2025, 9.30-12.30, Boardroom

Committee	Quality and Safety (Q&S) Committee
Chair	Prof. Andrew Hassell, Non-Executive Director

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

Alert

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

- In terms of patient flow, the impact and level of Non-Criteria to reside (NCTR) patients was discussed and the Committee wanted to escalate to the Board for the full Board to understand the data, responsibilities and actions.
- Chair's AAA Report from Cancer Services Group alerted the significant increase in dermatology referrals and urology, impacting on meeting the cancer standards for patients. Impact on histopathology and Multi-Disciplinary Team (MDT), with a plan to increase capacity internally and externally including potential mutual aid.

Assure

(matters in relation to which the Committee received assurance)

- Progress against Care Quality Commission (CQC) Urgent Emergency Care (UEC) Section 29a warning notice action plan. Risks remain for sepsis (evidence on compliance with national standards), patient experience (particularly reducing 12 hour waits), equipment servicing (low risk equipment), medicines management documentation (specifically neck of femur patients which is a worsening position and needs urgent action). In summary, 28 concerns resolved in full, 7 with strong plans progressing and 1 deteriorating with further action needed.
- Integrated Performance Report (IPR) extract from quality and safety received including highlights, exceptions and areas for action. Areas noted were risks assessment compliance improved but not at target; pressure ulcer work continuing and detailed review of data provides important detail that needs to be considered; sepsis and patient flow aligned to CQC action plans; timely closure of complaints and concerns. Committee were made aware of two new Strategic Executive Information System (STEIS) reported incidents and reviews commenced.
- Quality Governance Group Chair's AAA report provided assurance across a wide range of areas aligned to their responsibilities. Alerts were nutrition, discharge letters, stroke, section 29a action plan progress, and outstanding mortality reviews, with updates provided to the Q&S Committee and it was confirmed clear actions are in place for these areas with Q&S Committee asking for further reports to be provided on some of these items.
- Safety surveillance received confirming themes, learning and ongoing levels of incident reporting including significant low and no harm supporting the learning culture.
- Perinatal quarter 2 update providing assurance on compliance with the standards (including Maternity and Neonatal Incentive Scheme) and any actions remaining.
- Discharge letters within 24 hours with work continuing through a task and finish group to improve performance.

- Clinical audit update with an action to review the approach and reporting for the next Committee meeting.

Advise

(items presented for the Board's information)

- Patient story received which was from a compliment submitted from a patient. It was agreed that it would be good to respond to the patient to thank them for their feedback.
- Verbal update on October 2025 CQC assessment of UEC, medicine and end of life care. Immediate response and evidence has been submitted to the CQC. The Trust is currently in the process of responding to the subsequent information request which is extensive and has a short deadline for submission.
- Cancer harms review paper received, noting that action is being taken regarding the outstanding cancer harms reviews for patients experiencing extended waits for treatment and further assurance is required including information on any harm identified.

Risks

(discussed and new risks identified)

- Review of Board Assurance Framework (BAF) 1 and related high risks. Recognising the risk management improvement work that continues. Updates on a number of risks recorded as high were provided noting that calibration of scoring is required.

(PUBLIC) Board of Directors
25th November 2025

Report	**Agenda Item 12.**	**Care Quality Commission (CQC) Improvement Plan including Well Led**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton			Director of Nursing and Quality / Deputy Chief Executive				
Author(s)	Karan Wheatcroft			Director of Governance, Risk and 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	Regular updates against the action plan have been provided to the Board of Directors. Previous paper 30th September 2025.							
Executive summary	The purpose of this report is to provide assurance on progress with the Trust's Improvement Plan, including Well Led, in response to the regulatory breaches identified within the CQC's report and reflected within the subsequent CQC ratings. Thet Trust continues to monitor progress against the action plans including a separate urgent and emergency care action plan assurance report to the Quality and Safety Committee. Recognising the breadth of actions and alignment to some of the business as usual work including improving performance against key metrics in the integrated performance report, the intention is to review the most effective way of tracking and reporting progress. In addition, work has commenced on the development of a well led self-assessment aligned to the single assessment framework which will incorporate and supersede the well led actions. An update will be brought to the Board in January 2026.							

	As an interim update the following provides a summary of the actions from the combined CQC and well led action plan that are still progressing: • Combined UEC and patient flow action plan delivery. • SARD capacity and demand review and job planning. • Out of date policy recovery programme reported through Audit Committee. • Staff survey and action plans reported through People Committee. • Digital and Data Strategy refresh reported through Finance and Performance Committee. • Voice Recognition/ Ambient Voice Technology. • New Sepsis screening action plan developed and reported through Quality and Safety Committee. • E' discharge compliance reported through Quality and Safety Committee. • 5 year financial plan development. • Development of an Estates strategy. • Risk Management improvement plan delivery reported through Audit Committee. • Mandatory training compliance reported through People Committee. • Improvement team priorities being aligned with Director of Delivery through Program Delivery Office. • Organisation learning policy. • Stroke services, mental health services, medical devices and equipment.
Recommendations	The Board of Directors is asked to: • **Note** the update the progress of the consolidated CQC and well led Improvement Plan and the plan to review the most effective way of tracking and reporting progress.

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.

(PUBLIC) Board of Directors
25th November 2025

Report	**Agenda Item 13.**	**Perinatal Services Quarterly Update (Quarter 2)**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton			Director of Nursing and Quality / Deputy Chief Executive				
Author(s)	Natasha Macdonald Sara Brigham Liz Kewin			Director of Midwifery Associate Medical Director Divisional Director				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X**	BAF 1 – Failure to maintain quality may negatively impact patient and family experience BAF2 - Gaps in safety and harm prevention can compromise patient outcomes. BAF 3 – Failure to meet operational planning standards or address patient backlogs may lead to poorer outcomes and financial risk for the Trust.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Quality and Safety Committee 6th November 2025.							
Executive summary	This report provides assurance to the Board of Directors regarding the safety, quality, and performance of maternity and neonatal services for Quarter 2 (July–September 2025). It summarises progress against the Maternity and Neonatal Incentive Scheme (MIS) Year 7 standards, key quality and safety metrics, perinatal mortality data, and learning from incidents, complaints, and reviews. Oversight is maintained through the Perinatal Assurance and Improvement Board and Women and Children's Governance committee and reported to the Trust Board in line with the Perinatal Quality Surveillance Model (NHSE 2020).							

	Overall performance remains stable with no maternal deaths, stillbirths, no neonatal deaths after 24 weeks gestation requiring escalation. The Trust is compliant or on track with all ten MIS Safety Actions, demonstrating sustained adherence to national safety standards, robust workforce planning, and good governance. The Perinatal Mortality Review Tool (PMRT) continues to drive system learning, with lessons from reviews disseminated across clinical areas. The *Saving Babies' Lives Care Bundle v3* achieved 93% compliance this quarter, with focused work underway to improve resident medical staff training, preterm birth temperature management, and implementation of the updated diabetes guideline. Collaboration with the Maternity and Neonatal Voices Partnership (MNVP) continues to strengthen co-production and patient experience. The Trust demonstrates a mature safety culture and transparent learning environment. The Committee is asked to note the assurance provided that maternity and neonatal services are safe, effective, and compliant with national standards, and that improvement actions identified through PMRT, incident review, and patient feedback are actively implemented and monitored through established governance structures.
Recommendations	The Board of Directors is asked to note the assurance provided regarding the safety, quality, and compliance of maternity and neonatal services, and to be assured that identified learning and improvement actions are monitored through established governance processes.

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

Perinatal Services Quarterly Update (Quarter 2)

Introduction

Maternity and neonatal quality and safety remain a Trust priority, aligned with national standards and the Ockenden Report (2020). This report summarises performance, safety concerns, serious incidents, and progress on the Maternity Incentive Scheme (MIS), using agreed local and national measures under NHSEI's Perinatal Quality Surveillance Model (Dec 2020). It supports Board oversight by providing ward-to-board insight and highlighting current or emerging safety issues.

Background

Maternity and neonatal services remain under close scrutiny, with the Ockenden Report (2020) reinforcing the need for robust oversight. Now in it's seventh year, the Maternity Incentive Scheme (MIS) drives CNST-linked safety actions. This report summarises Year 7 MIS progress, key initiatives including the Saving Babies' Lives Care Bundle v3, MSDS compliance, and learning from serious incidents and perinatal reviews.

Purpose

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

MIS Progress Update.

The Trust has embedded the ten MIS safety actions into routine practice, making them part of business as usual.

	Safety Action	Assurance	Progress
1	**Safety action 1:** Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?	Q2 2025/26 paper presented to quality and safety	On track
2	**Safety action 2:** Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	July scorecard has passed the requirements	Completed
3	**Safety action 3:** Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?	-	On track
4	**Safety action 4:** Can you demonstrate an effective system of clinical workforce planning to the required standard?	All evidence complete and full compliance achieved	Completed

	Safety Action	Assurance	Progress
5	**Safety action 5:** Can you demonstrate an effective system of midwifery workforce planning to the required standard?	The service confirms that midwifery staffing levels are compliant with BirthRate Plus recommendations, providing assurance that workforce capacity meets recognised national standards. Paper to BOD November 2025	Completed
6	**Safety action 6:** Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Saving Babies Lives, complaint for year 7 MIS	Completed
7	**Safety action 7:** Listen to women, parents and families using maternity and neonatal services and coproduce services with users.		Completed
8	**Safety action 8:** Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Training is ongoing, and we remain on track to sustain compliance with this standard.	On track
9	**Safety action 9:** Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	We have established a clear oversight mechanism to provide assurance to the Board on maternity and neonatal safety and quality issues.	On track
10	**Safety action 10:** Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025	Q2 2025/26 No cases referred to MNSI or Early notification. No ongoing cases	On track

Dashboard

Maternity performance remained stable. There were no maternal deaths, stillbirths, with one neonatal death prior to 24 weeks managed inline with British Association of Perinatal Medicine's guidance for extreme preterm birth, and no immediate risks requiring escalation. Strategic priorities remain focused on:

- Reducing avoidable neonatal term admission
- Sustaining reductions in third-degree perineal tears

- Managing postpartum haemorrhage (PPH) rates, particularly in line with new guidance implementation

Perinatal Mortality Rate

The national average for stillbirth rate is 3.9 per 1,000 births and 1.4 per 1,000 births for neonatal death 24 weeks or over (2023). These rates are presented and adjusted by MBRRACE-UK according to the number of births per maternity service and whether the service has a Neonatal Intensive Care Unit (NICU). The rolling 12-month stillbirth rate at COCH is 2.2. per 1,000 births, The Neonatal Death rate for births ≥24 weeks gestation is 1.1 per 1000.

Saving Babies' Lives Care Bundle (SBLv3)

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	80%	Partially implemented	80%
Element 2	Fetal growth restriction	Partially implemented	95%	Partially implemented	95%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Partially implemented	96%	Partially implemented	96%
Element 6	Diabetes	Fully implemented	100%	Partially implemented	83%
All Elements	TOTAL	Partially implemented	94%	Partially implemented	93%

The September Saving Babies' Lives (SBL) assurance assessment reports a compliance score of 93% for the Countess of Chester Hospital, positioning the Trust joint second in the region. This represents a minor reduction from the previous quarter's 96% compliance. Full compliance was achieved in two elements, with partial compliance recorded in the remaining four. Three key areas for improvement have been identified to achieve full compliance: (1) further streamlining of mandatory training for all staff, with a particular focus on resident doctors in relation to Carbon Monoxide monitoring, Very Brief Advice (VBA) to smokers, and standardised fundal height measurement; (2) continued monitoring of preterm births below 34 weeks although the Trust has a very low rate, one of two babies born in this category had a marginally low temperature at birth, resulting in 50% compliance for this metric this quarter; and (3) final approval and implementation of the updated diabetes guideline, which is progressing through governance and expected to be in place for the next assessment, supporting improved compliance.

Chester MNVP

This quarter, the MNVP strengthened it's presence within the hospital and community through in-person events, direct engagement with families, and close collaboration with maternity and neonatal staff. Key activities included listening events, focus groups, and participation in governance meetings to ensure the patient voice informs service development. A notable co-production initiative involved working with parents of babies on the neonatal unit who reported missing meals, medication, or assessments while caring for their newborns. In response, the MNVP is co-designing a simple, accessible communication card to help parents identify their care team, record their needs, and organize their day, reducing anxiety and ensuring essential care is not missed. This tool is being developed with ongoing feedback from both parents and staff to ensure it meets real needs.
Broader feedback this quarter highlighted the importance of clear communication, continuity of care, and support for homebirth and breastfeeding, with both positive experiences and areas for improvement identified such as communication gaps, inconsistent advice, and challenges in postnatal discharge and tongue tie referrals. Additional co-production work included updated patient information materials. Upcoming projects focus on enhancing two-way communication, assessing service environments, and expanding regular feedback opportunities, all aimed at improving safety, experience, and outcomes for families.

Maternity Incidents Q2

Maternity Incidents
Serious Incidents Reports

- Neonatal death Baby born, care inline with BAPM extreme prematurity guidelines (subject to PMRT), After action review completed

Swarm: 0

Number of moderate and above incidents: **5 – 4** Moderate and **1** Severe (Decrease in Moderate incidents reported due to implementation of new perinatal PSIRF plan)

Moderate incidents included – PPH of 3 litres following a ventouse delivery, and a return to theatre with a cervical tear. PPH of 2366 mls following an emergency c/s, which involved a return to theatre with a haematoma and then transfer to HDU.

The Severe incident was - 23+2 week neonatal death.

Total reported (total number of obstetric incidents reported): 226
Open currently at Q2: 79
Closed: 147

CQC escalations There were no CQC escalations received in this quarter
There was no regulation 28 received for maternity services during this quarter.

Maternity Risk Register Update – Q2
There are no high-risks on the risk register.

Moderate risks added to the risk register include:

- Cerner discharge process
- Overdue policies across the division.

Learning from Concerns and Complaints – Q2 2025/26

There were 2 new formal complaints received by the service during Q2. One historic from 2022 around communication and analgesia.

Triangulated Analysis of Incidents, Complaints and Claims Women & Children's Division – Maternity and Neonatal Services

To provide assurance to the Trust Board regarding the safety culture, learning processes, and risk management within maternity and neonatal services, through triangulated analysis of patient safety incidents, complaints and concerns, and clinical negligence claims.

Background
The Women & Children's Division continues to embed a proactive approach to patient safety and learning, aligned with the Patient Safety Incident Response Framework (PSIRF) and SEIPS methodology. This report covers the Quarter three and four 2024/25
and triangulates key themes and learning across incidents, complaints, and claims to inform improvement and assurance.

Key FindingsPatient Safety Incidents

- 467 incidents reported across maternity and neonatal services.
- 372 no harm, 35 low harm, 56 moderate, 3 severe, 1 fatal.
- Common themes: postpartum haemorrhage, shoulder dystocia, perineal trauma, delays to!induction, intrauterine transfers, and term admissions to the neonatal unit.
- Learning under PSIRF and SEIPS is well established and actively shared across teams.

Complaints and Concerns

- 41 complaints/concerns received – all related to obstetric/midwifery care.
- Key themes: communication, postnatal care, clinical decision-making, traumatic birth experience, and administrative access issues.
- No complaints were recorded in neonatal care
- Emerging areas: duty of candour, continuity of care, and compassionate communication

Clinical Negligence Claims (NHS Resolution Scorecard)

- Obstetric claims: 35, valued at £47.2m.
- Neonatal claims: 19, valued at £58.2m.
- Combined, these account for ~30% of Trust total claims value.
- High-value claims relate to treatment delays, diagnostic errors, CTG interpretation, and care!around caesarean section.
- Several recent neonatal claims are linked to post-Letby notifications.

Analysis and Learning

While not all themes directly align due to differing timeframes and reporting metrics, the division continues to cross-reference all data sources to identify system learning and reduce harm. Key improvement areas include:

- Strengthened risk assessment and timely escalation.
- Enhanced documentation and handover processes.
- Improved multidisciplinary communication and compassionate engagement with families.

Assurance to the Board

- There is clear evidence of a robust reporting and learning culture.
- Learning from incidents, complaints and claims is shared systematically and informs local improvement plans.
- The financial exposure linked to high-value neonatal claims is recognised and monitored through Trust governance structures.
- Ongoing focus on communication, compassionate care, and prevention of recurring themes will continue to strengthen safety and experience.

Conclusion

The Division demonstrates a strong commitment to safety, openness, and continuous learning. Ongoing triangulation of safety data and sustained focus on communication and compassionate care will further enhance outcomes for women, babies, and families

Recommendations

The Board of Directors is asked to note the assurance provided regarding the safety, quality, and compliance of maternity and neonatal services, and to be assured that identified learning and improvement actions are monitored through established governance processes.

Appendix: Glossary of Terms and Acronyms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(PUBLIC) Board of Directors
Tuesday 25th of November 2025

Report	**Agenda Item 14a.**	**Maternity and Neonatal Bi-annual Safer Staffing Report January to July 2025**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton			Director of Nursing and Quality / Deputy Chief Executive				
Author(s)	Claire Davies			Head of Midwifery				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X** **X** **X**	Contributes to the assurance for a range of BAF risks.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X**
Previous considerations	People Committee – 14th October 2025							
Executive summary	This bi-annual safer staffing report provides assurance that maternity and neonatal services remain safely and appropriately staffed in line with national standards. The Trust continues to meet all requirements of the NHS Resolution Maternity Incentive Scheme (MIS) Safety Action 5 and the Ockenden (2022) recommendations. The recommended 1:27 midwife-to-birth ratio and 100% compliance with one-to-one care in labour have been consistently maintained. Fill rates remain above the national 85% benchmark, supported by daily acuity reviews and robust redeployment processes. Neonatal services remain fully compliant with BAPM standards, with 70% of nurses now QIS-qualified.							

	All red flag events were effectively managed, and specialist midwife provision exceeds national recommendations. Workforce transformation, including the introduction of an inpatient on-call rota and revised community on-call arrangements, continues to strengthen resilience. The Board can be assured that maternity and neonatal staffing remains safe, compliant, and responsive to demand. Ongoing recruitment and workforce planning are in place to sustain these standards.
Recommendations	The Board of Directors is asked to note this report and confirm the Trust's compliance with Maternity Incentive Scheme Safety Action 5.

Corporate Impact Assessment	
Statutory/regulatory requirements	The Trust remains aligned with Foundation Trust status and continues to meet all statutory and regulatory obligations.
Risk	Key organisational risks are regularly identified, assessed, and proactively managed, with mitigation measures in place to protect service quality and l resilience.
Equality & Diversity	The Trust fully complies with the Equality Act 2010 and Public Sector Equality Duty (PSED), fostering an inclusive environment that values diversity and ensures all voices are heard and represented
Communication	Timely and transparent communication processes are in place, including the publication of key documents on the Trust's website to support public access and accountability.

Midwifery Bi-annual Safer Staffing Report
January to June 2025

Purpose

This report assures the Trust Board of an effective system for midwifery workforce planning and monitoring of safe staffing levels from January to June 2025.It meets the requirements of the NHS Resolution Maternity Incentive Scheme (MIS) for Safety Actions 5 and demonstrates compliance with the Ockenden Report (2022) recommendations for safe and effective staffing.

Background

NHS providers must ensure safe nursing and midwifery staffing in line with National Quality Board (NQB) standards, with the right staff, skills and deployment to deliver safe care.

NICE (2017) requires maternity services to use a systematic, evidence-based approach to establish staffing levels that ensure continuity and safety. To comply with the NHS Resolution Maternity Incentive Scheme (MIS), this report provides dedicated assurance on midwifery, obstetric and anaesthetic staffing.

The Trust meets the MIS requirements by:

- Completing a systematic establishment review within the last three years
- Aligning the staffing budget to the agreed establishment
- Rostered supernumerary labour ward coordinators with escalation plans in place
- Ensuring one-to-one midwifery care for all women in active labour

A biannual midwifery staffing report is presented to the Trust Board, in line with NICE guidance, providing assurance of compliance with national standards and continued delivery of safe, effective maternity care.

Birthrate Plus® Workforce Planning

In line with NICE (2015, 2017) guidance and Maternity Incentive Scheme requirements for a systematic, evidence-based review every three years, discussions are underway with Birthrate Plus to schedule the next assessment. This will take place following the move to the new Women and Children's Building and will account for the anticipated increase in birth activity, ensuring staffing remains aligned with service demand and acuity.

The Trust remains compliant with Birthrate Plus recommendations and national standards. In accordance with the Ockenden Report (2022), assurance of compliance will continue to be formally recorded in Board minutes, confirming that midwifery staffing is appropriately resourced to deliver safe and effective care.

Birth to Midwife Ratio

The birth-to-midwife ratio is monitored monthly using the Birthrate Plus methodology and actual delivery data. The Trust remains compliant with the recommended ratio of 1:27.

Planned Versus Actual Midwifery Staffing Levels

Daily reviews of acuity and activity inform staff redeployment to maintain safe care. Fill rates remain above 92%.

Planned Staffing Levels:

- Labour Suite: 6 (Day), 6 (Night), 6 (Weekend)
- Ward 33: 3 (Day), 2 (Night), 3 (Weekend)

Monthly inpatient fill rates consistently exceed the 85% benchmark, with adequacy assessed in relation to acuity and activity.

Priority Fill Rate and Escalation Measures

To maintain safe staffing, priority is given to out-of-hours shifts, with day shifts supported by specialist midwives and senior managers. When staffing levels fall below the optimum, the escalation policy is implemented, which may include:

- Redeployment of specialist midwives and Band 7+ managers to clinical duties
- Adjustment of elective workload to release staff
- Reallocation to ensure one-to-one care in labour and supernumerary coordinators
- Requests for mutual aid from Cheshire & Mersey LMNS
- Activation of on-call community midwives
- Use of the Northwest divert policy or temporary unit closure if required

All actions are recorded in the Birthrate Plus live acuity tool. Staffing pressures are primarily associated with sickness, long-term absence, and mandatory training.

Workforce Transformation / Quality Improvements

Between January and June 2025, the Head of Midwifery, in collaboration with matrons, managers and key stakeholders, implemented two service changes:

1. Introduction of an inpatient on-call rota
2. Adjustment of community midwifery on-call start and finish times

Following consultation, the inpatient on-call rota was implemented on 3 March 2025

Specialist Midwives

Birthrate Plus recommends excluding 8–11% of the total establishment from clinical figures (11% for multi-site trusts) to account for specialist roles such as perinatal mental health, infant feeding, screening, smoking cessation, fetal monitoring, bereavement support, guidelines, audit and training (Birthrate Plus Report, December 2021)

The Trust currently has 15.73 WTE specialist midwives across clinical and non-clinical roles. Of this, 5.9 WTE (6%) work clinically. Overall, specialist roles represent 16.03% of the total midwifery workforce, rising to 17% if the Saving Babies' Lives vacancy is filled. This exceeds the 2021 Birthrate Plus recommendation, reflecting national NHS England guidance which has since expanded the range of required specialist functions in line with the needs of women and birthing people.

Birthrate Plus Live Acuity Tool

The Birthrate Plus Live Acuity Tool provides real-time assessment of midwifery workload and staffing requirements. Using evidence-based indicators, it supports compliance with NICE NG4 (2015) by ensuring one-to-one care in labour and triggering timely escalation during periods of high acuity.

The tool is completed every four hours by the labour ward coordinator, providing continuous oversight of staffing, activity and actions taken to maintain safety. This offers assurance that staffing risks are identified and mitigated in real time

Supernumerary Labour Ward Coordinator

A supernumerary coordinator must be allocated for every shift and must start each shift with protected supernumerary status. This is a mandatory requirement under Maternity Incentive Scheme (MIS) Safety Action 5 and forms part of national maternity safety standards.

The role is critical in providing oversight of safety and coordination within the labour ward. The Trust has achieved 100% compliance with this requirement.

One to One in Established Labour

In line with national maternity safety standards, all women in established labour receive one-to-one care from an assigned midwife. While the same midwife may not remain throughout, continuous one-to-one support is maintained at all times.

The Trust achieved 100% compliance with one-to-one midwifery care in labour during the reporting period, in full alignment with national maternity safety standards and Maternity Incentive Scheme (MIS) requirements.

Midwifery Red Flag Incidents

A midwifery red flag event (NICE, 2015) indicates a potential shortfall in staffing that could impact safe care. When such an event occurs, it is escalated immediately to the midwife in charge, who assesses whether staffing contributed and initiates appropriate action.

At the Countess of Chester, red flag events are recorded in real time via the Birthrate Plus Live Acuity Tool, ensuring visibility and prompt escalation. Between 1 January and 30 June 2025, 69 midwifery red flag events were reported a reduction from 80 in the previous six-month period, evidencing improved staffing resilience. The events were analysed thematically, and mitigation actions implemented to reduce recurrence.

Red flag monitoring remains a key element of the maternity staffing assurance framework, supporting early identification of pressures and timely action to maintain safe, high-quality care. These findings provide assurance to the Board that escalation and mitigation processes are effective in maintaining safe staffing and service delivery.

Neonatal Nursing Workforce

To meet Maternity Incentive Scheme (MIS) Safety Action 4, the neonatal unit must evidence compliance with the national neonatal nursing service specification. Improved outcomes are consistently achieved where staffing meets national nurse-to-baby ratios and a high proportion of nurses hold a Qualified in Specialty (QIS) neonatal qualification.

National safe staffing standards, as defined by the British Association of Perinatal Medicine (BAPM) and the Department of Health Toolkit for Neonatal Services (2010), are:
1:1 Intensive Care
1:2 High Dependency Care
1:4 Special Care

The neonatal unit remains compliant with these BAPM standards. Recruitment activity has reduced vacancies, and investment in QIS training continues to increase the proportion of qualified neonatal nurses.

Workforce compliance is monitored through the Neonatal Nursing Workforce Calculator (2020), which determines the number of nurses required to staff declared cots safely. Current modelling shows 33.39 WTE nurses are required, of which 23.37 WTE (70%) should be QIS trained

In line with national requirements, the Trust formally records in the Trust Board minutes annual compliance with BAPM nurse staffing standards, evidenced through the Neonatal Nursing Workforce Calculator. This provides assurance that neonatal staffing is safe, sustainable, and compliant with national standards.The neonatal unit remains fully committed to sustaining safe staffing and BAPM compliance, with continued focus on recruitment, retention, and QIS training.

Conclusion

This report confirms the Trust's adherence to biannual maternity staffing reviews, which are required for transparent reporting to the Board of Directors. Our alignment with NHS Resolution Maternity safety actions highlights our commitment to patient safety.

The evidence presented demonstrates the robustness of our workforce planning system, ensuring safe staffing levels within the Maternity unit. Through monitoring, we consistently match staffing levels with patient acuity, enabling interventions and the delivery of optimal care.

Our continuous efforts in workforce planning and monitoring confirm the commitment to providing exceptional maternal care.

Recommendation

The Board has been asked to note this report and confirm the Trust's compliance with Maternity Incentive Scheme Safety Action 5.

(PUBLIC) Board of Directors
25th November 2025

Report	**Agenda Item 14b.**	**Bi-annual Safer Nurse Staffing Report (mid-year establishment review 1 January to 30 June 2025)**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton			Director of Nursing & Quality / Deputy Chief Executive Officer				
Author(s)	Melanie Kynaston			Deputy Director of Nursing & Quality				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X**	BAF impact is to maintain quality of care would result in poorer patient & family experience			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Full paper presented to People Committee 14th October 2025.							
Executive summary	This paper has been produced to provide assurance that budgeted nurse establishments across wards and departments are sufficient to meet the needs of patients commonly seen within the area. The Board paper is a summary of the full report which was received at the People Committee on the 14th October 2025. The data presented relates to a 6-month period, between 1 January 2025 and 30 June 2025. The paper includes any risks and issues experienced within the reporting period and outlines any recommended changes needed in response. The mid-year establishment review has demonstrated that in most wards and departments the budgeted establishment correlates with the last two SNCT data collections.							

	There have been four recommended changes to establishments, one in urgent care and three in planned care. These changes are: 1. Ward 45, to increase the HCSW numbers on the long day from 4/4, 4/4, 3/3 to 4/5, 4/5, 3/3. 2. Ward 54, to increase the HCSW numbers on the late and night shift from 4/4, 4/3, 3/2 to 4/4, 4/4, 3/3. 3. Change the skill mix in preoperative assessment, replace x2 band 5 posts with band 4s and uplift x1 band 5 post to band 6 to increase nurse-led clinics. 4. Recruit to the ten band 6 posts in theatres (budget uplifted in last assessment from band 5) and recruit to band 7 quality and education lead (no cost). These changes address the risks identified within the divisional establishment reviews. The divisions have completed a financial impact assessment and have identified funding from within each division to move resource to the highest risks identified. However, urgent care has £19k unallocated following the proposed changes and planned care are £19k short. **It is therefore recommended that the balance in urgent care is allocated to planned care to achieve the safe staffing requirement across both divisions.** The vacancy gap continues to close (1.6% for RNs and 9.4% for HCSWs). Unavailability of staff has largely been a result of sickness and absence (7%) and parenting (maternity) leave (3.37%), both of which are above the national comparators. In addition, the pressure to fill the multiple escalation spaces across the Trust has stretched existing teams further and is impacting on the number of redeployments being made, which is likely driving absence as the most reported reason for sickness is stress and anxiety. Maternity staffing is covered within a separate paper.
Recommendations	The Board of Directors is asked to **note** the assurance provided in the paper.

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

BI-ANNUAL SAFER NURSE STAFFING REPORT – September 2025 (mid-year establishment review – 1 January to 3 June 2025)

BACKGROUND

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

PURPOSE

2.0 This paper has been produced to provide assurance that budgeted nurse establishments across wards and departments are sufficient to meet the needs of patients commonly seen within the area. The data presented relates to a 6-month period, between 1 January 2025 and 30 June 2025. The paper includes any risks and issues experienced within the reporting period and outlines any recommended changes needed in response.

METHODOLOGY

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

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

Nurse sensitive outcomes must be triangulated with the data collected.

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

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

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

of patients. Application of professional judgement has been standardised in this reporting period, using the 2023 Professional Judgement Framework: a guide to applying professional judgement in nurse staffing review.

The version of the SNCT used in the Trust does not capture enhanced supervision or 1 to 1 nursing requirements. This is collected alongside the SNCT data, over the audit period. This data is then averaged to report on the number and % of patients requiring this additional support in each area.

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

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

SUMMARY OF FINDINGS

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

4.1 Urgent Care

The urgent care division has made one recommended change to nurse establishments; this is within the medical specialities. The SNCT data collected in October 2024, and April 2025 has in most wards correlated with the budgeted establishment.

The division has experienced workforce challenges relating to vacancy, supporting sickness absence, high patient acuity, and supporting the pressures within several escalation areas, including the ED cohort, SDEC escalation, SDEC frailty and corridor, Respiratory Unit, Cardiac Day Suite and Modular Ward. In view of this, the wards have not always worked within their roster template numbers.

4.1.1 Urgent and Emergency Care (UEC)

UEC has not made any recommendations to change establishments. During the next reporting period it is planned that a formal establishment review is undertaken in the emergency department, UTC and SDEC, to review how to best utilise the workforce and skill mix across these areas.

The data collected in AMU shows a potential over establishment, however, no change to establishment is recommended at this time. This is due to 3 additional escalation beds being in use and 2 further single rooms which will soon be added to the permanent bed base (+ 5 additional beds). In addition, the emergency department has significantly decrease lengthen of stay from 72 hours to 12 – 24 hours, meaning that the most acutely unwell patients are now flowing to AMU and it is anticipated that the data collected in the next reporting period will reflect this.

4.1.2 Medical Specialities

The medical specialities have made one recommendation, to increase the HCSW numbers in ward 45 on the long day (recommended template 4/5, 4/5, 3/3 – previously 4/4, 4/4, 3/3). This is to address the increasing demand for enhanced supervision and 1 to 1 nursing care, in response to an increase in patients

withdrawing and demonstrating challenging behaviour. This ward is managing several agitated and aggressive patients, and there has been significant 'near miss' incidents in this reporting period. To release resource to make this change, budget will be taken from ward 44, as this is showing an over establishment in the assessment.

There are also 3 other wards (cardiology, stroke, and respiratory) where the data has highlighted a possible over establishment. However, when the data is triangulated with nurse sensitive outcomes, professional judgement and royal college or society standards, it has been agreed the safe staffing template needs to remain in place and unchanged.

In addition, there are imminent operational changes being made, with the release of beds from planned care to urgent care, which will result in a change in establishment for the affected areas (this is outside of the scope of this review and forms part of the bed reconfiguration work).

4.2 Planned Care

The SNCT data collected in October 2024, and April 2025 has in most wards correlated with the budgeted establishment. However, the planned care division has made 3 recommended change to nurse establishments:

- Ward 54, to increase the HCSW numbers on the late and night shift from 4/4, 4/3, 3/2 to 4/4, 4/4, 3/3.
- Change the skill mix in preoperative assessment, replace x2 band 5 posts with band 4s and uplift x1 band 5 post to band 6 to increase nurse-led clinics.
- Recruit to the 10 band 6 posts in theatres (budget uplifted in last assessment from band 5) and recruit to band 7 quality and education lead.

The division has experienced workforce challenges relating to vacancy, supporting sickness absence, high patient acuity, and surgical demand. In view of this, the wards have not always worked within their roster template numbers.

4.3 Therapies and Integrated Community Care

The therapies and integrated community care division has not made any recommendations to change nurse establishments.

4.4 Children's Unit

The children's unit has not made any recommendations to change nurse establishments.

RISKS & CHALLENGES

5.0 **Escalation**

The Trust continues to operate unfunded beds in response to the pressure on UEC pathways. These beds are activated as part of the Trusts full capacity protocol, when the OPEL 3 and/or 4 triggers are met. Where possible, nursing teams stretch to cover areas with additional beds (52 unfunded beds in total), however, **an additional 55.78 WTE in total is required when all escalation areas are open and in use**. The shortfall in staffing requirement is covered by temporary staffing (bank and agency).

Despite needing to use temporary staff (bank and agency) the Trust is committed to reducing this requirement as far as possible and has stretched the existing establishment to cover several of the unfunded beds.

In addition, during the reporting period the Trust has continued to successfully progress the agency reduction programme and has plans in the next reporting period (1 July – 31 December 2025), to implement the Cheshire and Merseyside cost improvement programmes for:

- Standardising bank rates
- 50% reduction in overtime (nursing and AHPs)
- Reduction in additional shifts for 1 to 1 care

5.1 **Vacancy and Unavailability (in WTE)**

The RN vacancy was minimum at 11.02 WTE (1.6%), whilst the HCSW vacancy is much larger at 46.19 WTE (9.4%). To mitigate the vacancy gap temporary staffing is used.

5.2 **Use of temporary nursing staff**

During this reporting period the use of temporary staff has been driven by the vacancy gap (57.21 WTE), unfunded escalation beds (55.78 WTE to operationalise), sickness and absence rates (7% equals 82.56 WTE) and additional staff for patient acuity (for example, 1 to 1).

With the use of temporary staff, fill rates have been maintained overall for registered and unregistered staffing. However, this does not include the unfunded escalation areas, which pull down the fill rate as staff are redeployed to support.

CONCLUSION

6.0 The mid-year establishment review has demonstrated that in most wards and departments the budgeted establishment correlates with the last 2 SNCT data collections.

There have been 4 recommended changes to establishments, one in urgent care and three in planned care. These changes are:

1. Ward 45, to increase the HCSW numbers on the long day from 4/4, 4/4, 3/3 to 4/5, 4/5, 3/3.

2. Ward 54, to increase the HCSW numbers on the late and night shift from 4/4, 4/3, 3/2 to 4/4, 4/4, 3/3.

3. Change the skill mix in preoperative assessment, replace x2 band 5 posts with band 4s and uplift x1 band 5 post to band 6 to increase nurse-led clinics.

4. Recruit to the 10 band 6 posts in theatres (budget uplifted in last assessment from band 5) and recruit to band 7 quality and education lead (no cost).

These changes address the risks identified within the divisional establishment reviews. The divisions have completed a financial impact assessment and have identified funding from within each division to move resource to the highest risks identified. However, urgent care has £19k unallocated following the proposed changes and planned care are £19k short. It is therefore recommended that the balance in urgent care is allocated to planned care to achieve the safe staffing requirement across both divisions.

There have been significant challenges within the reporting period in maintaining the safe staffing numbers due to vacancy, unavailability and escalation, which is driving the use of temporary staff (bank and agency). The Trust is using a slightly higher proportion of bank compared to other organisations; however, this is coupled with a favourable position nationally on agency use, which remains low and continues to reduce.

The vacancy gap continues to close (1.6% for RNs and 9.4% for HCSWs). Unavailability of staff has largely been a result of sickness and absence (7%) and parenting (maternity) leave (3.37%), both of which are above the national comparators. In addition, the pressure to fill the multiple escalation spaces across the Trust has stretched existing teams further and is impacting on the number of redeployments being made, which is likely driving absence as the most report reason for sickness is stress and anxiety.

RECOMMENDATION

7.0 The Board of Directors is asked to **note** the assurance provided in the paper.

(PUBLIC) Board of Directors
25th November 2025

Report	**Agenda Item 15.**	**Safety Surveillance and Learning Report – Quarter 2 2025/26**						
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 and Safety Committee – 6th November 25							
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 Patient Safety Incident Response Framework (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. 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 and examples of this are shared in the paper. In Quarter Two, the Trust reported 2836 incidents. This is a decrease overall of incidents than the previous quarter. Variance is monitored and themes identified, the housekeeping of the Datix system is improving, reducing duplication of incidents and linking of records (in particular, pressure ulcer incidents and security incidents), which also may account for the reduction in the number of incidents being reported. No and Low harm incidents make up 96% of all incidents reported, with 4% being a moderate harm percentage and the remaining less than 1% are severe or catastrophic incidents. Progress of any moderate and above Patient Safety Incident Investigation (PSII) is managed through the weekly Patient Safety Oversight Meeting. To date in 2025/26 the Trust has reported 4 incidents to StEIS and Patient Safety Incident Investigations are progressing. 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, and a new monthly improvement and assurance meeting has commenced.
Recommendations	The Board of Directors is asked to: • **Note** the contents of the paper • **Note** the assurance that the Trust is continuing to promote a learning culture with evident and measurable actions to improve patient safety. • **Note** the improvements and sustainability in governance and oversight workstreams within the Countess of Chester Hospital • **Note** further improvement workstream outstanding regarding Learning from Deaths and Mortality Review. • **Note** the status of all StEIS/PSII reportable incidents.

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

Safety Surveillance and Learning

1. Introduction

The Safety Surveillance meetings take place monthly with divisional representatives and relevant departments e.g. Tissue viability, PALs, Legal team. The Terms of Reference for the meeting are to triangulate themes and learning from incidents, complaints and coronial inquests. This paper presents data for Quarter Two 2025/26.

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) and incidents that are deemed a moderate and above level of harm are monitored through the weekly Patient Safety Oversight Group (PSOM).

Colleagues from the Integrated Care Board, Quality team are invited to the oversight meeting when any PSII is being presented to ensure oversight and external scrutiny.

From November onwards, learning will be presented at the Learning and Sharing forum, under the same format, allowing for updates and improvements of the Quality, Safety and Experience priorities to be presented at the newly formed Quality, Safety and Experience Strategy monthly meeting.

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, develops and embeds the Patient Safety Incident Response Framework (PSIRF) with improved governance and assurances frameworks. A fully established governance forum and is the weekly Patient Safety Oversight Meeting. This provides scrutiny and oversight at an executive level of learning responses of moderate and above harms. 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.

This paper will continue but an additional Quality, Safety and Experience report will now be developed and presented at both Quality Governance Group and the Quality and Safety Committee from December 2025.

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 Two 2025/6

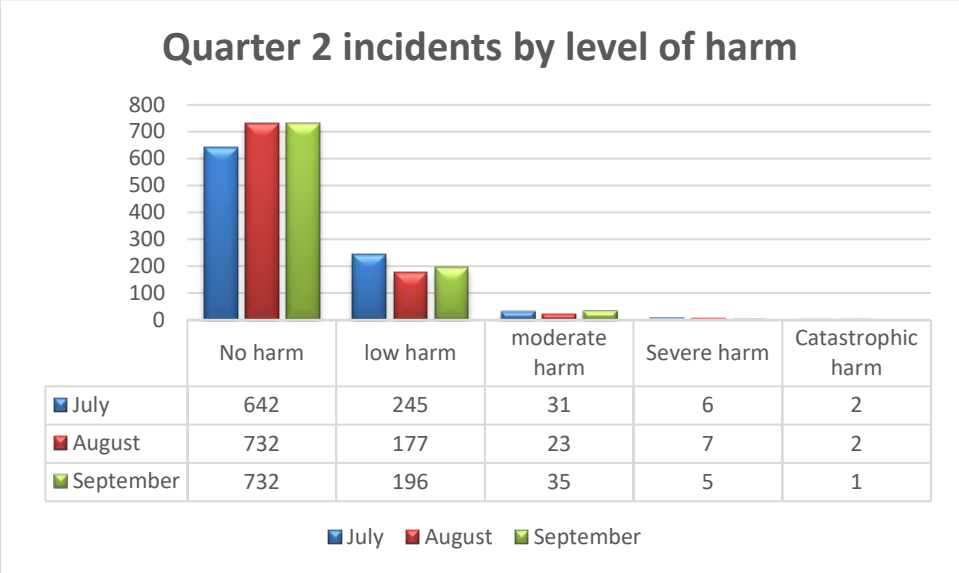
Incident Analysis

In Quarter Two, the Trust reported 2836 incidents. This is a significant decrease more than the previous quarter. No and low-level harm incidents make up 96% of all incidents reported, with 3% being moderate incidents and 1% being severe and catastrophic. This is demonstrated in both Graph 1 and Graph 2.

Variance is monitored and themes identified. 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 and pharmacy, all which can all have an impact on overall reporting numbers.

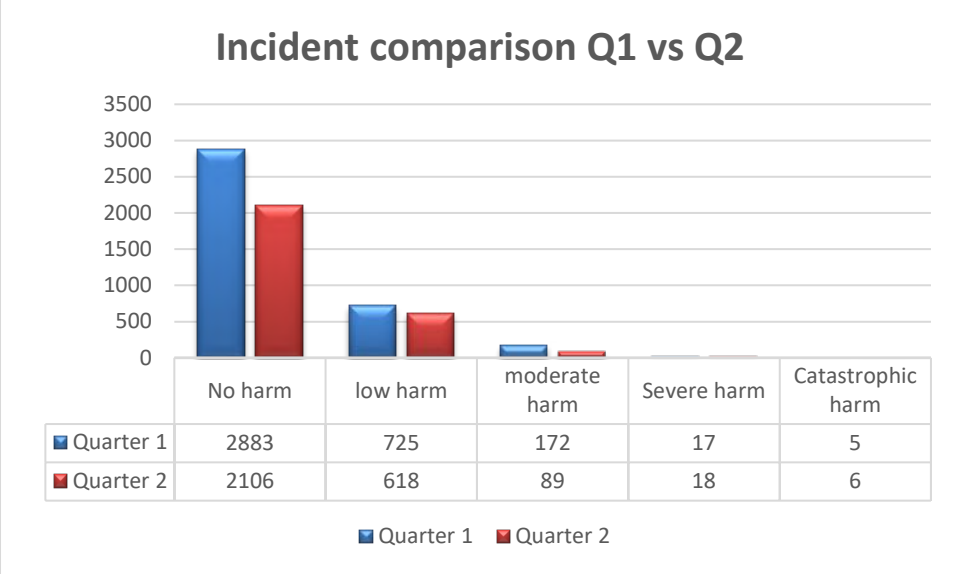
The housekeeping of the Datix system is improving, reducing duplication of incidents and linking of records (in particular, pressure ulcer incidents and security incidents), which also may account for the reduction in the number of incidents being reported.

Graph 1



	No harm	low harm	moderate harm	Severe harm	Catastrophic harm
July	642	245	31	6	2
August	732	177	23	7	2
September	732	196	35	5	1

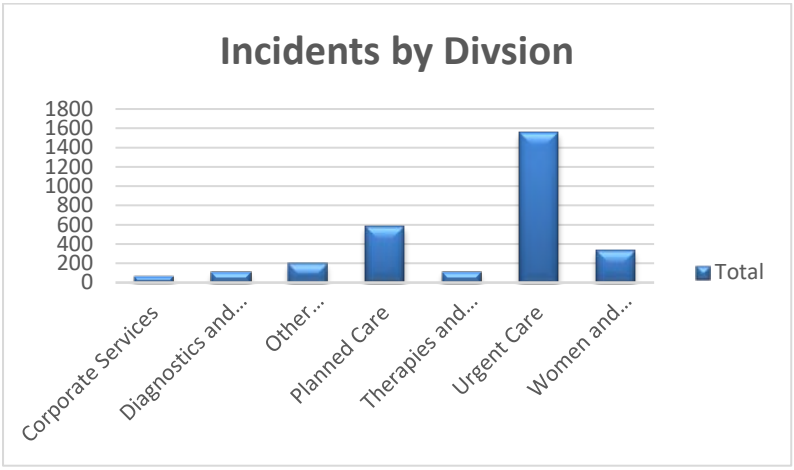
Graph 2



	No harm	low harm	moderate harm	Severe harm	Catastrophic harm
Quarter 1	2883	725	172	17	5
Quarter 2	2106	618	89	18	6

Urgent Care is the highest reporter of incidents, with Planned Care second. The number of overall incidents reported by division can be seen in Graph 3. There were also just under 200 additional incidents that did not occur at the Countess of Chester included in these numbers.

Graph 3



Scrutiny and education are provided to ensure that we are reporting incidents at the correct level of harm.

Moderate harm incidents

Interrogation of moderate incidents in quarter two demonstrates that there were 19 categories of moderate harm were reported. There were 16 categories with 1-3 incidents reported for each category. The top 3 categories of moderate harm were:

1. Skin Integrity (52)
2. Healthcare Associated Infections (HCAI) (11)
3. Treatment (10)

These are the same top 3 categories as the last quarter, and they make up 75 % of all moderate incidents reported.

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

Catastrophic and Severe

Quarter Two saw 5 incidents that have been initially reported as Catastrophic Harm and undergoing the appropriate level of learning response.
Two are being investigated as part of the coronial process
One was an escalation from the medical examiner
One incident related to a fall and one to the recognition of a deteriorating patient.

There were 18 severe incidents over 10 categories – themes of Pressure Ulcers on Arrival and Ophthalmology patient pathways.

Overall Incident Themes:

The top 5 reported incidents in Quarter Two are:

- Skin Integrity – 16%
- Slips, trips and falls – 9%
- Staffing – 6%
- Treatment – 5%
- Security response/ Abuse from patient to staff – 5%

Complaints and Concerns

Across services in Quarter Two, the most common themes center on delays, communication failures, and concerns about care quality. Within Women & Children's, issues include long waits, cancelled appointments, unclear or conflicting diagnoses, and poor follow-up in gynecology; traumatic births, inconsistent postnatal support, and conflicting information in obstetrics; and misdiagnosis concerns, poor communication, and staff attitude in pediatrics. TICC reports highlight problems with accessing services, appointment confusion, and dissatisfaction with communication and discharge processes. In UEC, patients report poor quality of care, delayed assessments and diagnostics, and unsafe or poorly communicated discharges. Non-UEC concerns mirror this, focusing on communication breakdowns, repeated cancellations, coordination failures, and worries about patient safety and basic care standards. Planned Care themes emphasise widespread communication lapses, long waits for appointments, tests, and surgery, and poor discharge planning or follow-up. Finally, DCSS feedback highlights delays in receiving results, staff attitude issues, alongside administrative concerns about record updates and personal information.

Examples of key learnings identified in complaints are as follows:

- The team have commenced work to improve this gap in care by implementing a mandatory Care and Compassion workshop for all Emergency Department staff to attend, running weekly from June through to September.
- Mobile medication carts have been provided to all nursing staff to ensure timely administration of medications to patients.
- Area leads have been allocated to each area within the department, with the expectation being that they have oversight of all patients and escalate to the Nurse Team leader or Matron if a patient's needs are not met.
- We have recently installed a Tannoy system in the Emergency Department and created a Standard Operating Procedure to give 2 hourly departmental updates, including what patients should expect during their time in the Emergency Department with details on how and who to escalate to, if basic needs are not met.
- Mandatory catheter plans are now included as part of the discharge checklist.

Examples of Learning shared can be seen in Appendix 1.

Learning from Deaths/Coroner Inquests

Every death in the Trust is 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.

Improvements 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 initiated, completed with PSOM oversight received. 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.

Examples from Learning from Deaths (coroners) are as follows:

- VTE monitoring/dashboard
- Education and training
- Explore digital solution to prevent the function of overriding VTE assessment alerts
- Education re early referral to Palliative care
- A 5-day, senior led departmental initiative to enhance early recognition and prompt management of sepsis, including accurate fluid balance and NEWS2 assessment and escalation.
- Training of resident doctors in the insertion and management of Ryle's tubes
- Operating Procedure for the management of patients with Ryle's tubes (specifically in cases where they are spigotted)

Patient Safety Incident Response (PSII)

In Quarter One of 2025/26 we reported three incidents to StEIS. These can be seen in table 1. Two are Never Events, both relating to a retained object (both guidewires). In Quarter Two we reported one PSII to StEIS.
Progress of any PSII is managed through the weekly Patient Safety Oversight Meeting.

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 when a PSII is to be presented

Table 1 - The current position of the Trust PSIIs 205/26

Table 1

Incident
Retained Object – NG Guidewire
Retained Object – Midline Guidewire
Delay in Treatment
Unexpected Death

Conclusion

The Trust continues in its journey with PSIRF, reviewing and changing processes as required, including the additional Quality, Safety and Experience strategy and subsequent oversight meeting. This will further support the quality, safety and experience culture in the trust.
Learning is shared at a variety of forums, which can be seen in Appendix 2. An Organisational learning policy is being developed and is in draft form for approval.

Process and governance surrounding coroners' inquests are 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.
A notable decrease in all incidents reported in Quarter Two, with incidents with moderate harm and above, making up less than 5% of all incidents reported. All PSII from previous year have been closed, bar two which are part of an external process. Four PSII have reported in this financial year.
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

Recommendations

The Board of Directors is asked to:

- Note the contents of the paper
- Note the assurance that the Trust is continuing to promote a learning culture with evident and measurable actions to improve patient safety.
- Note the improvements and sustainability in governance and oversight workstreams within the Countess of Chester Hospital
- Note further improvement workstream outstanding regarding Learning from Deaths and Mortality Review.
- Note the status of all StEIS/PSII reportable incidents

Appendix 1

Examples of Learning shared at the monthly Learning and Sharing forum.

Category of Learning	Learning Shared
Venous Thromboembolism (VTE assessment	All patients must have a VTE assessment and appropriate treatment initiated within 14 hours of admission to hospital.
Urinary Catheter Leg Straps	To avoid any skin integrity incidents, please ensure that the leg straps to secure the urinary catheter are in place and checked regularly.
Patients Identified at Risk of a Fall	A lying and standing blood pressure must be recorded for patients over 65 years old, or at risk of falls, or admitted with a fall. Bed rail assessments must be completed if the patient is at risk of having a fall. If a patient has been identified as at risk of a fall, ensure that the Care Plan has been initiated.
Sepsis Screening	ALL patients with a NEWS2 score of 5 or more, or score of 3 in one parameter MUST BE screened for sepsis
Fluid Balance	Please ensure that patients with: * Acute Kidney Injury * NEWS2 score of greater than 5 are commenced on a fluid balance chart. This chart must be completed in full every 6 hours to allow for accurate fluid / patient management.
Thrombo-Embolic Deterrent (TED)stockings	Please ensure that TED stockings are removed daily for personal hygiene and for skin integrity checks.
Urinary Catheter Passport	Please ensure that, prior to discharge, patients with a urinary catheter are given: emergency contact details a catheter passport
Hospital Passport/ This is Me	Any patient with a learning disability or autism should be offered a Hospital Passport to complete. Any patient with dementia should be offer a 'This Is Me' to complete. In both cases, support should be offered to complete the documents, a copy should be retained in their electronic notes, and the original should be accessible for all staff to review when delivering care.
Infection Prevention	When you are entering a clinical area in accordance with Trust policy, please ensure you are bare below the elbows.

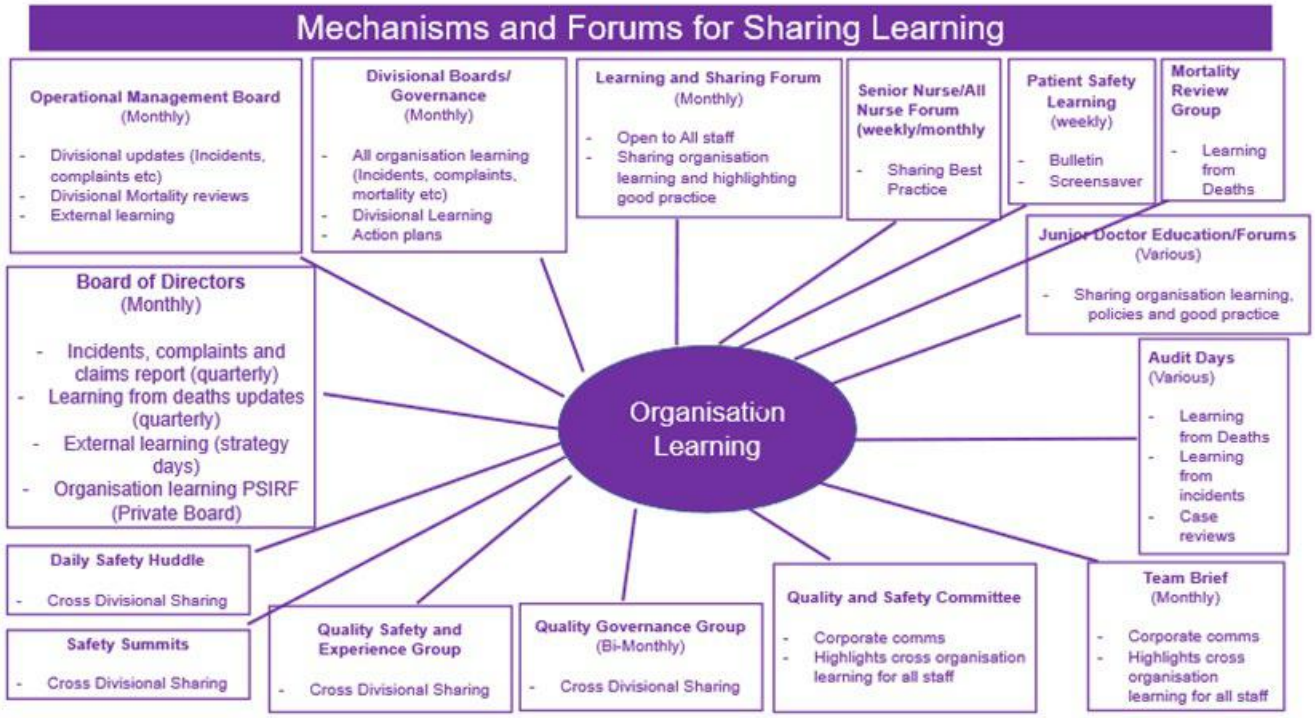
Learning and Sharing Forum – topics included:

- Quality Priorities
- Quality, Safety and Experience Strategy
- Infection Prevention Audit
- ETOC (Enhanced Therapeutic Observations of Care)
- Safeguarding decision tool
- IV additives
- MEG audit tool

- Pressure Ulcer Improvement
- Other forums for learning:
- Patient Safety Summit – July
- I Am More Than My Diagnosis" – a patient's story

All patient Safety Summits are recorded alongside other learning forums on the trust intranet for staff who were unable to attend to watch and learn.

Appendix 2



(PUBLIC) Board of Directors
25th November 2025

Report	**Agenda Item 16.**	**Quarter 2 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**				
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 ongoing 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 July 24 - June 25 is 90.0 ('as expected' range) • HSMR for July 24 – June 25 is 94.9 ('as expected' range) • SMR for July 24 – June 25 is 94.9 ('as expected' range) There is currently a backlog in the timeliness of specialty M&M review of some cases due to the previous absence of the learning from deaths administrator. Further work is being undertaken to improve the reporting and capturing of quality care and avoidability of death assessments within mortality reviews							

	A detailed mortality and pathway review is currently being undertaken due to persistent statistical significant outlier status for patients admitted with a Stroke. This review is due to be available in January 2026. 2 previous reviews have been undertaken when on 2 separate occasions a CUSUM alert identified higher number of deaths than expected. Appropriate care was confirmed.
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	Legal and regulatory compliance.
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 2 2025-6

Mortality Review	Mortality Rate (SHMI / HSMR)
• 240 patients died (inpatient) in the Trust between 1st July 2025 – 31st September 2025 • 100% were scrutinised by the Medical Examiner's Office • 44 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 • A pathway mortality review is being undertaken into patients presenting with acute cerebrovascular disease (Stroke) due to observed > expected mortality (Outlier status).	• SHMI for July 24 - June 25 is 90.0 ('as expected' range) • HSMR for July 24 – June 25 is 94.9 ('as expected' range) • SMR for July 24 – June 25 is 94.9 ('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
July 2025	83	83	13	10	1
August 2025	75	75	12	7	1
September 2025	83	83	19	12	1

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

Potential delay in clinical review and response to increasing NEWS score (Incident logged)
Review the decisions for treatment against the advice of the palliative care team
Review the decisions for amount of blood transfusion. Complex care across many teams. Was location of her care correct?
Suggest case is reviewed as cardiac arrest in CT scan (Incident logged)
Didn't lead to death, however patient experience in ED was not optimal. Delays in assessment.
Multiple concerns by family members about standards of care (Incident logged)
External agency: Patient managed as approaching end of life but no apparent community planning as to palliative care / preferred place of death.
On balance, care given to this unfortunate man was of a god standard. Potential delay in correcting his electrolyte imbalance
Lack of Advanced Care Planning between hospital and Community
Numerous ward moves.
Given the complexity of the case and NG insertion, could a permanent method of feeding have been considered earlier?

Learning themes from Mortality reviews

Since February 2024, the themes for learning are reviewed monthly and themes /areas for learning are chaired 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. There is a significant overlap in aspects of care identified by the medical examiners, mortality reviews, clinical incidents and complaints.

There has been a gap in the learning from deaths administration due to illness, so there is a backlog of outstanding Mortality review requests at Specialty level. A paper outlining an action plan / tracker is being monitored by Quality and Safety Committee.

Good care	Gaps in care / Learning identified
Good care supplied, Pre-op optimisation, Pre op MDT discussion. Post op orthogeriatric management Seen by ED and stroke team in very timely manner, Prompt referral to Walton. MDT management of the case, considered patients wishes and respect her beliefs in choosing treatment plan Appropriate escalation throughout Excellent out of hours care received. (2 offsite consultants attending within 30 mins) Good care & initial management from ED and early ITU input / escalation Good documentation with medical and nursing colleagues about communication with family Mult disciplinary team discussion (Orthopaedic, medical and anaesthetic) led to decision against operating. Family involvement Prompt assessment and agreed ceilings of care CT Head done in timely manner Responsible consultant spoke with next of kin following death.	Safeguarding concerns could have been flagged in early part of patient journey. Update required on confirmation of death (EPH) especially out of hours (Policy update has been competed) Delay in CT imaging (initially delayed appropriately due to poor renal function and contrast) Early imaging may have allowed better prognostication / conversation with family. Did not alter patient outcome/care. Neuro-observations were not undertaken (as patient combative) not clearly documented as to the reason. Full falls assessment incomplete. Due to complex decisions/management, Clinical team may have been best to seek second opinion. Delay in documentation of complex family discussions. Awareness of involving cardiology in withdrawal of care due to de-activation of PPM/ICD.

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) suggest impending outlier indices. The Mortality Surveillance Group reviews these diagnosis groups with targeted case reviews.

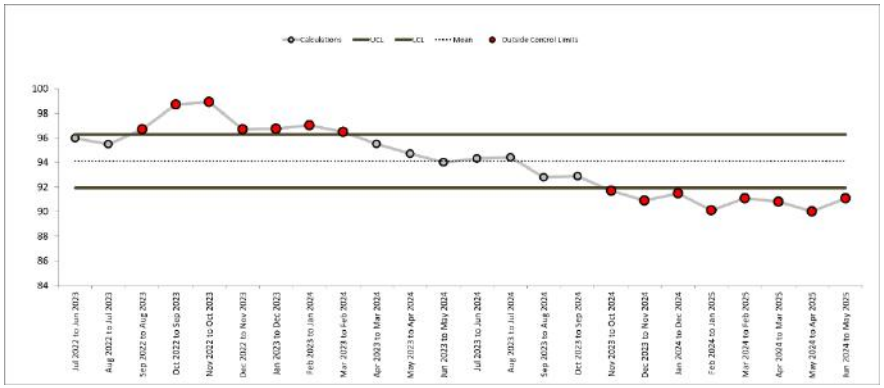
Cerebrovascular Disease remains on the Mortality Surveillance review list as a significant increase in mortality in Feb and March 2024 will continue to influence the statistics until the 12-month rolling period expires. A second review of mortality was undertaken in January 2025 (period up to November 2024) and similar to that done in mid-2024 did not find any cause for concern to account for the higher than expected mortality.

The Stroke team are currently reviewing all deaths in a 12 month period, along with outcomes, pathway compliance to provide a comprehensive overview. This is due to be completed January 2026.

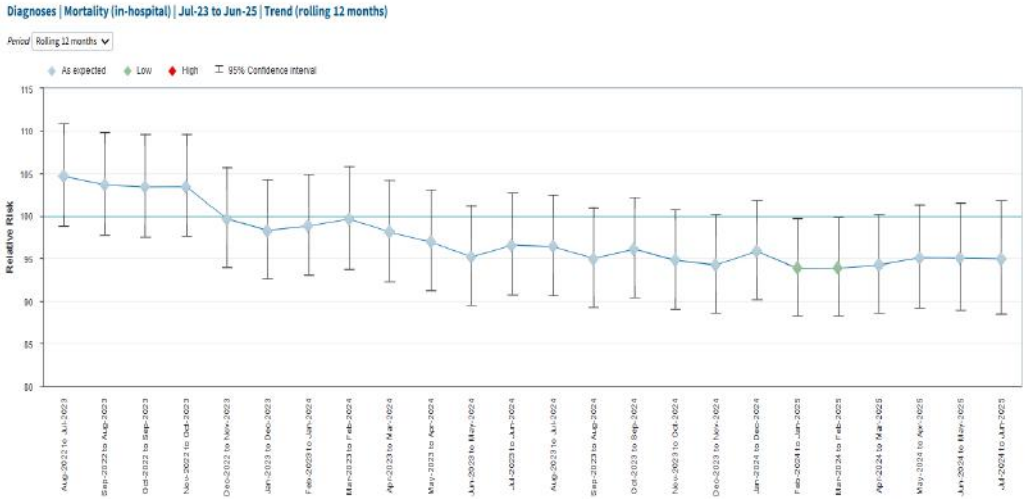
The Trust is a positive outlier across several diagnoses' groups:

Aortic and peripheral arterial embolism or thrombosis, Non Hodgkin's lymphoma, Other GI disorders and septicaemia

Mortality Data



SHMI Trend



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

HSMR Regional Position

Notes:

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).

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.

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

Committee Chair's Report
Thursday 25th September 2025, 8.00am – 1.00pm
Boardroom, 1829 Building

Committee	Operational Management Board (OMB)
Chair	Ms Jane Tomkinson, Chief Executive Officer

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

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

- There were no new items to alert to the Board.
- The OMB received an update on RTT performance and recovery plans; and CIP scheme maturity and delivery.

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

- Review of outpatient areas had been initiated and actions required to ensure clarity of accountability to drive standards.
- Integrated Performance Report exceptions reviewed with deep dive into RTT performance and recovery plans.
- People metrics improving across many areas, notwithstanding pockets of lower performance and action needed. A number of projects are progressing including flexible working arrangements. An update on culture was shared with OMB.
- Quality and harms update with an overview of incidents, themes and learning. Timeliness of responses to complaints was an area that as a Trust we need to improve and revised processes were proposed to support this. An update was provided on the actions being taken in respect of sepsis management.
- Inpatient survey results were presented, including the areas requiring action.
- Finance position on plan at month 5 including cash position, and CIP delivery.
- CIP/PDO report demonstrated progress in maturity of schemes, with further work required to close the gap.
- Research update provided.
- Divisional Performance and Risk updates were provided by each clinical Division. These covered quality and safety, activity, finance, risk and people metrics.

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

- Research Strategy being developed.

Risks discussed and new risks identified

- Work continues to develop risk management processes and reporting with the Risk Management Committee receiving Divisional Risk Reports.

Committee Chair's Report
Thursday 23rd October 2025, 8.00am – 1.00pm
Boardroom, 1829 Building

Committee	Operational Management Board (OMB)
Chair	Ms Jane Tomkinson, Chief Executive Officer

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

Alert ***(matters that the Committee wishes to bring to the Board's attention)***
• Admin/secretarial vacancies and impact on typing backlogs with a plan due to be reviewed through Executive Directors Group (EDG), recognising the future implementation of Ambient Voice alongside mitigating the current risks. • NHS Oversight Framework (NOF) position was discussed with OMB along with an update on performance and recovery plan progress including Referral to Treatment (RTT), Urgent Emergency Care (UEC), Infection Prevention & Control (IPC) and finance.
Assure ***(matters in relation to which the Committee received assurance)***
• Estates and facilities update demonstrating the work being undertaken to improve governance, decision making, risk management and escalation. Included environmental improvements aligned to IPC standards, water safety and specialist compliance, policies, governance, reputation and engagement with stakeholders, strengthened health and safety processes, security services, facilities and cleaning standards, clinical engineering and equipment maintenance, financial performance and efficiency, strategic estates and facilities assurance and planning aligned to national standards and requirements. Key priorities include infrastructure resilience, sustainability and net zero, operational excellence, people and culture, financial efficiency, assurance and governance. • People metrics improving across many areas, notwithstanding pockets of lower performance and action needed. Divisional updates provided confirmation of this. • Quality and harms update with an overview of incidents, themes and learning. Increase in concerns escalating to complaints and seeing more complaints from historic events. Infection Prevention Control MRSA cases including learning and areas for quality improvement. Update on band 2 to 3 project, and wider changes in national nursing and midwifery profiles. • Finance position on plan at month 6 but position is £5.1M overspend due to non-receipt of deficit support funding. Pressure on cash position, CIP delivery and escalation costs. Recovery plan in place and focus needs to remain on closing the gaps. Director of Delivery establishing further work and engagement with Directorates to identify opportunities. • Divisional Performance and Risk updates were provided by each clinical Division. These covered quality and safety, activity, finance, risk and people metrics. OMB requested further updates on admin/secretarial gaps and

actions, microbiology risk, phlebotomy services, policy updates and ward moves.
Advise *(items presented for the Board's information)*
• Revised People Strategy shared with OMB prior to Board review and approval. • Verbal update on Ambient Voice technology business case being developed and procurement pipeline alongside Regional funding streams. • Innovation fortnight (November 2025) being proposed through Cheshire & Merseyside (C&M) system as a catalyst to drive change and do things differently. CoCH mobilising this locally with the kick off meeting planned 3rd November 2025 and follow up 10th November 2025. • NHS England (NHSE) undertakings shared with OMB. • C&M blueprint shared with OMB with a further, more in-depth session planned for OMB and Clinical Leads day in November 2025. • Verbal update provided on E'roster progress, next steps and roll out of implementation. • Verbal update on mutual aid request from Wirral University Teaching Hospitals NHS Foundation Trust (WUHFT) following standing up a major incident regarding decontamination and impact on surgery, with support to be provided to access orthopaedics kits and where clinically appropriate diversion of patients (including trauma and cancer surgery) on fair distribution.
Risks discussed and new risks identified
• Risk report demonstrated some triangulation to the key areas on the agenda, and updates provided by Divisions. Work continues to develop risk management processes and reporting, with a new guidance document and the development of training material to be rolled out.

Committee Chair's Report

4th November 2025, 13.30-16.30, Boardroom, 1829 Building

Committee	Finance & Performance Committee
Chair	Ms H Gunawickrema, Non-Executive Director

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

Alert

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

- Update on Hybrid Theatres recognising that this has been paused and therefore the Committee won't receive the timetable and deep dive on the Full Business Case (FBC) until such time the decision is to progress.
- Funding being explored to support winter planning capacity to mitigate reductions in beds (circa movement to minus 15 beds without the options being supported with potential cost pressures of £700k). Context also provided of the growth in attendances through the Emergency Department (ED).
- Cash position remains a concern; the mitigating actions are being progressed recognising short and long term challenges.
- Under delivery of recurrent Cost Improvement Programme (CIP) offset by other non-recurrent actions and continue to drive CIP forward.

Assure

(matters in relation to which the Committee received assurance)

- Update on digital and data priorities and projects. Included discussion on governance and risks related to the deployment of Artificial Intelligence (AI), and ambient voice technology. Digital and data annual report and Senior Information Risk Owner (SIRO) report.
- Emergency Preparedness Response & Resilience (EPRR) annual report and core standards compliance demonstrating improvement from partial compliance to substantial across the wide range of standards assessed.
- Winter plan update including escalation space, Urgent & Emergency Care (UEC) flow improvements, and options for capacity being discussed within the Trust and with NHS England including funding options (this would be brought back to Finance & Performance Committee). The plan included assurance statements on capacity, Infection, Prevention & Control (IPC), leadership and a risk assessment. This was approved by Chair and Chief Executive Officer on behalf of the Board following the Board review of the plan for the submission in September 2025.
- Operational performance in the Integrated Performance Report (IPR) demonstrating progress against plan and recovery trajectories.
- Month 6 financial position was £5.1m adverse variance to plan, due to not receiving deficit support funding of £4.9m and 0.2m associated with industrial action.
- Chair AAA reports received from reporting Committees and groups with no areas of alert for escalation to the Board.

Advise ***(items presented for the Board's information)***
• Update on Annual planning including leads, timetable and planning meetings, notwithstanding we are awaiting publication of the national guidance. Review of submission timeframes and Board meetings will be reviewed to ensure we have clear governance for Board scrutiny, assurance and sign off. • Level of No Criteria to Reside (NCTR) continuing to impact performance, importance of flow and discharge actions, and continued increase in dermatology referrals as discussed at the Board.
Risks **(discussed and new risks identified)**
• Review of the Board Assurance Framework (BAF) 3, 5, 6, and 7 and related high risks. Recognising the risk management improvement work that continues.

Committee Chair's Report
7th October 2025

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

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

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

- No specific items to alert but a number of areas identified below to keep under review through the Audit Committee.

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

- Anti-fraud progress report demonstrated a range of activity against plan.
- Freedom to Speak Up (FTSU) arrangements and processes, with continued focus on improvement including triangulation with other routes and sharing learning with People Committee.
- Provider licence compliance checklist received with a mid-year update on key aspects of the requirements, notwithstanding the long standing performance challenges.
- System Oversight Framework (SOF) data quality complex patient discharge pathways received limited assurance and identified some areas for action. Divisional Director, Therapies and Integrated Community Care (TICC) provided assurance that these actions are nearing completion including data validation, narrative for Board reporting and Standard Operating Procedure (SOP).
- Data Security and Protection Toolkit (DSPT) audit review provided assurance of Trust assessment but recognised more work to do to improve compliance with toolkit.
- Audit recommendations tracker and follow up showed good progress of implementation. Discussion took place on some of the extension to timeframes to ensure clarity of rationale.
- Continued progress with the recovery programme for out of date policies, recognising a significant number of clinical policies are expected to progress through a further extraordinary Quality Governance Group meeting in October 2025.
- Standing Financial Instruction (SFI) procurement waiver compliance 2024/25.

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

- Five ongoing fraud investigations at various stages.
- Approved an update to the anti-fraud, bribery and corruption policy and response plan to include reference to the failure to prevent fraud legislation.
- Governance organogram will be further developed following the Mersey Internal Audit Agency (MIAA) Divisional governance support which is in progress.

• Technical updates from Internal and External audit both referred to Artificial Intelligence(AI) governance and this is something that should be considered for a future Board development day.
Risks discussed and new risks identified
• Received the Board Assurance Framework (BAF) 8 extract relating to the work of the Committee and discussed the potential to reduce the residual risk in Quarter 3. The Committee also noted the importance of the BAF being a key tool in the Trust and the need to continue to embed this across Committees.

(PUBLIC) Board of Directors
25th November 2025

Report	**Agenda Item 21.**	**Emergency Planning & Resilience (EPRR) Core Standards Annual Report**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Cathy Chadwick			Chief Operating Officer				
Author(s)	Emma Binns			EPRR Manager				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X** **X** **X** **X** **X** **X**				
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	EPRR Annual Report and full core standards submission provided to the Finance and Performance Committee on the 4th November 2025.							
Executive summary	This report provides an executive overview of the Trust's Emergency Preparedness, Resilience and Response (EPRR) arrangements, focusing on compliance with the NHS England EPRR Core Standards for 2025/26. It highlights progress since the previous year, identifies current gaps, and outlines the action plan to achieve full compliance. The Annual report and full core standards submission was presented to the Finance and Performance Committee on the 4th November 2025. Compliance Status: • The Trust self-assessed as "substantially compliant" with fifty-six out of sixty-two applicable standards fully met, and six partially met. This marks an improvement from 'partial' to 'substantial' compliance compared to last year. • No standards were assessed as non-compliant.							

	• The Trust's EPRR arrangements meet statutory and regulatory requirements, including the Civil Contingencies Act 2004, NHS EPRR Framework 2022, and other relevant legislation. Governance and Assurance: • The self-assessment was reviewed and agreed by the NHS Cheshire & Merseyside EPRR Team, with constructive feedback provided. • Five randomly selected standards were fully assessed: Evacuation & Shelter, On-call Mechanism, Decision Logging, Testing & Exercising, and PPE Access. • Progress will be monitored by the EPRR Strategy Group, OPELG, and the Finance & Performance Committee. • The Trust is actively participating in multi-agency exercises (e.g. Exercise Paddock) to further test and embed EPRR arrangements. Action Plan: • The report includes a detailed action plan addressing areas of partial compliance, with clear target dates and responsible leads. • Key focus areas for improvement include Evacuation and Shelter, Business Continuity, Training & Exercising, and Hazmat/ CBRNe equipment and exercising. The Trust has made significant progress in strengthening its EPRR arrangements, moving towards full compliance with NHS Core Standards. Continued focus on the identified action areas and regular review of plans, training, and exercises will ensure ongoing resilience and preparedness for emergencies.
Recommendations	The Board of Directors is requested to**:** • **Note** the improvement in compliance with the EPRR Core Standards from "partial" to "substantial"**.** • **Note** the actions to be taken within the action plan and the progress made in embedding the EPRR agenda across the Trust.

Corporate Impact Assessment	
Statutory/regulatory requirements	Meets the requirements of the Civil Contingencies Act 2004 and NHS EPRR Framework 2022
Risk	Aligns with the Trust Risk Management Policy and National and Local Community Risk Registers for EPRR.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published on Trust website following approval.

Emergency Planning & Resilience (EPRR) Core Standards Annual Report

1.0 Executive Summary

1.1 The annual NHS England EPRR Core Standards Assurance is the minimum standard all providers and commissioners of NHS services are required to meet with regards to their Emergency Preparedness Resilience and Response (EPRR) portfolio. It forms the basis of assurance against NHS Resilience, seeking to understand whether organisations will be capable of maintaining critical services whilst responding to or managing a disruption. All findings ultimately report through to the Department of Health and Social Care (DHSC) and the Secretary of State for Health and Social Care.

1.2 There were 62 standards applicable to the Countess of Chester Hospital (CoCH) for 2025/26. The return along with supporting evidence was submitted in draft to the Cheshire & Merseyside Integrated Care Board (ICB) EPRR Team on the 3rd of October and was self-assessed as **"substantially compliant"**. The Annual Self-Assessment Assurance process, which was reviewed by the NHS Cheshire and Merseyside EPRR Team aims to provide constructive feedback to allow for continuous development. The process is achieved by reviewing the evidence submitted against 5 randomly selected core standards from the 62.

The 5 standards that were randomly selected for CoCH were:

Core Standard:	Title:	Standard detail:
16	**Evacuation and Shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.
20	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.
29	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24-hour access to a trained loggist(s) to ensure support to the decision maker

48	**Testing & Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.
65	**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7

1.3 A letter from the Director of Performance and Planning / AEO at Cheshire & Merseyside NHS was received by the Trust AEO, Cathy Chadwick on the 20th October confirming that they agree with the self-assessment. The outcome and feedback are attached at 5.0. An action plan inclusive of recommendations has been included at appendix 1.

2.0 Legal and Regulatory requirements

2.1 The content of this report is directly applicable to requirements listed in:

- Civil Contingencies Act 2004.
- Emergency Preparedness Regulations 2005,
- Emergency Response and Recovery, 5th Edition, 2013, and
- associated Cabinet Office guidance.
- Expectations and indicators of good practice set for category 1 and 2 responders
- Section 46 of the NHS Act 2006, as amended by the Health & Social Care Act 2012.
- Health & Safety at Work Act 1974.
- Health and Care Act 2022.
- Equality and health inequalities legal duties.
- The National Risk Register.
- Skills of Justice NOS.
- Minimum Occupational Standards for NHS Emergency Preparedness, Resilience and Response (**MOS**).
- NHS England Business Continuity Management Framework (Service Resilience).
- NHS EPRR Framework, 2022.
- ISO 22301:2019 Security and resilience – Business continuity management
- NHS Constitution.
- NHS Standard Contract(s).
- NHS Core Standards for Emergency Preparedness, Resilience and Response.

- Other EPRR guidance available on the NHS England website.

2.2 Other applicable items include:

- The Counter Terrorism and Security Act 2015.
- Control of Major Accident Hazards Regulations 2015.
- Radiation Emergency Preparedness& Public Information Regulations 2001.
- Management of Health & Safety at Work Regulations 1999.
- Data Protection Act 2018.
- General Data Protection Regulations.
- Health Protection Legislation (England) Guidance 2010.
- Caldicott Principles.

3.0 EPRR Core Standards

3.1. Whilst there are a total of 73 standards and 11 domains, the applicability is dependent on the organisation's function and statutory requirements. COCH is rated against standards applicable to "Acute Providers". The overall assurance rating is reached via percentage of standards assessed as 'fully compliant'.

3.2. This year COCH was assessed against 62 standards, 56 of which were rated as 'fully compliant' and 6 were rated as 'partially compliant'. This provides an increased assurance rating from 'partially compliant' to **substantially compliant.** . No standards were assessed as non-compliant.

3.3. In 2024 the Trust:

Achieved full compliance against 50 standards.
Partial compliance against 12 standards

The criteria between full, partial and non-compliance of standards is as follows:

Individual Standard Compliance level	Compliance Definition (Main return)
FULLY COMPLIANT	**Fully compliant** with the core standard.
PARTIALLY COMPLIANT	**Not compliant** with the core standard. However, the organisation's EPRR work programme demonstrates **sufficient evidence of progress and an action plan** is in place to achieve full compliance within the next 12 months.
NOT COMPLIANT	**Not compliant** with the core standard. The organisation's EPRR work programme shows compliance will **not** be reached within the next 12 months.

4.0 Process of assurance

4.1 The EPRR Manager completed the self-assessment spreadsheet, and evidence was cross referenced and submitted via the NHS Cheshire & Merseyside ICB Resilience Direct depository on the 3rd October 2025.

4.2 As highlighted above, the Trust have been fully assessed against 5 of the 62 Standards (selected at random) as follows:

Domain 3 Duty to maintain plans – Evacuation & Shelter
Domain 4 Command and Control – On-Call Mechanism
Domain 7 Response – Decision Logging
Domain 10 Business Continuity – Testing & Exercising
Domain 11 Hazmat/ CBRN – PPE Access

4.3 Further evidence was requested in support of three of the standards, this was uploaded and agreed in the final report.

4.4 The EPRR work programme will be updated to incorporate the recommendations from this process where they cannot be rectified immediately.

4.5 Progress against this workplan will be overseen by the Emergency Preparedness Resilience and Response (EPRR) Strategy Group, Operational and Executive Led Group (OPELG) and the Finance & Performance Committee (F&P).

4.6 Summary of compliance against the NHS England EPRR Core Standards 2024 submitted by COCH.

ASSESSMENT			WORKPLAN		
Ref	**STANDARD**	**Self- assessed rating** *Fully compliant = 58* *Partially compliant = 2*	**Action Lead**	Projected date of completion **2025/26**	 **2026/27**
Domain 1: Governance					
1	Senior Leadership	Fully compliant	CEO		
2	EPRR Policy Statement	Fully compliant	EPRR Manager		
3	EPRR board reports	Fully compliant			
4	EPRR work programme	Fully compliant			
5	EPRR Resource	Fully compliant	AEO/ EPRR Manager		

6	Continuous improvement	Fully compliant	EPRR Manager		
Domain 2: Duty to Risk Assess					
7	Risk assessment	Fully compliant	EPRR Manager		
8	Risk Management	Fully compliant			
Domain 3: Duty to Maintain Plans					
9	Collaborative planning	Fully compliant	EPRR Manager		
10	Incident Response	Fully compliant			
11	Adverse Weather	Fully compliant			
12	Infectious disease	Fully compliant			
13	New and emerging pandemics	Fully compliant			
14	Countermeasures	Fully compliant			
15	Mass Casualty	Fully compliant			
16	Evacuation and shelter	Partially compliant		Q3 – Q4	
17	Lockdown	Fully compliant	EPRR Manager Head of Health & Safety Fire Safety Officer		
18	Protected individuals	Fully compliant			
19	Excess fatalities	Fully compliant			
Domain 4: Command and Control					
20	On-call mechanism	Fully compliant	EPRR Manager		
21	Trained on-call staff	Fully compliant			
Domain 6: Training & Exercising					
22	EPRR Training	Fully compliant	EPRR Manager		
23	EPRR exercising and testing programme	Fully compliant			
24	Responder training	Fully compliant			
25	Staff Awareness & Training	Partially compliant			
Domain 7: Response					
26	Incident Co-ordination Centre (ICC)	Fully compliant	EPRR Manager		
27	Access to planning arrangements	Fully compliant			

28	Management of business continuity incidents	Fully compliant			
29	Decision Logging	Fully compliant			
30	Situation Reports	Fully compliant			
31	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Fully compliant			
Domain 8: Warning and Informing					
33	Warning and informing	Fully compliant	Head of Comms/ EPRR Manager		
34	Incident Communication Plan	Fully compliant			
35	Communication with partners and stakeholders	Fully compliant			
36	Media strategy	Fully compliant			
Domain 9: Cooperation					
37	LHRP Engagement	Fully compliant	EPRR Manager/AEO		
38	LRF / BRF Engagement	Fully compliant			
39	Mutual aid arrangements	Fully compliant			
40	Arrangements for a multi area response	Fully compliant			
43	Information sharing	Fully compliant			
Domain 10: Business Continuity					
44	BC policy statement	Fully compliant	EPRR Manager	Q3/Q4	
45	Business Continuity Management Systems (BCMS) scope and objectives	Fully compliant			
46	Business Impact Analysis/Assessment (BIA)	Partially compliant			
47	Business Continuity Plans (BCP)	Partially compliant		Q3 - Q4	Q1 – Q4
48	Testing and exercising	Partially compliant			
49	Data Protection and Security Toolkit	Fully compliant	Cyber Security Senior Specialist		
50	BCMS monitoring and evaluation	Fully compliant	EPRR Manager		
51	BC audit	Fully compliant	AEO / EPRR Manager		

52	BCMS continuous improvement process	Fully compliant	EPRR Manager		
53	Assurance of commissioned providers / suppliers BCPs	Fully compliant	EPRR Manager Head of Operational Procurement & Supplies		
Domain 11: HazMat/ CBRNE					
55	Governance	Fully compliant	EPRR Manager Clinical EPRR Lead PDN ED		
56	Hazmat/CBRN risk assessments	Fully compliant			
57	Specialist advice for Hazmat/CBRN exposure	Fully compliant			
58	Hazmat/CBRN planning arrangements	Partially compliant			
59	Decontamination capability availability 24/7	Fully compliant			
60	Equipment and supplies	Partially compliant		Q3 – Q4	
61	Equipment - Preventative Programme of Maintenance	Fully compliant			
62	Waste Disposal Arrangements	Fully compliant			
63	Hazmat/CBRN training resource	Fully compliant			
64	Staff training - recognition and decontamination	Fully compliant			
65	PPE Access	Fully compliant		Q3 – Q4	
66	Exercising	Partially compliant			

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5.0 ICB Feedback on assessed Core Standards

Appendix 1 Core Standard	Domain	Standard Name	Standard Detail	Supporting information - including examples of evidence	Feedback	Comments
16	**Duty to maintain plans**	**Evacuation and Shelter**	**In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.**	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Agree	Submitted as partially compliant. Draft plan to be updated to align with core standard requirements.
20	**Command and control**	**On-call mechanism**	**The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.**	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/hand-book available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	Agree	EPRR Policy updated to include governance. On the next review please ensure times of on-call shifts are referenced and would suggest including into On-Call Rota/Handbook.

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29	**Response**	**Decision Logging**	**To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure sup-port to the decision maker**	• Documented processes for accessing and utilising loggists • Training records	Agree	Would advise that the Trained Loggist list is available in the ICC in the event that the website is unavailable.
48	**Business Continuity**	**Testing and Exercising**	**The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.**	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	Agree	Submitted as partially compliant. Testing and exercising schedule to be completed

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65	**Haz-mat/CBRN**	**PPE Access**	**Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7**	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	Agree	Please be aware the 'PRPS only training' package is branded with 'NARU', which no longer

6.0 Next Steps

6.1 An updated version of the EPRR Policy was approved at OPELG on the 16th October.

6.2 The EPRR Manager will continue to undertake the EPRR work programme and focus on the following areas:

- Business Continuity
- Training & Exercising
- Evacuation and Shelter
- Embedding of the EPRR agenda across the Trust
- CBRNe
- Maintenance of existing plans.

6.3 The Trust now has a suite of emergency plans, it is essential that these are maintained, reviewed and tested and aligned to the requirements of the Core Standards. Staff awareness and training is key to ensuring that a robust response can be delivered to a disruption to the organisation's critical services and to support this, training is extended to other departments and divisions.

6.4 The Trust is participating in Exercise Paddock, a multi-agency exercise taking place at Chester Racecourse on the 18th November. An exercise planning group has been established and the aim is to test the following areas:-

- Tactical and Strategic Control Centres
- ED and SDEC
- Clinical Site Coordination
- Theatres / ITU
- Radiology
- Pharmacy
- Pathology
- Orthopaedic/General Surgery
- Portering
- Switchboard

6.5 The Board of Directors is requested to**:**

- **Note** the improvement in compliance with the EPRR Core Standards from "partial" to "substantial"**.**
- **Note** the actions to be taken within the action plan and the progress made in embedding the EPRR agenda across the Trust.

Appendix 1 - Core Standards Action Plan

Core Standard Title	Compliance Rating	Action required	Target Completion Date	Supporting documents in place
Evacuation and shelter	Partial	A meeting has taken place with the Head of Health & Safety and the Fire Safety Officer to progress the review of the existing plan. A scoping exercise was undertaken that identifies the areas with the most at-risk patients and those that are non-ambulant. A framework is under development that supports a scalable evacuation approach. A full evacuation will require a regional response however, the Local Health Resilience Partnership Evacuation Group has not met for some time.	January 2026	Draft Evacuation Plan Fire Evacuation Plans
Business Impact Analysis/Assessment (BIA)	Partial	Business Impact Analysis have been undertaken across the majority of departments within the Trust. There is a BC monitoring report to track progress. The Business Continuity Group is to be scheduled quarterly to progress the BC arrangements, exercising and the review of any incidents.	December 2025	BC Policy BC SOP BC Checklist Departmental BIAs
Business Continuity Plans (BCP)	Partial	Business Continuity Plan are in progress across the majority of departments within the Trust. There is a BC monitoring report to track progress. The Business Continuity Group is to be scheduled quarterly to progress the BC arrangements, exercising and the review of any incidents.	February 2026	BC Policy BC SOP BC Checklist Departmental BCPs Incident response Plan BC Monitoring Report

BC Training & Exercising	Partial	An exercise schedule has been developed with some plans already tested. This will be the main focus for the next 12 months to enable the Trust to progress to Full Compliance with the Core Standards. Debriefs will be undertaken following the exercises and any lessons learnt will be incorporated into plans. There will also be a forum within the BC Group to share good practice between divisions and departments.	September 2026	BC Policy BC SOP Departmental BCPs Debriefing Guidance Incident Response Plan BC Monitoring Report
HAZMAT/CBRNe Equipment and supplies	Partial	New equipment has been procured and received by the ED. The chemical personal protective suits were serviced in August. The plan is to assemble the equipment prior to the NWAS CBRNe Audit in December.	January 2026	CBRNe Plan EPRR Budget PRPS Suits (servicing certificates) ED Training Records ED Training Presentations.
HAZMAT/CBRNe Exercising	Partial	New equipment was purchased in Q3 2025. A training programme was also delivered to ED staff. It is necessary to plan an exercise to familiarise newly trained staff and test the new equipment.	March 2026	CBRNe Plan ED Training Records ED Training Presentations.

(PUBLIC) Board of Directors
25th November 2025

Report	**Agenda Item 22.**	**People Strategy – 2025 – 2028**						
Purpose of the Report	Decision	**X**	Ratification		Assurance		Information	
Accountable Executive	Vicki Wilson			Chief People Officer				
Author(s)	Vicki Wilson			Chief People Officer				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X**	BAF impact is to develop a great workplace culture, staffed by effective and motivated staff to deliver the very best patient care.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X**
Previous considerations	Board of Directors – 29 July 2025 People Committee – 10th December 2024, 8th April 2025, 10 June 2025 & 14 October 2025.							
Executive summary	The new draft People Strategy was reviewed and approved at People Committee on 10th June 2025 and due to be approved by Board in July 2025. A paper was included in the pack for the Board meeting on 29th July 2025. Due to the absence of the Chief People Officer, the item was deferred. In light of this, the opportunity was taken to update the new People Strategy to reflect more recent discussions and work in relation to culture. The current People Strategy which was developed in 2021 concludes in 2026. Whilst progress has been made in several areas, as reflected in improvements in the 2024 Staff Survey, further work is needed to improve culture and embed change and enhance staff experience. The focus for 2025 and beyond will be on sustaining this progress and delivering the new People Strategy. The development of this strategy has been led by the people function; however, it remains a co-owned and co-delivered effort between the People function, clinical divisions, corporate services, and							

	staff side colleagues. The People Strategy 2025-2028 is aligned to the national people plan and built upon four themes: 1. Looking after our people 2. Creating a sense of belonging 3. Developing our people to be their best 4. Building the future workforce The People Strategy and accompanying 3-year action plan is provided. The version shared in the July Board pack has been updated to including an additional page referencing the Countess Culture, and the priorities and 3-year plan have also been updated to include this work. A dashboard to monitor the success measure Key Performance Indicators (KPIs) is in development, and this will be shared and monitored at People Committee. The final updated version was approved by People Committee on 14th October 2025 to be shared with Board for ratification.
Recommendations	The Board of Directors is asked to **approve** the updated People Strategy 2025 – 2028.

Corporate Impact Assessment	
Statutory/regulatory requirements	CQC/Constitution/other regulation/legislation
Risk	To develop a great workplace culture, staffed by effective and motivated staff to deliver the very best patient care, risk included on strategic risk register
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published as part of the agenda pack.

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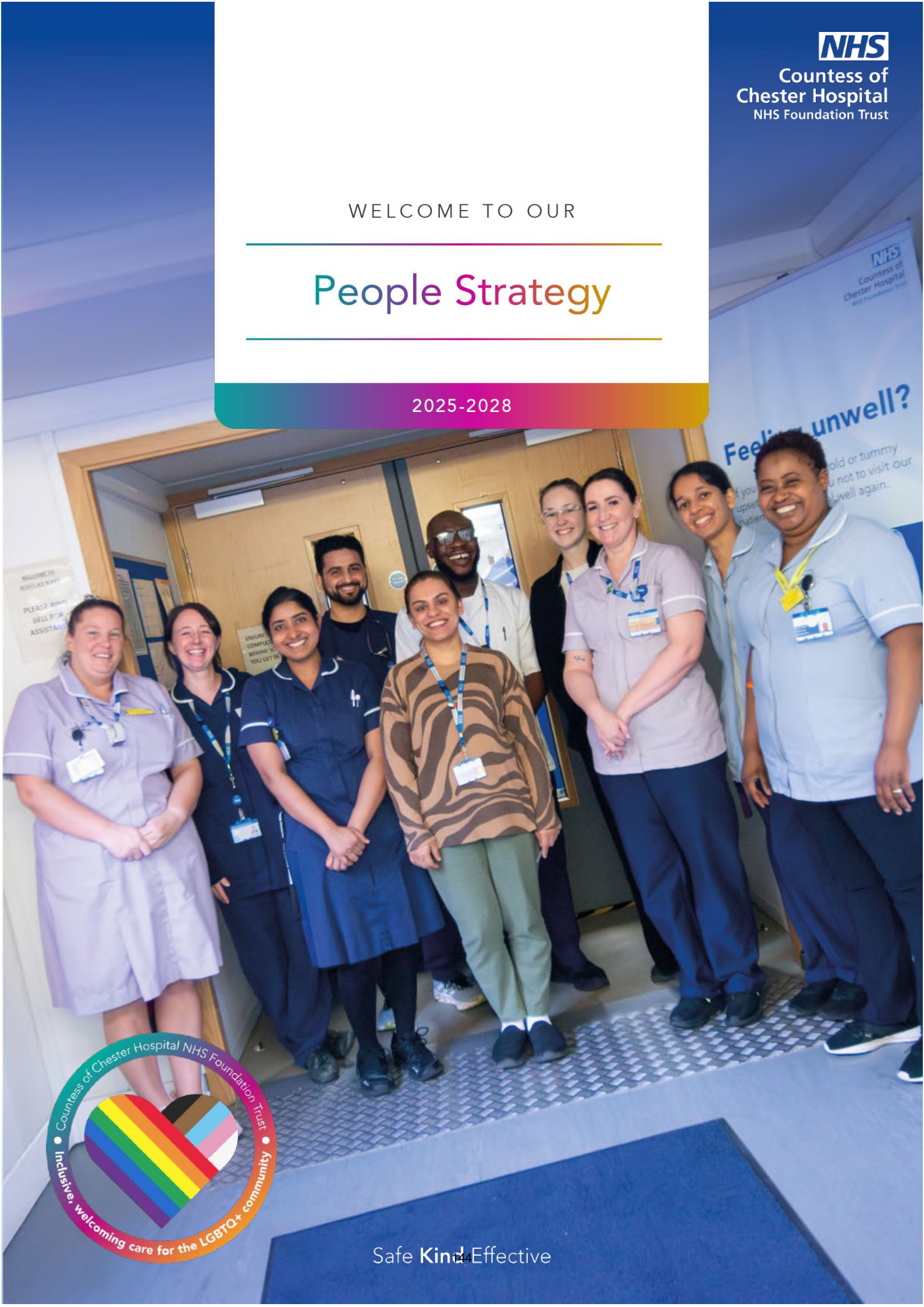
WELCOME TO OUR

People Strategy

2025-2028



Safe **Kind** Effective

Contents

A message from Vicki Wilson, Chief People Officer and Wendy Williams, Non-Executive Director and Chair of People Committee

At the Countess of Chester Hospital NHS Foundation Trust, our people are the driving force behind every success, every innovation, and every compassionate act of care. This People Strategy for 2025–2028 reflects our unwavering commitment to creating an environment where every individual feels supported, valued, and inspired to thrive.

This strategy is not just a document—it is a shared promise. It is built on what our people have told us matters most: wellbeing, inclusion, growth, and a culture of kindness and civility. We know that to deliver outstanding care, we must first take care of our own, ensuring our staff are healthy, empowered, and have the tools and support they need to be their best.

Over the next three years, we will focus on four key themes: looking after our people, creating a sense of belonging, developing our people to be their best, and building the future workforce. These themes are rooted in the NHS People Promise and shaped by feedback from across our Trust. They are also anchored in a strong belief that culture is everyone's responsibility—from the boardroom to the ward.

Our vision is to be not only a provider of outstanding care but also an exceptional place to work. Together, we will continue to build a workplace where people feel proud, safe, and supported to be and do their best.

Let's make Team Countess a place where everyone belongs, and where every colleague knows they matter.

Vicki Wilson
Chief People Officer

Wendy Williams, Non-Executive Director and Chair of People Committee

Introduction

At the Countess of Chester Hospital NHS Foundation Trust our people are at the heart of everything we do. We understand that our organisational strength and potential is our people and that it is through our people that are we are able to create an inclusive, supportive, and high-performing workplace that enables our staff to provide outstanding care to our patients.

Our People Strategy sets out our commitment over the next three years to looking after each and every one of our almost 6,000 members of staff, volunteers and governors. The strategy is built on four key themes that align with the NHS People Plan, ensuring we create an environment where our workforce feels valued, empowered, and prepared for the future.

Influenced by your feedback, we know what we need to do to and how we are going to do it. We want to work together with staff, Staff Side colleagues and Staff Networks to make this Trust a great place to work. We hope the approach described in this document gives you the confidence that this Trust is a place where you want to come to work, care for patients, and can be proud to be part of Team Countess.

About Us and Our People

The Countess of Chester Hospital NHS Foundation Trust includes the Countess of Chester Hospital – a 550-bed hospital which provides the full range of acute and specialist services, Ellesmere Port Hospital – a rehabilitation, intermediate and outpatient facility, and Tarporley War Memorial Hospital which is located 12 miles outside and provides community-based services to serve the local rural population.

The Trust provides acute emergency and elective services, primary care direct access services and obstetric services to a population of approximately 343,000 residents in Chester and West Cheshire which includes rural areas, Ellesmere Port and Neston as well as the Deeside area of Flintshire which has a population of just over 50,000.

The Trust employs almost 5,000 staff, has almost 1,000 temporary staff registered on its internal staff bank and over 100 volunteers.

Our Vision

Our Trust vision is to achieve outstanding patient care for our patients and families.

The Trust's strategy, Transforming Care Together, sets out a commitment to improve patient care and ill health prevention through strong leadership, a positive culture and robust collaborations with partners across the NHS and social care.

Our vision for our people strategy is ***to make our Trust a great place to work***.

To achieve this, we need everyone taking responsibility for the culture, inclusivity and the success of the organisation as a whole. In order to move towards this goal, in 2024 we launched the Trust's civility statement which was voted for and chosen by our colleagues. Our chosen statement is:

'We will always treat everyone with respect and kindness, be polite and professional, listen to them and help each other whenever we can'

Following the launch of the civility statement, the Culture & Civility handbook was created with the aim to support colleagues to understand what civility is, its impact and the part that every team member plays in making the Trust a civil organisation.

You can read the civility handbook online on the intranet: here.

Our Values

The Trust's vision is supported by our ways of working and a program of continual learning and improvement. Our values underpin everything we do:

- **Safe:** at the heart of everything we do
- **Kind:** always caring and compassionate
- **Effective:** services that are responsive to our patients' needs.

Our People Promise

Our **People Promise** sets out 7 things our staff should be able to say about working for us. Only by making Our People Promise a reality will we become the best place to work – where we are part of one team that brings out the very best in each other.

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

For some colleagues, some parts of the Promise will already match their current experience. For others, it may still feel out of reach. We must all pledge to work together to make these ambitions a reality for all of us.

The people best placed to say when progress has been made are those who work in our Trust. We will continue to engage with our workforce to understand how we we're meeting these promises in the Trust. We ask quarterly through our People Pulse and again in the annual NHS Staff Survey which was redesigned to align with Our People Promise and we commit to listening and take action based on what we hear.

Creating the Countess Culture

Creating and sustaining the right culture is central to everything we do at the Countess. Culture is the foundation of our success – shaping how we care for one another, how we perform, and how we deliver outstanding care to our patients and communities. It reflects both how people feel and how we behave. A positive culture is one that balances compassion with candour – ensuring kindness and respect are matched with clarity, consistency, and follow-through. Our aim is to foster a psychologically safe environment where people can speak up, learn from mistakes, and take responsibility with confidence and support.

To achieve our vision of being an outstanding place to work, we must build a culture where kindness, respect, and accountability sit side by side, and where every member of Team Countess feels safe, heard, and empowered to make a difference.

Over recent years, we have taken significant steps to strengthen leadership visibility, improve staff engagement, and promote civility and respect through initiatives such as our Civility Statement, Culture & Civility Handbook, and the High Performing Teams (TED) programme. These have helped to rebuild confidence and improve engagement. However, we acknowledge that deep-rooted cultural challenges remain. Inconsistent behaviours, variable accountability, and limited psychological safety in some teams continue to affect how people experience work.

Our data and staff feedback show that we are a culture in transition. To sustain progress, we must move beyond surface-level interventions. We will take a structured and evidence-based approach to developing the Countess Culture. Guided by the King's Fund Culture Framework and the NHS Culture and Leadership Programme (CLP), we will focus on strengthening six key characteristics of a healthy culture: vision and values, goals and performance, support and compassion, learning and innovation, effective teamwork, and collective leadership. This approach will be practical and embedded within our existing systems and processes, including leadership development, appraisals, team engagement, and staff experience processes, ensuring every leader models the values and behaviours we expect.

We will build capability across our organisation to hold constructive, compassionate conversations that promote both learning and accountability. Visible leadership, proactive listening, and partnership working with Staff Side and staff networks will remain at the heart of this work.

1. Looking After Our People

Our Commitment: *We will ensure that we create the conditions that enable our people to feel supported and well including a focus on health and wellbeing and attendance and support people to work in a way that enables them to balance their work and home life. We will act proactively to protect our people from violence and aggression and ensure that where incidents occur, our focus is on supporting people are ensuring organisational learning.*

We understand the importance of staff feeling healthy and well both physically and mentally and having the flexibility to balance their work and home life commitments. We recognise the need to more effectively manage workloads to help reduce burnout and fatigue amongst out workforce and will ensure that our managers are well equipped for this. We know there is more to do to address staff experience of violence and aggression, and we will prioritise work to ensure we take a robust and consistent approach to improve this. Where there are challenges, we will take a compassionate approach, in particular exercising discretion where patients may be cognitively impaired. We will increase opportunities for flexible working across our workforce and take advantage of digital solutions, for example e-rostering, to support in this area.

Key Actions

- Violence and aggression: take proactive steps to ensure robust approach to managing staff experience of violence and aggression including creation of violence and aggression group with a focus on supporting staff and ensuring organisational learning.
- Management support: Delivery of Management Essentials programme to ensure that managers are equipped to effectively manage staff and workloads to help reduce burnout and fatigue, ensuring adequate rest and recovery time and a compassionate leadership approach.
- Health and wellbeing support: Expand access to occupational health and well-being, including psychological support and proactive health checks for staff.
- Flexible and agile working: Enhance flexible working options, including remote and hybrid working where possible, to support work-life balance.

Measures of Success

- Reduction in violence and aggression towards staff
- Improved response to violence and aggression including evidence of staff support and sharing of organisational learning.
- Reduction in sickness absence rates and reduction in stress related absences
- Improved staff well-being scores in surveys
- Increased uptake of well-being initiatives
- Increased uptake of flexible working opportunities
- All managers having completed Management Essentials programme

2. Creating a Shared Sense of Belonging

Our Commitment: *We will foster an inclusive and diverse workplace where every individual feels respected and valued, our people are treated fairly, and any inequalities are addressed. We will support our people to feel safe and empowered to speak up and to feel proud and fully engaged in the work they do. We cannot be complacent and we will be proactive in addressing incivility, disrespect and bullying behaviours.*

We want our people to feel proud to be part of Team Countess, to feel that they are supported and valued for their individual and collective contributions. We know that there are currently unacceptable levels of violence and aggression towards our staff and will work hard to address this through our violence and aggression group. We are determined to see a reduction in behaviour related incidents and cases of bullying and will adopt a zero-tolerance approach to all forms of harassment, abuse and discrimination. We will continue to strengthen our approach to EDI, ensuring representation at all levels and addressing disparities in recruitment, pay, progression experience. We will do more to promote awareness campaigns and cultural events that highlight and celebrate the diversity of our workforce and foster a culture of inclusion and belonging. We recognise the contribution of our Trade Union colleagues and we will work together to strengthen our Staff Side and enhance our partnership working activities.

Key Actions

- Continue to develop reward and recognition strategies with increased engagement from all areas of the organisation.
- Strengthen our EDI strategies, ensuring representation at all levels and addressing disparities in recruitment, pay, progression and experience.
- Increase awareness campaigns and cultural events that highlight and celebrate the diversity of our workforce
- Support development of Staff Side and partnership working arrangements.
- Expand and empower staff networks, ensuring diverse voices are heard and influence decision-making.
- Continue to promote opportunities for speaking up, understand and address potential barriers to speaking up and share learning when action is taken.

Measures of Success

- Increased engagement with reward and recognition programmes
- Improved staff engagement and experience scores
- Higher representation of diverse groups in more senior roles
- Reduction in reported cases of bullying and discrimination, or behaviour related incidents, particularly in relation to minority staff groups.
- Increase in staff feedback and speaking up, including FTSU.
- Increased engagement in Staff Networks
- Increased Staff Side representatives and Staff Side engagement

3. Developing Our People to Be Their Best

Our Commitment: *We will support the continuous learning, development, and career progression of our workforce to enable them to reach their full potential.*

We recognise that developing our people's capability today, is creating the capacity to deliver care tomorrow. We will ensure all colleagues are able to participate in meaningful appraisals which support individual development and ensure every person has a clear development plan. We recognise the importance of high performing teams and will continue to support use of the Team Engagement & Development (TED) tool across all teams in the Trust. We are committed to being a learning organisation and will enhance our approach to learning when things don't go as expected and celebrating and learning from successes.

Key Actions

- Continued focus on appraisal process and rollout of quality of appraisal feedback as part of process
- Continued rollout of TED tool across all teams
- Build upon existing approach to learning when things don't go as expected and celebrating and learning from successes and promote awareness across all areas of the organisation.

Measures of Success

- Increased appraisal compliance and improved feedback on quality of appraisals
- Increased mandatory training scores
- Expand use of TED across all teams and increase in TED scores.
- Increased instances of organisational learning and greater sharing of lessons learned.
- Improved staff experience scores in staff survey areas relating to 'we are always learning' and 'we are a team'.

4. Building the Future Workforce

Our Commitment: *We will develop a sustainable, skilled, and adaptable workforce that meets the future needs of our patients and communities.*

We will use a data and evidence-based approach to predict workforce needs, address gaps in critical roles and utilise digital technologies to support productivity and efficiency of our workforce, including expanding our use of e-rostering and e-job planning. Our plans will include a focus on new roles, widening participation and development of career pathways.

Key Actions

- Development of annual workforce plan to support annual operational planning
- Development of longer-term strategic workforce plan, aligned to the Trust's future Clinical Strategy.
- Increased use of apprenticeships for clinical and entry level roles and increase in advanced practice and new roles. Improved links between widening participation activities and future workforce needs.

Measures of Success

- Annual workforce plan which is financial sustainable and aligned to actual workforce utilisation.
- Long term strategic workforce plan which is aligned to the Trust's future Clinical Strategy.
- Growth in apprenticeships and training placements, advanced practice and other new roles.
- Reduction in vacancy and turnover rates
- Improvement in recruitment and retention figures
- Reduction in premium rate temporary staffing solutions

Developing People Services

We recognise that there is opportunity to enhance People Services and how we support the organisation. We have set a number of objectives for year one of our strategy (2025/26) to support us in doing this.

Area	Objective
Resourcing	Roll out of electronic rostering and e-job planning.
Transactional HR	Improve accessibility of transactional HR information and improve use of digital solutions to improve transactional processes.
Business HR	Implementation of HR Business Partner model to support divisional and corporate teams.
Staff Experience	Integrated approach to improving staff experience, aligned to the People Promise.
Workforce Reporting	Improved workforce reporting.

Our People Priorities

Strand	Workstream	What will good look like?
Creating the Countess Culture	Culture & Leadership	An outstanding place to work with a culture where every colleague feels safe, valued and accountable – proud to work for Team Countess, confident to speak up, consistently living our values and delivery outstanding care.
1. Looking after our people	Health & wellbeing	Our people are safe, competent, healthy and well in their mental and physical wellbeing. Comprehensive health and wellbeing offer available including physical, mental and financial wellbeing to all staff
	Violence & aggression	The Trust consistently takes a robust approach to violence and aggression against staff, taking active steps to minimize risk and ensuring learning from incidents and support to staff.
	Flexible working	People are able to work flexibly in a way that balance home and work commitments. Flexible working by default and increase in number of people working flexibly.
	Management & Leadership Development	Managers have the essential skills and knowledge to support staff and demonstrate a compassionate leadership approach. All managers undertake Management Essentials programme and access relevant leadership development.
2. Creating a sense of belonging	Staff Experience	People are proud to work here, feel supported, recognised, equally valued and feel that they belong (improved staff experience measures, increased engagement with reward and recognition programmes).
	Equality, Diversity & Inclusion (EDI)	A strong stance against bullying, harassment, and discrimination, with clear reporting mechanisms and accountability. Representation at all levels and addressing disparities in recruitment, pay, progression and experience. Reduction in cases of bullying and harassment or behaviour related incidents.

Strand	Workstream	What will good look like?
	Engagement and empowerment	Expand and empower staff networks, ensuring diverse voices are heard and influence decision-making. Increased Staff Side representatives and Staff Side engagement. People feel able to speak up and understand the positive contribution speaking up makes (increase in staff feedback and FTSU).
3. Developing our people to be their best	Performance management Team Development Organisational learning	All colleagues participating in meaningful appraisals (increase in appraisal completion & effectiveness ratings). Development for all colleagues to build on their potential. High performing individuals and teams (improved TED scores). Regular and proactive learning when things don't go as expected and celebrating and learning from successes.
4. Building the future workforce	Workforce planning Building career pathways	Our services are appropriately staffed and financially sustainable (workforce plan). Our workforce plans look to the future, are agile and support the Transforming Care Together and the Trust's Clinical Strategy. Increased use of apprenticeships for clinical and entry level roles and increase in advanced practice and new roles. Improved links between widening participation activities and future workforce needs.

How will we deliver this?

The development of this strategy has been led by the people function; however, it is co-owned and co-delivered together with our leaders, managers, staff and staff side colleagues.

Our high-level People Priorities, as reflected in this strategy, are included within this document. A 3-year People Strategy action plan has been developed to support us in delivering the ambitions we have set out. The People function will work closely with clinical divisions and corporate services so that we deliver on our promises to you and progress against this plan will be reported and monitored through the People Committee.

The People Strategy action plan also has a specific focus on improving performance across workforce key performance indicators - getting the basics right for our people. These indicators are split between regulatory targets as described by the NHS Oversight Framework and internally set Trust targets.

Conclusion

This People Strategy sets out our commitment to making our Trust a great place to work. We will create a positive, inclusive, and high-performing workplace where our staff feel supported, valued, and empowered to deliver outstanding care. Working together, we will bring out the best in each other and create a culture where we can all be proud to be a part of Team Countess.

3-year plan

2025-2028

Safe **Kind** Effective

People Strategy – 3-year plan

Strand	Workstream	What will good look like?	Year 1	Year 2/3	KPIs*
Creating the Countess Culture	Culture & Leadership	An outstanding place to work with a culture where every colleague feels safe, valued and accountable – proud to work for Team Countess, confident to speak up, consistently living our values and delivery outstanding care.	Delivery of CLP focusing on strengthening six key characteristics of a healthy culture.	Implementation of Leadership Strategy and interventions identified through CLP.	• Improved staff survey scores in relation to FTSU, engagement, leadership behaviours, feeling valued. • Reduction in ER cases
Looking after our people	Health & wellbeing	Our people are safe, competent, healthy and well in their mental and physical wellbeing. Comprehensive health and wellbeing offer available including physical, mental and financial wellbeing to all staff.	Expand access to occupational health and well-being, including psychological support.	Facilitate proactive health checks for staff.	• Reduction in sickness absence rate and in stress related absences • Increased uptake of well-being initiatives
	Violence & aggression	The Trust consistently takes a robust approach to violence and aggression against staff, taking active steps to minimize risk and ensuring learning from incidents and support to staff.	Launch of V&A group, proactive management of risk, standardised de-briefing, support to staff and approach to learning.	Expansion of training and support for staff to manage V&A and embedding of learning approach.	• Reduction in V&A incidents against staff. • Increased number of standardised debriefs & reporting learning. • Improved staff well-being scores in surveys
	Flexible working	People are able to work flexibly in a way that balance home and work commitments. Flexible working by default and increase in number of people working flexibly.	Launch flexible working campaign.	Expand types of flexible working making use of digital systems to support teams (eg team rostering)	• Increased uptake of flexible working opportunities
	Management & Leadership Development	Managers have the essential skills and knowledge to support staff and demonstrate a compassionate leadership approach. All managers undertake Management Essentials programme and access relevant leadership development.	Develop and launch Manager Essentials programme.	Expand roll out to include aspiring managers.	• All managers having completed Management Essentials programme

Strand	Workstream	What will good look like?	Year 1	Year 2/3	KPIs*
Creating a sense of belonging	Staff Experience Equality, Diversity & Inclusion (EDI) Engagement and empowerment	People are proud to work here, feel supported, recognised, equally valued and feel that they belong (improved staff experience measures, increased engagement with reward and recognition programmes). A strong stance against bullying, harassment, and discrimination, with clear reporting mechanisms and accountability. Representation at all levels and addressing disparities in recruitment, pay, progression and experience. Reduction in cases of bullying and harassment or behaviour related incidents. Expand and empower staff networks, ensuring diverse voices are heard and influence decision-making. Increased Staff Side representatives and Staff Side engagement. People feel able to speak up and understand the positive contribution speaking up makes (increase in staff feedback and FTSU).	Develop reward and recognition offer with increased engagement. Create calendar of events and increase number of campaigns supported. Embedding Civility & Respect campaign with focus on speaking out to challenge incivility or bullying behaviours. Positive action to address underrepresentation. Support the expansion and engagement of networks. Support development of Staff Side and partnership working. Continue to promote opportunities for speaking up, understand and address potential barriers to speaking up.	Increase Trust wide engagement with R&R initiatives. Further increase number and diversity of campaigns supported. Promote positive role modelling and demonstrate impact across organisation to support embedding of culture change. Enhance the role of staff networks and partnership working arrangements in influencing organisational decision making and driving cultural change. Improve sharing of organisational learning from speaking up.	• Increased engagement with R&R programmes • Improved staff engagement and experience scores • Reduction in cases of bullying, discrimination, or behaviour related incidents, particularly in relation to minority staff groups. • Higher representation of diverse groups in more senior roles • Increased Staff Side representatives and Staff Side engagement • Increased engagement in Staff Networks • Increase in staff feedback and speaking up, including FTSU.
Developing our people to be their best	Performance management	All colleagues participating in meaningful appraisals (increase in appraisal completion & effectiveness ratings). Development for all colleagues to build on their potential.	Continued focus on appraisal process compliance and rollout of quality of appraisal feedback.	Further enhance appraisal process based on learning from quality of appraisal feedback analysis.	• Increased appraisal compliance and improved feedback on quality of appraisals

Strand	Workstream	What will good look like?	Year 1	Year 2/3	KPIs*
	Team Development Organisational learning	High performing individuals and teams (improved TED scores). Regular and proactive learning when things don't go as expected and celebrating and learning from successes.	Prioritised rollout of High Performing Teams / TED tool. Build upon existing approach to learning when things don't go as expected	Expand rollout of High Performing Teams / TED tool across organisation. Celebrating and learning from successes and promote awareness across all areas of the organisation.	• Increased mandatory training scores • Expand use of TED across all teams and increase in TED scores. • Increased instances of organisational learning. • Improved staff survey scores in 'we are always learning' and 'we are a team'.
Building the future workforce	Workforce planning Building career pathways	Our services are appropriately staffed and financially sustainable (workforce plan). Our workforce plans look to the future, are agile and support the Transforming Care Together and the Trust's Clinical Strategy. Increased use of apprenticeships for clinical and entry level roles and increase in advanced practice and new roles. Improved links between widening participation activities and future workforce needs.	Implementation of medical e-roster. Rollout of e-roster for clinical areas (shifts) Development of e-job plans for medics. Annual workforce plan. Increase use of apprenticeships for clinical and entry level roles including development of HCSW apprenticeship programme.	Increase e-rostering level of attainment. Use of job plans in other clinical areas, eg specialist nursing. Development strategic workforce plan, aligned to Clinical Strategy. Increase in advanced practice and new roles and development of clear career pathways for nursing. Development of additional apprenticeship programmes in E&F, admin and digital.	• Levels of attainment for nursing & medical workforce • % clinical staff with job plans • Annual workforce plan on track. • Long term strategic workforce plan which is aligned to the Trust's future Clinical Strategy. • Growth in apprenticeships and training placements. • Increase in advanced practice and new roles. • Improvement in vacancy and turnover rates for high turnover roles. • Reduction in premium rate temporary staffing

**Specific KPI targets will be identified within the People Strategy dashboard to support monitoring (under development).*

Committee Chair's Report

14th October 2025

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

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

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

- Annual workforce plan progress demonstrated a gap in current performance. Discussion provided context to numbers and actions. The Committee requested a clearer narrative, actions and trajectories.
- General Medical Council (GMC) survey results identified continued challenges in Emergency Medicine, and an NHS England visit is planned as well as the Urgent Emergency Care (UEC) Care Quality Commission (CQC) report. Obstetrics and Gynaecology have been in support category 2 and have been recognised as one of the most improved nationally. Cardiology have also made significant improvements. A small number of other departments are on the watch list. Departments have provided action plans, and this needs to be considered alongside implementation of the 10-point plan. Progress against action plans will be monitored through Education, Learning and Organisation Development Sub Committee via the Medical Education Group.
- Equality, Diversity & Inclusion (EDI). While the Committee signed off the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and gender pay gap for external reporting and improvements to WRES and WDES are being seen, the Trust remains below national average across the majority of indicators and there is significant work to do.

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

- People promise and staff survey update including work being undertaken to improve staff experience, manager essentials training delivery, divisional level staff survey action plan progress, quarterly People pulse and staff survey.
- Work is being undertaken on violence and aggression, including a new policy. A Violence and Aggression Group has been established to focus on incidents, learning and action needed.
- Integrate Performance Report (IPR) People metrics for Month 5. Majority of areas showing improved performance against targets including reductions in sickness absence, improvements in mandatory training and appraisal rates. Dashboards at Divisional level also provided. Work ongoing for variable pay and further controls being implemented. Resident doctor exception reporting and work schedules, and nursing Key Performance Indicators (KPIs) now also included in the report.
- A self-assessment has been completed against the nationally published resident doctors 10-point plan to improve working lives of doctors in training. An action plan is in place with improvements needed in timeliness of work schedules and consistent application of processes (e.g. annual leave; exception reporting).
- Response to the Leng Review with progress being made against the recommendations regarding Physician Associates (now Physician Assistants) with the majority of actions due to be complete by November 2025. This will be monitored through the Workforce Sub Committee and assurance provided through the AAA Chair Reports to the People Committee.

- Safer staffing reports (January to June 2025) received for both nursing and midwifery and neonatal providing assurance on compliance and processes. Reports to be reviewed to streamline reporting from Sub Committee level to People Committee.

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

- Staff story regarding transgender employee and their experience within the Trust. Recognising the importance of education and using the resources from the staff networks to support.
- Chief People Officer (CPO) report on national and local updates including sexual safety charter, 10-Point Plan for residential doctors, national Staff Survey launch, flu campaign, flexible working policy and Celebration of Achievement Awards.
- The culture framework range of work is ongoing including, leadership development programmes, Emergency Department (ED) RESET programme, and a Board session planned in October 2025.
- Draft People Strategy 2025-28 presented including the additional update on culture, which will be presented to Board for ratification in November 2025.
- Job evaluation processes and governance in place to respond to the review of national nursing and midwifery job profiles. Progress planned for Q3/4 to finalise Trust position, and preparation for NHS England (NHSE) data collection as well as review of current job descriptions. The Committee noted the update and sought further assurance on progress and potential risks.
- System led procurement for e-roster has been unsuccessful and the Trust will proceed at pace with its own process to award a contract to its preferred provider based on the stakeholder engagement work and system demos which have already taken place.

Risks discussed and new risks identified

- Reviewed Board Assurance Framework (BAF) extract. Two high risks on the risk register and keen to understand consistency of scoring and confirmation of actions being taken to mitigate these risks. Agreed this needs to be raised with Divisions through Operational Management Board (OMB).
- Risk noted through Joint Local Negotiating Committee (JLNC) regarding rate card changes and staffing risks, with the British Medical Association (BMA) entering into dispute with the Cheshire & Merseyside (C&M) Integrated Care Board (ICB). Potential local implications for the Trust to cover sessions and maintain delivery of activity. Processes are in place for agreed actions and escalation.

(PUBLIC) Board of Directors
25th November 2025

Report	**Agenda Item 24.***		**Council of Governors Report – October 2025**					
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Karan Wheatcroft		Director of Governance, Risk & Improvement					
Author(s)	Nusaiba Cleuvenot		Head of Corporate Governance					
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research		**X** **X** **X** **X** **X** **X** **X** **X** **X** **X**	Relevant across all BAF areas.				
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X**
CQC Domains	Safe Effective Caring Responsive Well led							**X**
Previous considerations	Not applicable.							
Executive summary	The purpose of this report is to provide a summary of items discussed at the Council of Governors meetings.							
Recommendations	The Board of Directors is asked to **note** the report and the activity during this period.							

Corporate Impact Assessment	
Statutory/regulatory requirements	Meets the Trust compliance with Foundation Trust status.
Risk	Alignment with the Board Assurance Framework and Corporate Risk Register.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential.

Council of Governors Report

1. PURPOSE

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

2. BACKGROUND

The Council of Governors meetings are held on a quarterly basis. In between, informal Governor meetings are held, led by the Chair.

3. CURRENT POSITION

3.1 Council of Governors Meeting

A full Council of Governors meeting was held on 22nd October 2025, and key items included the following:

- A patient story was presented.
- An update was provided from the Chair and the Chief Executive Officer on key matters.
- Chair's reports were received from the Quality and Safety Committee, People Committee, Audit Committee and Finance & Performance Committee.
- Lead Governor update.
- The Trust System Oversight Framework (SOF) was provided setting out the Trust's performance in key areas from the NHS Oversight Framework Report including Operational Performance, Quality, Safety, Finance and People.
- Membership & Engagement Committee Chair's report (including new Membership Strategy).
- Amendments to the Trust Constitution.
- Feedback from Non-Executive Director/ Governor Walkabouts.

Following the Council of Governors meeting held in public, a private meeting was held. The Council of Governors received papers detailing summary reports from the last Private Board meetings. Following approval at the Governors Nominations Committee, the Council also received a report on Non-Executive Directors Appointments which set out the recruitment process and appointment recommendations. The Council approved the appointment of two new Non-Executive Directors.

3.2 Council of Governors Workshops and Informal Meetings

The Trust Chair has implemented regular informal meetings for Governors to promote engagement and facilitate information exchange. These sessions allow the Chair to share updates on current Trust activities between the quarterly Council of Governors meetings and offer Governors an additional forum to discuss issues beyond the set agenda, raise questions, and provide feedback.

A Council of Governors workshop also took place on 22nd October 2025. Two further informal Chair and Governor meetings took place on 6th August and 3rd September 2025.

3.3 Annual Members' Meeting

The Annual Members Meeting took place on 1st October 2025, where the newly elected public and staff governors were formally appointed. A governor election process conducted by Civica Election Services had taken place between June and September 2025.

4. RECOMMENDATIONS

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