Countess of Chester Hospital NHS Foundation Trust

Public meeting of the Board of Directors Agenda
(published items)
Tuesday 27th January 2026, 08.30 – 12.00
VENUE TO BE CONFIRMED

Chair	Mr N Large, Trust Chair
Apologies	Ms H Gunawickrema, Non-Executive Director
In attendance	Ms N Macdonald, Director of Midwifery (Items 13. and 14.), Ms C McClennan, Programme Director/LMNS SRO, Women's Health and Maternity (WHaM) Programme (Item 13.) and Dr P Bamford, Director of Clinical Research (Item 18.)

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.	Service Showcase (to be presented on the day)			
09.00	4.	Staff Story (to be presented on the day)			
09.15	5.	Minutes of the previous meeting held on 25th November 2025 (attached)	Trust Chair	4 - 24	For approval
09.20	6.	To consider any matters arising and action log (attached) Action 5 - The impact of the national thresholds for visa sponsorship Update (verbal)	Trust Chair Chief People Officer	25 - 28	For noting For approval
09.25	7.	Chief Executive Officer's Report (attached)	Chief Executive Officer	29 - 33	For noting
09.35	8.	a) Chair's Update (verbal) b) Non-Executive Director Roles (attached)	Trust Chair Trust Chair	34 - 36	For noting For approval
09.45	9.	NHS England Enforcement Notice (attached)	Director of Governance, Risk & Improvement	37 - 46	For noting
09.55	10.	a) Board Assurance Framework – 2025/26 Q3 Update (attached)	Director of Governance, Risk & Improvement	47 - 67	For decision

		b) High Risks Report (attached)	Director of Governance, Risk & Improvement	68 - 79	For decision
Quality of Care					
10.05	11.	Quality & Safety Committee Chair's Report – 8th January 2025 (attached)	Chair Quality & Safety Committee	80 - 81	For assurance
10.00	12.	Care Quality Commission (CQC) Improvement Plan including Well Led (attached)	Director of Nursing & Quality / Deputy Chief Executive	82 - 86	For decision
10.10	13.	Maternity Incentive Scheme Year 7 Compliance and Assurance Report (attached)	Director of Midwifery	87 - 101	For decision & assurance
10.20	14.	Maternity Survey Results 2025 (attached)	Director of Midwifery	102 - 107	For noting
Comfort Break (10.30 – 10.40)					
Operational Performance					
10.40	15.	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	16.	Operational Management Board Chair's Report – 22nd January 2026 (verbal)	Chief Executive Officer		For assurance
Finance, Use of Resource and Performance					
11.05	17.	Finance & Performance Committee Chair's Report –18th November 2025 and 17th December 2025 (attached) 21st January 2026 (verbal)	Chair Finance & Performance Committee	108 - 111	For assurance
Strategic Change					
11.10	18.	a) Research Update (to be presented on the day)	Director of Clinical Research		For assurance

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		b) Research Strategy (to follow)	Director of Clinical Research		For approval
Leadership, Improvement Capability, Organisation Development and People					
11.25	19.	People Committee Chair's Report – 9th December 2025 (attached)	Chair People Committee	112 - 113	For assurance
11.30	20.*	Annual Health Education England Quality Self-Assessment Audit (attached)	Chief People Officer	114 - 120	For noting
Items for noting					
11.35	21.*	Items for noting and receipt (attached): ***Sent under separate cover*:** **Minutes of Committee Meetings:** a) Approved minutes of the Quality & Safety Committee – 6th November 2025 (attached) b) Approved minutes of the People Committee – 14th October 2025 (attached) c) Approved minutes of the Finance & Performance Committee – 4th November 2025 and 18th November 2025 (attached) d) Research and Innovation Committee Chair's Report 21st December 2025 and Minutes 5th September 2025 (attached) **Other items:** e) Board of Directors Workplan 2025/26 (attached)	Trust Chair		For noting
Other items					
11.40	22.	Any Other Business (verbal)	Trust Chair		For noting
11.50	23.	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 22nd January 2026*** **Future Dates:** 31st March 2026 19th May 2026 21st July 2026 29th September 2026 24th November 2026 26th January 2027 16th March 2027	Trust Chair		For noting
12.00	24.	Closing remarks (verbal)	Trust Chair		For noting

Next Meeting: Tuesday 31st March 2026 at 8.30am, venue to be confirmed

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

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MINUTES OF THE PUBLIC BOARD OF DIRECTORS

Tuesday 25th November 2025, 08.30 – 12.00

Boardroom, 1829 Building

Members	20/05/25	29/07/25	30/09/25	25/11/25		
Trust Chair, Mr N Large MBE	☑	☑	☑	☑		
Chief Executive Officer, Ms J Tomkinson OBE	☑	☑	☑	☑		
Non-Executive Director, Mr D Williamson	☑	☒	☑	n/a		
Non-Executive Director, Mr P Jones	☑	☑	☑	☑		
Non-Executive Director, Mr M Guymer	☑	☒	☒	n/a		
Non-Executive Director, Mrs P Williams	☑	☑	☑	n/a		
Non-Executive Director, Professor A Hassell	☑	☑	☑	☑		
Non-Executive Director, Mrs W Williams	☑	☑	☑	☑		
Non-Executive Director, Mrs S Corcoran	☑	☑	☑	☑		
Non-Executive Director, Mrs H Gunawickrema	n/a	n/a	n/a	☑		
Non-Executive Director, Mr P Williams	n/a	n/a	n/a	☑		
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**	**25/11/25**		
Head of Corporate Governance, Mrs N Cleuvenot	☑	☑	☑	☑		
Consultant Dermatologist/Skin Cancer Lead, Dr E Domanne	☑ (item 3)	n/a	n/a	n/a		
Healthcare Assistant, Ms M Facer	☑ (item 3)	n/a	n/a	n/a		
Director of Midwifery, Ms N Macdonald	☑ (item 11 and 12a)	☑ (item 4)	☑ (item 11)	n/a		
Director of Clinical Research, Mr P Bamford	☑ (item 23)	n/a	n/a	n/a		
Deputy Medical Director, Dr I Benton	n/a	☑	n/a	n/a		
Maternity and Neonatal Voices Partnership Lead, Ms R El Boukili	n/a	☑ (item 4)	n/a	n/a		
Director of Pharmacy and Medicines Optimisation and Controlled Drugs Accountable Officer (CDAO), Ms K Adams	n/a	☑ (item 15)	n/a	n/a		
Intensive Care Consultant and Organ Donation Clinical Lead, Mr D Zeinali	n/a	n/a	☑ (item 4)	n/a		
Safeguarding Lead, Ms J Cooper,	n/a	n/a	☑ (item 10)	n/a		
Deputy Chief Operating Officer, Mr S Brown	n/a	n/a	☑	n/a		
Freedom to Speak Up Guardian, Ms H Ellis	n/a	n/a	☑ (item 13)	n/a		
Named Nurse for Safeguarding Children, Ms L Ates	n/a	n/a	n/a	☑ (item 3)		
Head of Nursing - Infection Prevent & Control, Mr M Woodward	n/a	n/a	n/a	☑ (item 4)		

Associate Medical Director, Dr S Brigham	n/a	n/a	n/a	☑ (item 13)		
Head of Midwifery, Ms C Davies	n/a	n/a	n/a	☑ (item 14a)		
Deputy Chief People Officer, Mr P Marston	n/a	n/a	n/a	☑		

Observers in attendance:

- Cheryl Finney - Staff Governor
- Tony Fisher – Public Governor
- John Jones – Lead Governor

Agenda No.	Agenda item	Action
1.	**Welcome, apologies and Chair's opening remarks** Mr N large (NL), Trust Chair opened the meeting and welcomed Hasintha Gunawickrema (HG) and Peter Williams (PW), the two recently appointed Non- Executive Directors. Apologies were noted for Ms C Chadwick (CC), Chief Operating Officer; and Ms V Wilson (VW), Chief People Officer. Mr S Brown (SB), Deputy Chief Operating Officer; and Mr P Marston (PM), Deputy Chief People Officer were in attendance as their deputies.	
2.	**Declarations of Conflicts of Interest with agenda items** There were no declarations of interest to note.	
3.	**Patient Story** Ms L Ates, Named Nurse for Safeguarding Children presented a detailed patient story involving a vulnerable 16-year-old patient, highlighting the safeguarding team's collaborative work with social care, police, and community partners to address matters of complex trauma, substance misuse, and criminal exploitation. Discussion covered multi-agency safeguarding interventions, hospital care challenges, and positive outcomes through community engagement. The Chair asked about safeguarding referral volumes. LA confirmed approximately 300 referrals a month and described ongoing community partnership work including tackling ketamine misuse. The Board thanked LA for attending and **noted** the patient story. *LA exited the meeting.*	
4.	**Service Showcase – Infection Prevention and Control (IPC)** Mr M Woodward (MW), Head of Nursing - Infection Prevent & Control; and Ms F Stevens (FS), Matron - Infection Prevent & Control were in attendance to present the service showcase.	

	The IPC team shared significant achievements, including a 27% reduction in healthcare-associated infections and a successful gloves off reduction campaign resulting in cost savings and improved hand hygiene. Development of fit testing for respiratory protective equipment was highlighted, with compliance surging to 80% since FS joined the Trust. The team outlined future national priorities including learning from the last pandemic, preparing for future outbreaks, and tackling antimicrobial resistance. Mrs W Williams (WW), Non-Executive Director thanked the team for their presentation, noting the Trust was previously behind other North West hospitals and much work had been done to improve our IPC arrangements. WW asked about staff engagement with IPC. FS explained that audits now focus on high-risk interventions, governance has been strengthened, and learning is driven by understanding the chain of infection and its impact on patients. MW addressed the culture of IPC, emphasising the shift towards shared accountability and making IPC everyone's responsibility. Mr N Large (NL), Chair asked how IPC practices are embedded and whether staff call out issues. FS responded that both staff and patients are encouraged to challenge poor practice, with peer reviews and divisional leadership support to empower staff. Ms S Pemberton (SP), Director of Nursing and Quality / Deputy CEO commented on the increased accountability driven through Divisions and praised the IPC Team's commitment to raising standards. Mr P Williams (PW), Non- Executive Director noted the strong IPC profile in corporate induction, signalling its importance to new employees. Mr A Hassell (AH), Non- Executive Director asked about influencing antibiotic prescribing. FS described real-time interventions, review of resistance, and ongoing antimicrobial stewardship, noting the process depends on sample submission and formulary updates. NL highlighted MW's daily IPC updates through the 8am site call and the live, active nature of IPC processes, thanking MW and FS for their impact on patient care. FS reiterated that patients are at the center of IPC work, with education making a significant difference across the Trust. The Board thanked MW and FS for attending and **noted** the IPC Service Showcase. *MW and FS exited the meeting.*	
5.	**Minutes of the previous meeting held on 30th September 2025** The minutes of the previous meeting held on 30th September 2025 were **approved** as a true and accurate record of the meeting.	
6.	**To consider any matters arising and action log** The following updates were provided. **Action 1:** Update provided and confirmed as closed. **Action 2:** Trajectory development presented at October Board Development Day; first set of trajectories to be added to the Integrated Performance Report (IPR)for November Board. It was noted that updates to the IPR were still in development.	

	Action 3: Deferred to January 2026; multiple action plans to be collated, but a brief update has been included in the pack. **Action 4:** Board to deep dive at December Development Day; action remains open. **Action 7:** Deferred to January 2026, aligned with next research update. **Action 11:** Mr P Marston (PM), Deputy Chief People Officer provided a verbal update sharing that they are seeking Home Office clarification and raised this at Cheshire and Merseyside Provider Collaborative (CMPC) Chief People Officer (CPO) group and are awaiting feedback. The Chair asked about timeline. PM responded they are expecting an update soon but awaiting national response. Mr N Scawn (NS), Medical Director asked if feedback has been shared with the staff in question and it was confirmed that they have not been updated yet as the national response has not been received. Ms J Tomkinson (JT), Chief Executive Officer explained the delay is to ensure proper legal guidance and clarified that not all the individuals in questions would be impacted simultaneously and that the team are mindful of relevant deadlines. NL requested an update at next Board meeting; action remains open. 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: • Focus areas included system development, financial sustainability, and waiting lists/ RTT, with a deep dive scheduled later in the meeting. • Annual staff survey participation increased from 36% to 38% since the previous update; national average is 45%. Incentives and a final push are underway before survey closure. • Flu vaccine uptake at 40%, with continued efforts to increase coverage. There is no COVID vaccine programme for staff this year. • NHS England educational visit is taking place today, with feedback session scheduled for 3:30pm. • Negative press in the Telegraph regarding an employment tribunal for two porters. • Official opening of the Blue Skies Balcony took place, attended by Sam Dixon MP and the event was successful. The Board discussed the robust planning around recent industrial action, noting that approximately 90% of scheduled work was delivered despite significant staff absence. Dr N Scawn (NS), Medical Director clarified that about 65% of resident doctors did not attend during the strike, which required consultants to "act down" and cover gaps. This led to operational challenges, including the need to overstaff and then stand people down when attendance was uncertain. Mr N Large (NL), Chair asked whether doctors are required to give notice if they will not attend during strikes. NS responded that while the Trust asks	

	for notice, doctors are not obliged to provide it, resulting in last-minute staffing adjustments and inefficiencies. NL inquired about upcoming strike actions. NS stated that there is no confirmed information, but there are rumours of another strike before Christmas, and Consultants now also have a mandate to strike, suggesting escalation is likely. JT highlighted the financial cost of covering gaps caused by strike activity, estimating it at £300-400k. Mr S Brown (SB), Deputy Chief Operating Officer was commended for his leadership in minimising the reduction in activity. Mrs S Corcoran (SC), Non-Executive Director asked if there were any positive lessons from strike days, noting reduced corridor care and ED waiting times. NS explained this was due to increased senior consultant cover, enabling faster decision-making, but acknowledged that this level of staffing is not sustainable overnight due to cost and workforce limitations. Mrs H Gunawickrema (HG), Non-Executive Director asked if there is a mechanism to report the cost impact to NHS England. NS confirmed that costs are reported, but there is no dedicated funding for strike-related expenses. Previous funding had ceased, and the Trust currently absorbs these costs, which is a financial risk. NS advised the Board of a local issue where about 40% of resident doctor shifts are covered by bank doctors due to part-time working patterns. The region is moving to a lower "rate card" for these shifts, resulting in many unfilled shifts and additional pressures. The British Medical Association (BMA) is attempting to generate local industrial action over pay rates, with ongoing meetings between the BMA and the Integrated Care Board (ICB). Mr P Williams (PW), Non- Executive Director asked if part-time doctors must fill full-time rota slots. NS explained that in larger specialties like anaesthesia, fellows are employed to fill known gaps, but this is not always feasible in smaller specialties. The Board **noted** the CEO report.	
8.	**Chair's Update** The Chair welcomed newly elected Governors and noted upcoming changes to the Non-Executive Director team, thanking all involved for their support in these processes. Strategic and system changes were discussed; while there is a plan, the infrastructure to deliver is not where it needs to be. The Chair emphasised the need to focus on internal planning assumptions and acknowledged the challenging environment, highlighting the importance of credibility in delivering the annual plan, waiting lists, and the Trust's CQC action plan for the coming year. Updates on Cheshire and Merseyside Integrated Care Board (ICB) leadership were shared with Sir David Henshaw as the new ICB Chair and Liz Bishop as Interim Chief Executive at the ICB. Steve Igoe has been appointed as the Chair at Wirral University Teaching Hospitals NHS Foundation Trust.	

	NL expressed gratitude to staff, noting that their hard work is not always reflected in National Oversight Framework (NOF) indicators. The Chair described the ongoing work with PwC as challenging and relentless, providing helpful scrutiny but also being overwhelming and demanding on the teams. Another feedback meeting is scheduled for December, with PwC still identifying risks in the Cheshire and Merseyside system. Thanks were extended to staff and Board colleagues for their efforts. Upcoming events to note included the carol service and a charity sportsman's lunch next week. Prof A Hassell (AH), Non-Executive Director congratulated the team on work in bowel cancer and asked about sharing good and bad practice with the CQC. JT confirmed the Trust will continue to provide positive news and feedback. Mrs W Williams (WW), Non-Executive Director praised the Urgent Care showcase she had attended, noting the enthusiasm, innovation, and engagement of the staff. The Board **noted** the Chair's update.	
9.	**a) Board Assurance Framework – 2025/26 Q2 Update** Mrs K Wheatcroft (KW), Director of Governance, Risk and Improvement, presented the Q2 Board Assurance Framework (BAF) update, with a full review completed with all Executive Director leads. The BAF provides an overarching view of strategic risks, their management, and assurance received. The Assurance Committees also review extracts of the BAF, and it is important to ensure triangulation with the Board agenda and Committee updates. The report stated that 8 out of 10 risks remain above risk appetite. KW noted that embedding actions takes time, and risk levels will reduce as improvements are sustained and outcomes demonstrated. Mrs S Corcoran (SC), Non-Executive Director highlighted a typo in BAF 5 regarding target risk achievement and questioned whether the expected achievement date of March 2026 for most risks is realistic. KW responded that while the aim is to reduce risks within the year, it is acknowledged that some may extend beyond that. SC commended the progress made and suggested including trajectories. Mr N Large (NL), Chair agreed the BAF is in a better place. Mr J Develing (JD), Director of Strategy and Partnerships noted that not all objectives are delivered in year one, as some are part of a longer-term strategy and this clearly aligned with the BAF. NL asked if current risk changes could be indicated since the last meeting. KW confirmed that graphs or arrows will be added to show changes as well as a static position. **Action:** KW to add arrows to the BAF report to indicate changes or a static position to risk levels in the BAF. Mrs H Gunawickrema praised the BAF as a high-level framework and asked when remaining risks from the risk register would be integrated. KW	**KW**

	explained that high risks are considered in BAF discussions, but more work is needed on consistency, calibration, and training for scoring mechanisms before meaningful triangulation can occur. Progress is being made, but foundational work on the use of Datix is still required. NL requested that the Assurance Committees review these risks in the new year and report back in April 2026, scrutinising timelines and scores. KW confirmed the review of the relevant BAF risks occurs at every Assurance Committee meeting. The Board of Directors: • **approved** the updates to the 2025/26 Board Assurance Framework at Q2 • **noted** the update on progress in delivering strategic objectives **b) High Risks Report** Mrs K Wheatcroft (KW), Director of Governance, Risk and Improvement, presented the high risk report, noting that some risks are still progressing through Divisional governance. The report provides transparent oversight for the Board of risks scored as high on the Datix system, with each Executive Director reviewing mitigations and ensuring actions are reported back. KW acknowledged the report is not perfect but offers updated visibility of high risks on the trust wide risk register. Mr P Jones (PJ), Non-Executive Director commended the significant progress made over the past 12 months, highlighting improvements in transparency, action plans, and target dates. The Chair noted that risks are well scrutinised, with some remaining ongoing. There was discussion on the antimicrobial risk, which has been on the register for a long time. Dr N Scawn (NS), Medical Director stated this risk is likely to be removed soon due to a specialty role appointment. Mr J Bradley, Chief Digital and Data Officer also noted that just because a risk was added a number of years ago this doesn't mean that changes haven't occurred during the period to date and reflected in the risk register. The Board considered 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.	
10.	**General Medical Council (GMC) National Training Survey 2025 Report** Dr N Scawn (NS), Medical Director, presented a high level summary of the General Medical Council (GMC) National Training Survey 2025. The full results had been reviewed by the People Committee. The survey had an 86% trainee response rate, above the national average. Results show a slight overall improvement, except for the induction process, which was affected by a change in the Director of Medical Education. The Trust was highest in the region for providing a supportive environment for trainees. NS explained the four levels of the Intensive Support Framework (ISF). Only two specialties (Obstetrics & Gynaecology and Emergency Medicine) were	

	on the ISF last year. Obstetrics & Gynaecology improved significantly and received a national award for most improved education. Each specialty has an action plan and the assurance from the education and learning sub-committee would be provided via the People Committee. Prof A Hassell (AH), Non-Executive Director confirmed the People Committee reviewed the full report and raised the issue of unplanned less than full-time (LTFT) working among resident doctors, suggesting that recruiting to 0.8 posts could reduce this. AH recommended pushing the Deanery for a solution, as this would improve workforce planning and reduce costs. NS reiterated that these are Deanery appointments and noted NHS Health Education England had previously discussed advertising 0.8 posts, but no progress had been made. AH suggested writing to the Deanery to request a solution, noting this was discussed at public board. The Chair asked about the risk and whether it should be on the risk register. NS confirmed it impacts recruitment and retention, and if trainees have a good experience, they are more likely to return as consultants. Lack of trainees can create significant service gaps. **Action**: Submit request to the postgraduate Deanery to consider less than full-time training posts, as this would have a significant impact on patient safety and finances. NS highlighted the disparity in trainee numbers across specialties and explained that at least three trainees are needed in a specialty for survey results to count, making small specialties more sensitive to negative feedback. NS noted the Trust is signed up to the NHS England 10-point plan to improve trainee experience, which includes metrics such as parking, hot food, and time off. The Chair questioned the trend of only 'slight' improvement. NS responded that the Trust has a strong response rate and has shown consistent improvement over the last five years. Mrs W Williams (WW), Non-Executive Director emphasised that a positive training experience increases the likelihood of trainees returning and highlighted the importance of innovation, environment, and culture. The Chair asked when an update should return to the Board. NS confirmed the survey is annual, with action plan progress managed through the People Committee and updates to the Board as needed. Mr P Williams (PW), Non-Executive Director suggested a more frequent pulse survey. NS noted this could dilute the completion of the annual survey, which already has a high response rate. Mrs S Corcoran (SC), Non-Executive Director asked about the impact of negative feedback in small specialties and whether leaders are addressing this. NS confirmed all specialties are targeted for improvement, and Dr L Cheater, Director of Medical Education leads this work. AH confirmed specialty-level responses were reviewed at the People Committee. The Chair confirmed the People Committee will continue monitoring the survey and action plans.	**NS**

	The Board **noted** the GMC national training survey update and confirmed monitoring of the delivery of action plans through the People Committee.	
11.	**Quality & Safety Committee Chair's Report – 6th November 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 first alert regarding the impact and levels of Non-criteria to reside (NCTR) had already been discussed by the Board. • NCTR will be addressed further at the Board development day in December 2025. • There had been an increased number of dermatology and urology referrals, with a resulting impact on histopathology. The Committee received a plan to address these pressures. • The Committee received a Cancer Harms Review update and requested further information, which will be brought to the next meeting The Board **noted** the Quality and Safety Committee Chair's report.	
12.	**Care Quality Commission (CQC) Improvement Plan including Well Led** Ms S Pemberton (SP), Deputy CEO/Director of Nursing and Quality, presented the CQC Improvement Plan update. Due to the recent CQC inspection and the intention to review the range of action plans in existence, the report focused on ongoing work rather than the usual full action plan update. As per the action log there are plans to review and streamline CQC action plan progress reporting, as there are currently three separate reporting streams. Mrs W Williams (WW), Non-Executive Director raised a question about progress on voice recognition and ambient voice technology, noting that many staff are burdened by administrative tasks and some are unaware of these options. All agreed this technology would be beneficial. Mr J Bradley (JB), Chief Digital and Data Officer provided an update on the Ambient Voice Technology programme being led by S Brown. We are currently advancing the business case and planning. Procurement was ready in early October, but regional funding was offered, causing a slight delay. The Trust is awaiting NHS England funding confirmation, with plans to roll out the technology in the new year. An update will be presented at the Clinical Leads away day this week. The pilot scheme for Cheshire and Merseyside will be substantial, with no user number limits. WW asked if the pilot aligns with ICB timeframes and funding. JB confirmed funding is from national transformation funds, managed in conjunction with the Cheshire and Merseyside Integrated Care Board and provider collaborative structures. WW sought clarification on the "new year" timeline. JB confirmed rollout is expected between January and March 2026. WW commented that this is an exciting development that will make a significant difference. The Board **noted** the update on the CQC action plan.	

13.	**Perinatal Services Quarterly Update (Quarter 2)** Dr S Brigham (SB), Associate Medical Director; and Claire Davies (CD), Head of Midwifery; presented the update, confirming prior review by the Quality and Safety Committee. SB highlighted: • The Maternity Incentive Scheme is on track to achieve all 10 safety actions, with updates provided for each. Action 8 remains tight but is expected to be achieved. The Trust is the second highest performing organisation in the region. • The dashboard is reviewed monthly at Women and Children's Governance meeting. • There was one neonatal death due to extreme prematurity and the stillbirth rate was shared. • The Chair has co-produced guidelines and communication cards for parents on the neonatal unit. • There has been a reduction in moderate harm incidents, attributed to the implementation of the PSIRF plan. • Two new complaints were received in the quarter, with no staff-related themes. Triangulation of incidents and complaints was shared with maternity safety champions; main themes were communication and treatment delays. Actions include strengthening risk assessment, enhancing documentation and handover, and improving multidisciplinary education. Mrs S Corcoran (SC), Non-Executive Director commented positively on the Maternity and Neonatal Voice Partnership (MNVP) lead and the service's response, noting an increase in bookings and the emerging maturity from the PSIRF programme. She raised ongoing staff concerns about staffing levels, which are being discussed with Mrs S Pemberton (SP), Director of Nursing & Quality/Deputy CEO. Mrs J Tomkinson (JT), Chief Executive Officer asked about the Maternity Incentive Scheme evidence, referencing last year's issues. SB reassured the Board that evidence provision is on track. SP noted that, as with the general hospital, this is a six-monthly staffing review. Targets are being met on paper and staff can manage workloads, though challenges remain. There is ongoing work on culture, particularly around perceptions of staffing needs. Mrs W Williams (WW), Non-Executive Director confirmed that safer staffing is reviewed at People Committee and assurance has been received. She asked if complaints and concerns relate to verbal or written communication. SB clarified these are mainly about written follow-up and discharge processes, which currently do not provide sufficient information to community midwives or GPs. Work is ongoing to improve this. WW asked Mr J Bradley (JB), Chief Digital and Data Officer if ambient voice technology could help. JB noted a broader review is underway, including EPR and ambient voice solutions, led by Dr Benton. SB emphasised the need to prioritise what information is included in discharge summaries.	114 - 120 114 -120

	The Board **noted** the Perinatal Services Quarterly Update at Q2.	
14.	**a) Maternity and Neonatal Bi-annual Safer Staffing Report January to July 2025** Ms Claire Davies (CD), Head of Midwifery, presented the report, confirming 904 deliveries in the period. The report has been reviewed at the Women and Children's Governance meeting and the People Committee. All Maternity Incentive Scheme (MIS) standards are met. From January to June 2025, there was 100% compliance with 1:1 care in labour. In March 2025, inpatient on-call was commenced. There were 69 red flags, a reduction from the previous report. Vacancy rate is 1.83%, with 12 new midwives recently recruited. Birthrate Plus assessment is underway. Mr N Large (NL), Trust Chair asked about staff experience in the new building. CD noted the next report may show differences, as the environment feels busier with more bookings. The change in environment may make staff feel short-staffed, although actual numbers have not changed. Work is needed to help staff adapt to the new environment and culture. The impact will be clearer in 6–8 months. Dr S Brigham confirmed the new site has aided recruitment. Mrs S Corcoran (SC), Non-Executive Director and Mrs S Pemberton (SP), Director of Nursing and Quality/Deputy CEO shared feedback from a walkabout, observing that the new space is very different and harder to navigate, which will be felt by staff during their shifts. Staff appreciate the environment, but tasks like cleaning now require more effort due to increased space. Dr N Scawn (NS), Medical Director raised concerns about the frequency of red flag incidents, asking about national benchmarks and comparison. CD explained that labour ward coordinators use a national acuity tool to record red flags. Completing red flags is safer, and there is no indication the Trust is above or below national standards. NS emphasised the importance of using the data effectively. NL commented that recording red flags is positive, where there are low numbers this may indicate under-reporting. CD agreed, noting that if red flags are low, it may mean band 7s are not completing the acuity tool. SP clarified that red flags are only one indicator, and the Trust triangulates this with other data. The process is thorough. NL noted that issues are also flagged in real time at the 8am safety calls. CD added that the Birthrate Plus assessment will include environmental factors. The Board thanked SB and CD for their presentation and **noted** the bi-annual maternity and neonatal safer staffing report (January to June 2025)**.** *SB and CD exited the meeting.* **b) Bi-annual Safer Nurse Staffing Report (mid-year establishment review 1 January to 30 June 2025)**	

	Mrs S Pemberton (SP), Director of Nursing and Quality/Deputy CEO, presented the report as a follow-on from the previous paper. A full report and deep dive was conducted at the People Committee meeting. The review focused on shifts in acuity, with recommended changes for Ward 45 and Ward 54, and a skill mix change for Pre-op. SP highlighted that recommendation number 4 regarding The Associate for Perioperative Practice (AFPP) review and theatre leadership is not yet accepted; further benchmarking and financial analysis is needed due to varied experience amongst Band 5 staff. The first three recommendations have been accepted. Staffing issues are mainly due to unavailability from sickness, leave, and maternity, which the Trust is working to resolve. Prof A Hassell (AH), Non-Executive Director asked about unfunded beds, specifically their duration of use and the Trust's approach. Ms J Tomkinson (JT), Chief Executive Officer explained that escalation capacity is used regularly, with some areas invested in recurrently, but not all are always in use. The Trust flexes capacity as needed and aims to reduce reliance on escalation space in the future. The escalation spaces cost about £3-4 million annually, and the Trust continues with non-recurrent solutions due to financial risk. Mr P Jones (PJ), Non-Executive Director asked for confirmation that the recommendations have already been approved at the People Committee, which was confirmed as set out above. The Board **noted** the bi-annual safer nurse staffing report (January to June 2025).	
15.	**Safety Surveillance and Learning Report – Quarter 2 2025/26** Mrs S Pemberton (SP), Director of Nursing and Quality/Deputy CEO, presented the update. The report was previously reviewed at Quality and Safety Committee on 6th November 2025. It provides assurance on robust governance and shared learning, with good attendance from Divisions and the PALS team. All Divisions present their learning from complaints. The report details levels of harm in each section. Going forward the report will incorporate the Quality and Safety Strategy. Key learnings highlighted included care and compassion work in ED, and improvements in learning from deaths and coroner inquests, with processes now much more robust than 18 months ago. One STEIS incident was reported in Q2. Mrs W Williams (WW), Non-Executive Director commented positively on the report and asked, given the strong Infection Prevention and Control (IPC) report earlier in the meeting and reductions in Healthcare Acquired infections (HCAIs), whether similar reductions were seen in this report and if they could be triangulated with IPC efforts. SP confirmed a recent peak but overall reductions in HCAIs, especially linked to improving catheter care, and noted the ongoing improvement efforts. The Board **noted** the Safety Surveillance and Learning Report – Quarter 2.	
16.	**Quarter 2 2025-2026 Mortality Surveillance Report (Learning from Deaths)**	

	Dr N Scawn (NS), Medical Director presented the report, noting 240 deaths in the quarter, all scrutinised by the Medical Examiner, with 44 escalated for further review. National benchmark standards (SHMI and HSMR) remain within the expected range for an acute trust of this size. Acute cerebrovascular disease was again flagged as a trending cause of death, with a previous blip early last year and another later in the year. Both were investigated, but no theme was found. The stroke team is now conducting a full review of all stroke deaths in the last 12 months to ensure nothing has been missed. Mrs S Corcoran (SC), Non-Executive Director suggested that, rather than including direct notes from mortality and medical examiner reviews, a summary would be more appropriate. NS proposed to discuss outside the meeting what summary content would be suitable. Prof A Hassell (AH) asked about including assessor field summaries in the annual report, such as the percentage of cases rated outstanding or suboptimal. NS clarified that 120–150 cases are reviewed annually and agreed this could be considered. Mrs W Williams (WW), Non-Executive Director enquired if the stroke ward blips could be linked to environmental factors, care, or staffing. NS responded that no cause or theme has been identified for these blips. Mr J Bradley (JB), Chief Digital and Data Officer suggested reviewing SHMI and benchmarking against other trusts. **Action:** Learning from mortality and medical examiners reviews to be summarised more clearly within the report. The Board **noted** the update.	**NS**
17.	**Integrated Performance Report (IPR)** **Operational Performance** Ms S Brown (CC), Deputy Chief Operating Officer provided an update on operational performance. In summary: • The Trust has seen improved 4-hour and 12-hour performance, ambulance handover times reduced by 8 minutes, and record-high ED attendance in October. • Significant transformational work is underway, and winter planning has been signed off at EDG to mitigate bed loss. Agreement with ICB to reduce non-criteria to reside to 15%. • Elective RTT performance improved in October, with overall compliance up and pathways over 52 weeks reduced (best position all year, though still off plan). Trajectory for over 65 weeks met. Consultant Connect continues to be used for RTT triage. • Emerging pressure in breast screening; Cheshire and Mersey Cancer Alliance funding secured to backfill radiologist gaps. Echocardiography remains a regional pressure. Ms J Tomkinson (JT), Chief Executive Officer raised concerns about echocardiography, requesting assurance and suggesting a deep dive at	

	Finance and Performance Committee (F&P). SB confirmed an action plan is in place and can be taken to the F&P Committee. **Action:** Echocardiography action plan progress/update to be reported to Finance & Performance Committee. Mrs W Williams (WW), Non-Executive Director asked about the numbers stated requiring mutual aid. SB explained corneal grafts are limited by tissue sourcing so numbers are lower. SB added that about fifty slots are being sourced for vascular patients. Discussion followed on vascular service, reduction in varicose vein demand, and use of Consultant Connect. Prof A Hassell (AH), Non-Executive Director asked about advice and guidance, noting decreasing utilisation. SB acknowledged additional regional costs and the need for robust advice and guidance, with further review required to prevent waiting list increases. Mrs S Corcoran (SC), Non-Executive Director asked about the impact of e-discharge. NS confirmed it is a safety concern raised by the Local Medical Committee (LMC), and it is monitored through the Quality Governance Group reporting up to the Quality & Safety Committee. SC stressed the need for a long-term solution. Mr P Jones (PJ), Non-Executive Director asked about key themes in the spike in ED attendance. SB noted most increases are walk-ins, with no specific themes identified. All trusts are experiencing high ED attendance. The Chair emphasised the importance of delivering targets by the end of March 2026 and encouraged the Board to continue to request assurance and to provide support if needed, highlighting the impact on individual patients. Concerns remain around urgent care, with further discussion planned for the Board development day in December 2025. **Quality** Ms S Pemberton (SP), Deputy CEO/Director of Nursing and Quality presented the Quality update: • Incident reporting increased in September; one incident reported to STEIS and eight cases of C Difficile, with no themes or lapses in care identified. • Continued reduction in patient falls since July 2025. • Friends and Family Test response rate is just above the national average; internal solution being explored as current provider will stop operating next year. • Sepsis screening is being conducted not just in ED but across clinical wards. • Emphasis on maintaining momentum in ED improvements. • Timely closure of complaints and concerns is a priority, with SP personally driving weekly progress. It was noted that increased family meetings may cause some delays but improve the quality of responses.	**SB**

- Innovation Fortnight is being led by Mandy Nagra, with a wrap-up session scheduled for next week to review outcomes and potential improvements.

Safety

Dr N Scawn (NS), Medical Director presented the Safety update:

- E-discharge process discussed as an ongoing issue.
- Sepsis: NL asked if the trust is on track for sepsis management. NS explained the approach has changed, with a need to shift focus from ED to ward patients to ensure proper screening. Sepsis as a diagnosis for death remains well below the national average.

People

Mr P Marston (PM), Deputy Chief People Officer presented the People update:

- Turnover remained below target at 8.9%, while sickness rates increased from around 5% to 6.1% in October, attributed to seasonal illnesses and stress/anxiety, with half-term periods also impacting absence levels.
- Mandatory training compliance stayed above target at 90.3%, and appraisal rates, though slightly dropped, remained above target at 80.6%.
- Agency usage has significantly decreased, with nursing shifts dropping from 250 to 4 compared to the previous year, and high-cost long-term agency workers being replaced by substantive appointments, reflecting progress in vacancy management.
- Despite increased support for staff, stress and anxiety remain leading causes of absence. Further consideration of accountability and performance measures is being undertaken, along with exploring how staff are utilising available support mechanisms.

WW commended PM for providing broader and more detailed data to the People Committee, enhancing assurance and enabling deeper dives into issues such as reasons for staff sickness. The Committee has also begun reflecting on appraisals and how to build in more accountability, with further discussion planned.

NS requested an update on e-rostering. PM reported that an initial project plan is in place, with a timeline of six months for implementation. PM noted this will have a significant positive impact.

Finance

Mrs K Edge (KE), Chief Finance Officer presented the Finance Update:

- At month 7 there is a year-to-date deficit of £19.7m, which is on plan, with mitigations achieved through non-recurrent benefits.
- There is a risk to the delivery of the Cost Improvement Programme (CIP).

	• The Better Payment Practice Code is an area of concern due to cash preservation measures. The Trust is prioritising payments to smaller providers within terms, which requires ongoing effort but is considered the right approach. • The forward plan is to meet the financial plan, with no adverse variance expected due to active recovery actions. The Trust has flagged its position for external scrutiny and is working hard on recovery plans, monitoring the success of these actions. The Chair inquired about the next iteration of the NOF (National Oversight Framework). Mr J Bradley (JB), Chief Digital and Data Officer confirmed internal figures have been updated since the last IPR, with the most recent external publication in September. The next NOF is due imminently, but it will be the March report which will reflect the more recent work. National survey results are annual so the impact of these will also be later next year. JT confirmed the financial plan is on track, but highlighted the biggest risk is Urgent and Emergency Care (UEC), with additional capacity agreed to support patient flow through winter. The volatility of this area poses planning challenges. SB noted that a single front door would help support 4-hour target delivery. NL suggested further discussion would be needed at the upcoming Board development day. The Board **noted** the Integrated Performance Report.	
18.	**Operational Management Board Chair's Report – 25th September 2025 and 23rd October 2025** The Board received the Operational Management Board (OMB) Chair's reports 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 referred to the alert from 23rd October 2025 meeting, highlighting that vacancies in admin roles are not being filled and while a formal vacancy freeze has not been implemented, all vacancies are under scrutiny. The pressure in these areas is recognised and plans progressing to address the risks. The Board **noted** the OMB Chair's reports.	
19.	**Finance & Performance Committee Chair's Report – 4th November 2025 (attached) and 19th November 2025** The Board received the Finance and Performance Chair's reports 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 H Gunawickrema (HG), Non-Executive Director presented the highlights of the reports. <u>4th November 2025</u> • Deep dive conducted on digital and cyber security. • Updates provided on the Cost Improvement Programme (CIP). • The hybrid theatre business case was raised for Board attention but will not proceed to Board yet as further work is required.	

	• Winter planning and additional outflow plans discussed. • Cash position reviewed. <u>19th November 2025</u> • Geothermal outline business case was discussed and would come to Board in full. • Medium term planning framework reviewed. Board was advised to take ownership and seek assurance, with a focus on how Executive Directors can provide this. The Chair enquired about the hybrid theatre; Mr J Develing (JD), Director of Strategy and Partnerships responded that the aim is to align activity and demand for all elective planned care and to develop the business case accordingly. The Board **noted** the Finance and Performance Committee Chair's reports.	
20.	**Audit Committee Chair's Report – 7th October 2025** The Board received the Audit Committee Chair's report which included areas to Alert to the Board, areas where Assurance had been received, areas to Advise the Board and any new risks discussed. Mr P Williams, Non-Executive Director presented the highlights of the report. It was noted that report had been signed off by the previous Audit Committee Chair Mr M Guymer prior to his departure on 31st October and a handover had taken place. The key updates were: • No specific alerts were raised. • Anti-fraud progress was reviewed. While there are long-standing cases, the Committee is assured the Trust is taking all possible actions. • Freedom to Speak Up (FTSU) arrangements were discussed. • Data Security and Protection Toolkit (DSPT): Auditors commended the Trust's self-assessment mechanism. • Audit tracker and out-of-date policies were reviewed. • Technical updates from internal and external audit included commentary on the use of AI: the Committee advocated for Board consideration of AI governance. **Action:** AI governance to be added to the Board development plan 2026/27. The Board **noted** the Audit Committee Chair's report.	**KW**
21.	**Emergency Planning & Resilience (EPRR) Core Standards Self-Assessment and Annual Report** Mr S Brown (SB), Deputy Chief Operating Officer presented the EPRR core standards assessment and annual report, highlighting overall compliance. This is year 3 of the Trust's core standards return; previous years focused on SOPs and standards, but the current focus includes evidence of training and exercises.	

	The Trust self-assessed against 62 standards. The Cheshire and Merseyside Integrated Care Board (ICB) randomly selected 5 standards for review and agreed with the Trust's self-assessment for these standards. There has been an improvement overall since last year, moving from partially compliant to substantially compliant. The aim is to achieve full compliance by September 2026, with several areas for improvement identified. SB commended the excellent work and leadership of the EPRR Manager. The Board **noted** the EPRR core standards self-assessment and annual report.	
22.	**People Strategy 2025 – 2028** Mr P Marston (PM), Deputy Chief People Officer presented the new People Strategy, noting the previous strategy was from 2021 and this was an opportunity for review and refresh. • The strategy commits to making the Trust a great place to work, aligning with the People Plan, and enhancing staff experience. • The four strategic themes are: - Looking after our people - Creating a sense of belonging - Developing our people to be their best - Building the future workforce • Additional detail has been added on culture, leadership, and embedding these values since the previous draft was shared with the People Committee and Board of Directors. • Delivery will be monitored through KPIs; focus areas include flexible working, Equality Diversity and Inclusion representation, improving appraisal quality, and growing apprenticeships. The Chair emphasised the importance of people in delivering our agenda. Mrs W Williams (WW), Non-Executive Director highlighted the inclusive approach in developing the strategy and the need for Board focus on staff support. Discussion covered the critical role of leadership, the need for a one-page summary (to be developed), dashboard timelines, and integrating reporting for all directors. Mr J Bradley (JB) Chief Digital and Data Officer, and Mr P Jones (PJ), Non-Executive Director shared discussions they have had regarding digital/data implications and preparing staff for new technologies. The Board **Approved** the People Strategy 2025 – 2028.	
23.	**People Committee Chair's Report – 14th October 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: • Annual workforce plan progress was discussed; concern remains over incomplete actions and trajectories, which will be revisited at the People Committee. • EDI progress was highlighted as essential for staff inclusion and performance; current efforts are ongoing but not yet at the desired level. The relevant sub-committee is newly established and beginning to address the actions. The Chair suggested EDI could be a future topic for Board discussion. **Action:** EDI to be added to the Board development plan 2026/27 The Board **noted** the People Committee Chair's report.	
24.*	**Council of Governors Report – October 2025** The report summarised the key topics presented and discussed at the Council of Governors meetings in October 2025 and Governor activity since the last Board meeting. The Board **noted** the Council of Governors Summary Report.	
26.	**Any Other Business** There was no other business to raise.	
27.	**Questions from Governors and members of the Public** There were no questions raised. **Future Dates:** 27th January 2026 31st March 2026	
28.	**Closing Remarks** The Chair invited feedback on the papers received during the meeting. Everyone confirmed their satisfaction with both the content and the format of the documents presented. Mr J Bradley (JB), Chief Digital and Data Officer specifically noted that the inclusion of an improved executive summary and an appendix for the Integrated Performance Report (IPR) had enhanced the overall presentation. The Board expressed agreement with the decisions made throughout the meeting. Mrs K Wheatcroft (KW), Director of Governance, Risk and Improvement, provided an update by comparing the current board meeting pack to the one presented at the same time last year with a reduction in pages of almost half the previous year with similar agenda items presented. She highlighted the significant progress made in presenting key points to the board, as well as improvements in the length of the meeting packs.	

	In conclusion, the Chair thanked all participants for their contributions and formally closed the meeting.	

Next Meeting: Tuesday 27th January 2026

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

NHS
Countess of Chester Hospital
NHS Foundation Trust

Public Board of Directors Action Log

Updated January 2026

Action No.	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/ Outcome	Due Date	Status
1	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. **Update 20th January 2026** – Trajectories continue to be added for key metrics, with ED trajectories added for the December IPR.	Sept -25	**Open**
2	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. **Update 15th January 2026** – Reviewed and action closed with paper included on the January 2025 Board of Directors agenda.	Jan-26	**Closed**
3	30th September 2025	Medical Director/ Director of	15.	National Inpatient Survey Results	It was agreed to add an update on the discharge pathway to the	**Update 17th November 2025** – Deep Dive to be included alongside NCTR at	Nov-25	**Closed**

Action No.	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/ Outcome	Due Date	Status
		Nursing & Quality			November Board agenda.	the December 2025 Board Development Day. **Update 7th January 2026** - The deep dive was covered in the NCTR update at December 2025 Board Development Day.		
4	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. **Update 7th January 2026** – Research Strategy included on the January 2026 Board of Directors agenda.	~~Nov-25~~ Jan-26	**Open**
5	30th September 2025	Chief People Officer	32.	Questions from the 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 updated to be shared in the November 2025 Board meeting. **Update 25th November 2025** – Chair requested a further update at the January 2026 Board meeting. **Update 7th January 2026** – Verbal update included on	Jan - 26	**Open**

Action No.	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/ Outcome	Due Date	Status
						the January 2026 Board of Directors agenda.		
6.	25th November 2025	Director of Governance, Risk and Improvement	9.	Board Assurance Framework – 2025/26 Q2 Update	KW to add arrows to indicate changes to risk levels in the BAF	**Update 15th January 2026** – Arrows are included in the report shared at the January 2026 Board of Directors.	Jan - 26	**Closed**
7.	25th November 2025	Medical Director	10.	General Medical Council (GMC) National Training Survey 2025 Report	Submit request to the postgraduate deanery to consider less than full-time training posts, as this would have a significant impact on patient safety and finances.	**Update 15th January 2026** – Dr N Scawn met with Deputy Post-Graduate Dean (Nadeem Khwaja) for the Northwest Deanery and whilst being sympathetic and acknowledging the issue, he felt that it is a national issue that he didn't feel that the Northwest Deanery could influence.	Jan - 26	**Open**
8.	25th November 2025	Medical Director	16.	Quarter 2 2025-2026 Mortality Surveillance Report (Learning from Deaths)	Learning from mortality and medical examiners reviews to be summarised more clearly within the report.	**Update 7th January 2026** – next Mortality Surveillance Report due to be received at the March 2026 Board of Directors.	~~Jan – 26~~ Mar-26	**Open**
9.	25th November 2025	Deputy Chief Operating Officer	17.	Integrated Performance Report	Echocardiography action plan progress/update to be reported to Finance & Performance Committee.	**Update 9th January 2026** – This action plan will be shared through OPELG, which it did in November 2025, December 2025 and January 2026 and then it will be shared to the Finance &	Feb-26	**Closed**

Action No.	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/ Outcome	Due Date	Status
						Performance Committee via the OPELG Chair Reports.		
10.	25th November 2025	Director of Governance, Risk and Improvement	20.	Audit Committee Chair's Report – 7th October 2025	AI governance to be added to the Board development plan 2026/27.		Mar-26	**Open**
11.	25th November 2025	Director of Governance, Risk and Improvement	21.	People Committee Chair's Report – 14th October 2025	EDI to be added to the Board development plan 2026/27		Mar-26	**Open**

PUBLIC – Board of Directors
27th January 2026

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

NHS England has published, for consultation, an Advanced Foundation Trust Programme (AFT). This has received widespread support from NHS Providers and NHS Confederation with reference to how this status will be awarded to small number of high performing Trusts, with all Trust becoming AFTs by 2035.

2. Regional Updates

NHS services across Cheshire and Merseyside remain under significant pressure, with demand for primary care, hospital services, mental health, and emergency services continuing to rise.

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

7th November 2025

The Leadership Board met on 7th November and discussed a number of important system wide issues.

Digital Programme – An update and emerging Digital Programme proposition was shared. A vision for a single CMPC approach was described that needed to be underpinned by clear governance and a shared enterprise architecture that should support multi-year investment and delivery. Details explored included short term workforce issues and risks and CDIO leadership of various envisaged workstreams. The Board noted that a single approach to digital and data will yield savings. A £3m RTF bid for ambient voice technology (AVT) was noted as having been successful. Alder Hey is leading this work, and the majority of providers will pilot technology. A further update on AVT roll-out will come to a future meeting.

The Board considered in year delivery and governance, and the key H2 priorities:

- Improve run-rate – challenge can be expected on action taken
- Under/over performance queries – ICB reviewing to mitigate income risks
- CIP requires full implementation, and slippage needs to be offset via non-recurrent controls – there are still risks associated with CIP
- Demonstrating appropriate measures to provide assurance on grip and control
- Balance sheet reviews
- The expectations for Trusts to be categorised as low, medium and high-risk was outlined

The Board also discussed the system approach to 2026/27 planning. It was noted that at present, it might be predicted that the M12 run rate requirement will not be met which would, manifest, as actions in readiness to improve productivity and reduce workforce being required by April 2026 as part of foreseen regulatory stretching ambition and mitigation plans. The role of collaboration and CMPC has been raised by PWC who have suggested CMPC lead on a number of items including service consolidation, corporate integration, and pathway design.

The Board also discussed a number of wider system issues:

- The need for action and grip on UEC. Both in order to improve patient experience and outcomes but also to alleviate pressures on patient flow. It was noted that leverage with Primary Care and Local Authorities is needed to make an impact and that effort needs to be aligned with and to the resource for UEC improvement/performance management sitting with the ICB and NHSE oversight of this area.
- Industrial action rate card for consultants – The Board endorsed use the rate card that was in place for the last round of industrial action.
- Children and Young People – the Board received an update on an Alder Hey facilitated discussion on CYP which included a number of CEOs and service leads. The discussion considered all aspects of CYP including acute services, community, neighbourhood and mental health. This work is being taken forward as part of the CMPC Blue Print work.

Friday 5th December

The Leadership Board reviewed a comprehensive digital transformation agenda intended to reposition digital as a system wide driver of clinical and operational improvement. The Board endorsed the direction of travel, including establishment of a Digital Centre of Excellence, development of shared architecture, and accelerated progress on key priorities. The Board agreed in principle to incorporate ICB digital functions into a shared collaborative model and requested a concise plan on a page summarising vision, milestones, and governance.

A strategic discussion on collaborative procurement highlighted £1.2bn annual addressable non pay spend and substantial efficiency opportunities. The Board endorsed progressing toward a single system wide procurement service, supported by phased implementation, and an accelerated business case.

Operational updates noted that Cheshire & Merseyside remains an outlier on 65 week elective waits. Workforce matters included agreement on a target of 95% attendance threshold. Decisions on visas and recruitment freezes were deferred pending further guidance from a scheduled NHSE webinar.

Friday 19th December

The CMPC Leadership Board convened to review system wide progress, organisational pressures, and future strategic direction. The meeting opened with an update from Liz Bishop, ICB CEO, highlighting rapid development of a commissioning strategy due in January, with a renewed focus on prioritised pathways, prevention, and a more standardised approach across Cheshire and Merseyside. ICB governance structures are under review, with executive appointments expected by the end of January.

A substantial portion of the meeting focused on in year delivery and planning, including discussion of the recent NHS England Undertakings issued to several providers. The Board agreed on the need to focus on a three year planning horizon supported by a small number of credible transformation schemes including workforce reduction strategies, corporate services consolidation, productivity improvements, and potential estate rationalisation.

The Board discussed workforce productivity tools, including acuity based rostering tools and redesign of outpatient provision.

Friday 9th January 2026

The Leadership Board met on 9th January 2025 to review key programmes and system priorities. The Board approved continuation of the Dermatology AI – Skin Analytics

programme, noting its strong clinical performance, and contribution to increased efficiency by reducing consultant appointments and biopsy rates.

The Board endorsed the proposed methodology for identifying fragile services across Cheshire & Merseyside, which applies a structured scoring matrix across quality, workforce, standards, and financial measures. This process will support the development of a prioritised shortlist by March. 114 -

A detailed update was provided on the LAASP business case. The work demonstrates a rigorous approach to assessing integration options across Liverpool providers. Key objectives include economies of scale, clinical pathway integration, improved workforce models and strengthened system working.

Updates on diagnostics and community capital planning highlighted tight national deadlines, with £41m available for diagnostics in 2026/27 and £14m across three years for community investment. Work is progressing to align a shared prioritisation matrix and to shift towards a more strategic system wide approach to capital planning.

The ICB's financial planning for 2026–28 indicates an early ICB draft position of £9.4m surplus and a £74.8m CIP requirement., noting this position will change as plans iterate. Concerns were raised regarding the sustainability of incremental growth models and the need for a strategic resource allocation framework aligned with the Blueprint.

The system remains broadly on track for delivery of the 65 week wait target, though immediate action is required to address residual cases. Trusts are encouraged to engage with Q4 outpatient sprint opportunity and RTT improvement funding to maximise activity delivery before year end.

Finally, the Board discussed the need for strengthened oversight of service changes to avoid unintended system impacts, agreeing to refine processes for reviewing ICB Service Change Panel outputs, and welcomed the decision of the ICB to reconsider the previously proposed decommissioning of virtual ward beds.

4. Cheshire West

Summary of Cheshire Place Priorities include:

Community Led Care

- Community Led Care Commission, which supports help at home, carers break and prevention is currently being reviewed to determine future viability and affordability. The group discussed the role that this Service provides and the support that it gives on the flow of patients through the system.

Pathway 2 Beds

- Both Hospitals within Cheshire West are reporting that they are experiencing a lack of capacity within Pathway 2 beds. A project to test out the use of a spot purchase arrangement utilising 1-2 Care Homes is underway with appropriate wraparound support.
- Occupational Therapy for people being supported by Continuing Healthcare
- Place Partners agreed the need to further explore and understand the pathway for people who have been committed Continuing Healthcare funding but require minor

adaptations or Occupational Therapy support.

- Unlimited Opening Online Access for GP Appointments
- GP Practices across the country are now required to open unlimited online access. It is noted that this is being disputed on a national level between the BMA and NHS England.

Transformation and Partnership Priorities

- The Cheshire West Transformation and Partnerships Team are continuing to progress the 2025/26 priorities and commissioning intentions around the key areas of Children and Young People, Mental Health and Neurodiversity, Planned Care, Unplanned Care and Primary Care.

5. Urgent Care showcase

Our Urgent Care showcase welcomed Lord Mayor, Councillor Sherin Akhtar, as we shared updates about the improvement work being led by colleagues.

This was a positive way to share how our teams are working to improve patient care, safety and experience.

6. Mobile Research Unit visits Frodsham

Our Acute Frailty team visited Frodsham in the Mobile Research Unit (bus), to help prevent falls. The first of a series of monthly events across the area, we will be taking expert NHS advice out into communities to help people learn more about keeping themselves healthy and well.

7. Financial Performance Recovery Meeting

The month 8 meeting focused on delivery of the planned outturn (less deficit support funding) and any potential risks and mitigations. Given the proximity to year end, the future focus will be on the process and assurance for 2026/27 CIP. The expectation is that the full target will be identified by 31st March 2026 with suitable leadership and PMO support.

8. Opening of the Women and Children's Building

The Women and Children's Building was opened by the Lord Lieutenant of Cheshire Lady Alexis Redmond with many former and current staff as well as stakeholder present to celebrate the event with the Trust.

9. Board Leadership update

We are delighted to welcome Angela Simpson to our Board as a new Non-Executive Director. Angela joins us from the University of Chester as an Appointed Non-Executive Director, bringing a wealth of experience and demonstrates the continued strengthening of our partnership working.

PUBLIC – Board of Directors
27th January 2026

Report	**Agenda Item 8b.**	**Non-Executive Director Roles**						
Purpose of the Report	Decision	**X**	Ratification		Assurance		Information	
Accountable Executive	Neil Large			Trust Chair				
Author(s)	Nusaiba Cleuvenot			Head of Corporate Governance				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X** **X** **X** **X** **X** **X** **X** **X**	Potential to link to all BAF risk areas.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X** **X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Not applicable							
Executive summary	Effective governance is fundamental to the success of NHS Foundation Trusts, ensuring that strategic objectives are met, risks are managed, and the interests of patients and the public are safeguarded. Non-Executive Directors (NEDs) play a pivotal role as part of the unitary board, providing independent oversight and constructive challenge. The Trust has recently completed the successful recruitment of two new NEDs. In addition, in line with updates to the Board composition as stipulated in the Trust Constitution, a University appointed NED has also joined the Board. Consequently, the portfolios assigned to NEDs have been reviewed and updated to reflect these changes. This paper sets out the updates to NED roles at Countess of Chester Hospital NHS Foundation Trust.							
Recommendations	The Board of Directors is asked to **Agree** the updated NED roles and responsibilities.							

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	Alignment with the Corporate Risk Register.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential.

Non-Executive Director Roles

1. Introduction

Effective governance is fundamental to the success of NHS Foundation Trusts, ensuring that strategic objectives are met, risks are managed, and the interests of patients and the public are safeguarded. Non-Executive Directors (NEDs) play a pivotal role as part of the unitary board, providing independent oversight and constructive challenge.

The Trust has recently completed the successful recruitment of two new NEDs. In addition, in line with updates to the Board composition as stipulated in the Trust Constitution, a University appointed NED has also joined the Board. Consequently, the portfolios assigned to NEDs have been reviewed and updated to reflect these changes. This paper sets out the updates to NED roles at Countess of Chester Hospital NHS Foundation Trust.

2. Background

The NHS England guidance, published in December 2021, introduced a new approach to NED champion roles, recommending that certain responsibilities be discharged through committee structures while retaining designated champion roles for specific areas. The intention is to embed oversight of critical issues within governance arrangements, enhancing assurance and Board effectiveness.

The statutory context for NED roles is provided by the Health and Social Care Act 2008, the Trust's Constitution, and the NHS Code of Governance. These require that Boards ensure effective oversight, risk management, and compliance with regulatory requirements, including the Equality Act 2010 and the Public Sector Equality Duty (PSED). NEDs are expected to contribute to all domains of the Care Quality Commission (CQC): Safe, Effective, Caring, Responsive, and Well-led.

3. Non-Executive Director Roles

NEDs serve as Chairs and members of key Board Committees, including Audit, Finance & Performance, Quality & Safety, People, and Charitable Funds. Additional duties can include

but is not limited to, the champion roles, walkabouts, attendance at the Council of Governors meetings and NED meetings. The proposed time commitment for NEDs is approximately four days per month, with flexibility for additional duties. This ensures that NEDs have sufficient capacity to fulfil their governance responsibilities while maintaining independence from operational management.

Following recent changes to the NED team, the updated roles and responsibilities have been set out in the table below:

NED	Champion roles	Audit Committee	Finance & Performance Committee	Quality & Safety Committee	People Committee	Charitable Funds Committee
Neil Large ***(Trust Chair)***						X
Paul Jones ***(Deputy Chair)***	Freedom to Speak Up	X	X			X (Chair)
Peter Williams	Digital	X (Chair)				X
Angela Simpson	Research			X	X	
Hasintha Gunawickrema			X (Chair)			
Professor Andrew Hassell ***(Senior Independent Director)***	Doctors Disciplinary			X (Chair)	X	
Wendy Williams	Wellbeing Guardian	X			X (Chair)	
Sarah Corcoran	Maternity Safety Champion		X	X		

In addition to the committees above, all NEDs are also required to attend the Nominations and Remunerations Committee (Executive) which is held on an ad hoc basis and chaired by the Trust Chair.

4. Recommendations

The Board of Directors is asked to **Agree** the updated NED roles and responsibilities.

PUBLIC – Board of Directors
27th January 2026

Report	**Agenda Item 9.**	**NHS England Enforcement Notice**						
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Jane Tomkinson			Chief Executive Officer				
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	A briefing on the draft NHSE Enforcement Notice and proposed Trust response was presented at the Board development day on the 21st October 2025. The response was subsequently circulated to Board members by email on 22nd October 2025 and the final draft undertakings considered by the Board at its private meeting on the 25th November 2025.							
Executive summary	NHS England has responsibility for the regulation of providers of NHS services (both ICBs and Providers), the exercise of provider enforcement powers, and producing and revising guidance on those powers. Following correspondence with NHSE, the enforcement undertakings were signed by both parties (as attached) on the 28th November 2025. At the time of receiving the letter, the Trust already had action plans in place and progressing: • Financial plan (including cost improvement programme and request for deficit support funding).							

	• Urgent and Emergency Care Improvement plan. • CQC Section 29a action plan. The Board receives assurance of performance against these and there is clear correlation through the Board Assurance Framework. Scrutiny has also been provided through a regionally led System Oversight Group. We are fully committed to delivering against these requirements and have a strong grip on the actions needed to do so. Significant work is firmly embedded and we are seeing measurable signs of improvement in all areas, including the quality and safety of care, operational effectiveness, and financial control. These changes are driven by strengthened leadership, clearer accountability, and a sustained focus on patient outcomes Embedding these improvements continues, but the trajectory is positive and firmly aligned with national expectations. Our priority remains on delivering safe, high-quality care for our patients. We are supporting our staff to achieve this by ensuring they have the right leadership, tools and resources, by listening carefully to frontline feedback, and by empowering teams to make and sustain improvements. We are also committed to being open and transparent about progress and challenges as we move forward.
Recommendations	The Board of Directors is asked to **note** the final NHSE enforcement undertakings.

Corporate Impact Assessment	
Statutory/regulatory requirements	Trust compliance with the 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	Published through Public Board papers.

ENFORCEMENT UNDERTAKINGS

LICENSEE:

Countess of Chester NHS Foundation Trust ("the Licensee")
The Countess Of Chester Health Park
Liverpool Road
Chester
Cheshire
CH2 1UL

DECISION

NHS England, on the basis of the grounds set out below, and having regard to its Enforcement Guidance, has decided to accept from the Licensee the enforcement undertakings specified below pursuant to its powers under section 106 of the Health and Social Care Act 2012 ("the Act").
The undertakings in this document supersede the undertakings previously agreed on 31 January 2025, which will now cease to have effect.

GROUNDS

1. Licence

1.1 The Licensee is the holder of a licence granted under section 87 of the Act.

2. Breaches

2.1 NHS England has reasonable grounds to suspect that the Licensee has provided and is providing health care services for the purposes of the NHS in breach of the following conditions of its licence:

2023 Licence	**Summary of condition**
NHS2(5)(a),(b),(c), (d), (f) & (g)	The Licensee shall establish and effectively implement systems and/or processes: (a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;

	(b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations; c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions; (d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the conditions of its licence; (g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery.
NHS2(6)(a) to (f)	The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: (a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) the collection of accurate, comprehensive, timely and up to date information on quality of care; (d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; ((f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and

	resolving quality issues including escalating them to the Board where appropriate.
CoS3	The Licensee shall at all times adopt and apply appropriate systems and standards of corporate governance and financial management.

3. Financial Sustainability and Governance

3.1 In particular:

3.1.1 the Licensee reported circa (c.) £23.6m deficit (excluding deficit support funding (DSF)) for the financial year (FY) 24/25. The outturn was in-line with plan.

3.1.2 the Licensee had a £19.8m Cost Improvement Programme (CIP) Plan in FY24/25 with a 100% recurrency target. The Licensee delivered £11.9m CIP recurrently in FY24/25, leaving a CIP gap of £7.9m.

3.1.3 the exit underlying position of the Licensee at 31 March 2025 was reported as a £33.2m deficit.

3.2 The PricewaterhouseCoopers FY25/26 Rapid Financial Diagnostic carried out across the Cheshire and Merseyside Integrated Care System in June 2025, highlighted the following financial risks at the Licensee:

3.2.1 run -rate reductions are required across the organisation to support delivery of the FY25/26 plan. These reductions have been profiled in plans and will be monitored through routine performance reporting.

3.2.2 the Licensee has a significant CIP target in FY25/26 and this will require a material increase in delivery from the prior year.

3.2.3 inflationary pressures have typically been higher than national estimates, which typically manifests as an in-year mitigation for the Licensee to offset.

3.2.4 costs associated with the public enquiry are assumed to be funded as they were in FY24/25. However, if this is not the case, there is a potential material risk to the position.

3.3 The matters set out above demonstrate a failure of financial governance arrangements and financial management by the Licensee, including, in particular:

3.3.1 a failure by the Licensee to adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as:

(a) suitable for a provider of the Commissioner Requested Services provided by the Licensee, and

(b) providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern.

3.3.2 a failure to establish and effectively implement systems and/or processes: 114- 120

(a) to ensure compliance with the Licensee's duty to operate efficiently, economically, and effectively;

(b) for effective financial decision-making, management, and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); and

(c) to identify and manage material risks to compliance with the conditions of its licence including through development and delivery of forward plans; and

(d) to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the licence conditions.

4. Performance

4.1 In particular:

4.1.1 following an unannounced inspection of urgent and emergency care (UEC) services at the Licensee between October and November 2023 by the Care Quality Commission (CQC), The Trust was given a rating of 'inadequate' for the provision of urgent and emergency care (UEC) services. This rating was given across three of the five domains; 'safe', 'effective' and 'responsive'.

4.1.2 the CQC noted that patients attending the Emergency Department (ED) at the Licensee could not always access the service when they needed it and there were significant delays in receiving the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

4.1.3 the Licensee's A&E performance for March 2025 was 59.4% (significantly below the national ambition for 24/25 of achieving 78%). Whilst June 2025 A&E performance for the Licensee has seen a marginal improvement (up to 63.7%), it is still significantly below the national ambition of 78% for March 2026.

4.1.4 similarly, the Licensee's performance for percentage of patients spending over 12 hours in ED currently sits at just over 22% (i.e. one in every five patients is likely to experience a wait in ED of over 12 hours). This is the fourth highest

percentage of all North West hospitals and double the national ambition for 2025/26 of less than 10% of patients spending over 12 hours in ED.

4.1.5 the Licensee is in the lowest percentile nationally for mental health waits above 12 hours . 42% of adult mental health patient attendances wait 12 hours or more in the ED.

The matters set out above demonstrate a failure of governance arrangements including, in particular, failure to establish and effectively implement systems or processes:

(a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;

(b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations; and

(c) to ensure compliance with healthcare standards binding on the Licensee.

5. Quality

5.1 In particular:

5.1.1 there is a concern that the patients attending with mental health care needs are not receiving appropriate and timely care within the ED setting at the Licensee.

5.1.2 the CQC issued a section 29A warning notice (of the Health and Social Care Act 2008) on 2 April 2025 in relation to their assessment of UEC. The notice was issued around a non- consistent approach to assessing and managing the risk to service users and was found that the governance systems were not effective to ensure action taken to address ongoing concerns are sustained and embedded.

5.2 The matters set out above demonstrate a failure of quality governance arrangements by the Licensee, including, in particular:

5.2.1 that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

6. Need for Action

6.1 NHS England believes that the action, which the Licensee has undertaken to take pursuant to these undertakings, is action to secure that the breaches in question do not continue or recur.

7. Appropriateness of Undertakings

7.1 In considering the appropriateness of accepting in this case the undertakings set out below, NHS England has taken into account the matters set out in its Enforcement Guidance.

UNDERTAKINGS

NHS England has agreed to accept, and the Licensee has agreed to give the following undertakings, pursuant to section 106 of the Act.

1. Financial planning

1.1 The Licensee will deliver the 2025/26 Financial Plan, as agreed with NHS England.

1.2 The Licensee will deliver a quarter-on-quarter run rate improvement from Quarter 3 2025/26 and throughout 2025/26.

1.3 The Licensee will comply with all documented actions required by NHS England through the oversight meetings, led by NHS England or its representative.

2. Funding conditions and spending approvals

2.1 Where interim support financing or planned term support financing is provided by the Secretary of State for Health to the Licensee pursuant to section 40 of the National Health Service Act 2006, the Licensee will comply with any terms and conditions which attach to the financing.

2.2 The Licensee will comply with any reporting requests made by NHS England in relation to any financing to be provided to the Licensee by the Secretary of State for Health pursuant to section 40 of the NHS Act 2006.

2.3 The Licensee will comply with any spending approvals processes that are deemed necessary by NHS England.

3. Performance

3.1 The Licensee will take all reasonable steps within its control to:

3.1.1 improve waiting times for patients attending A&E at Countess of Chester Hospital, with the ambition to achieve a minimum of 78% A&E performance by March 2026.

3.1.2 as a minimum, the Licensee will reduce the proportion of patients spending over 12 hours in ED in 2025/26 compared to 2024/25, with the aim of reducing to as close as possible to 10% or lower by March 2026, with an expected year on year improvement.

3.1.3 The Licensee will ensure that there is a robust action plan in place to address 12 hour waits in the ED. Timescales are as agreed in the overarching Emergency Department Improvement Plan.

4. Quality

4.1 The Licensee will ensure that by a date to be agreed with NHS England:

4.1.1 there is an overarching improvement plan to address the performance and quality of care for mental health wait (s) in the ED, within a timeframe agreed by NHS England.

4.1.2 there is an overarching CQC action plan to address the section 29 A warning notice concerns and has effective oversight and assurance processes in place to monitor improvement.

5. Reporting

5.1 The Licensee will provide regular reports to NHS England through the oversight meetings led by NHS England or its representative, on its progress in complying with the undertakings set out above.

5.2 The Licensee will attend monthly oversight meetings, or, if NHS England stipulates, conference calls, as required, to discuss its progress in meeting those undertakings. Oversight meetings will be led by NHS England or its representative, with attendees specified by NHS England.

5.3 The Licensee will provide NHS England with the assurance relied on by its Board in relation to its progress in delivering these undertakings, upon request.

5.4 The Licensee will comply with any additional reporting or information requests made by NHS England.

The undertakings set out above are without prejudice to the requirement on the Licensee to ensure that it is compliant with all the conditions of its licence, including any additional licence condition imposed under the Act and those conditions relating to:

- compliance with the health care standards binding on the Licensee; and
- compliance with all requirements concerning quality of care.

Any failure to comply with the above undertakings will render the Licensee liable to further formal action by NHS England. This could include the imposition of discretionary requirements under section 105 of the Act in respect of the breach in respect of which the undertakings were given and/or revocation of the licence pursuant to section 89 of the Act.

Where NHS England is satisfied that the Licensee has given inaccurate, misleading or incomplete information in relation to the undertakings:

(i) NHS England may treat the Licensee as having failed to comply with the undertakings; and
(ii) if NHS England decides so to treat the Licensee, NHS England must by notice revoke any compliance certificate given to the Licensee in respect of compliance with the relevant undertakings.

LICENSEE

Signed (Chair or Chief Executive of Licensee)

Dated: 28 November 2025

NHS ENGLAND

Louise Shepherd

Signed (North West Regional Director and Chair of the Regional Support Group)

Dated: 28 November 2025

PUBLIC – Board of Directors
27th January 2026

Report	**Agenda Item 10a.**	**Board Assurance Framework – 2025/26 Q3 Update**						
Purpose of the Report	Decision	**X**	Ratification		Assurance		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 Q3 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 with the exception of BAF 8 which has been reduced from a 12 and is now within the risk appetite: • 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 (8) ⇩ • BAF9 - system working (12) • BAF10 - research and innovation (12) 7 of the 10 risks on the BAF remain above risk appetite level. Actions are progressing, but given the strategic nature of these risks it is recognised that it will take time to fully implement and embed the improvements needed, along with ensuring clear evidence of assurance that the risks are being mitigated. The report demonstrates the progress being made against key actions aligned to BAF risks and strategic objectives including: • 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 • Continued focus on consistency of application of quality standards and expectations • Continued focus on leadership development and culture • Risk management improvements continuing to progress with a current focus the roll out of training • Medium term integrated plan development including financial sustainability • Digital and Data Strategy refresh and delivery of digital priorities • Research strategy development and continued strengthening of research governance
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 Q3 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

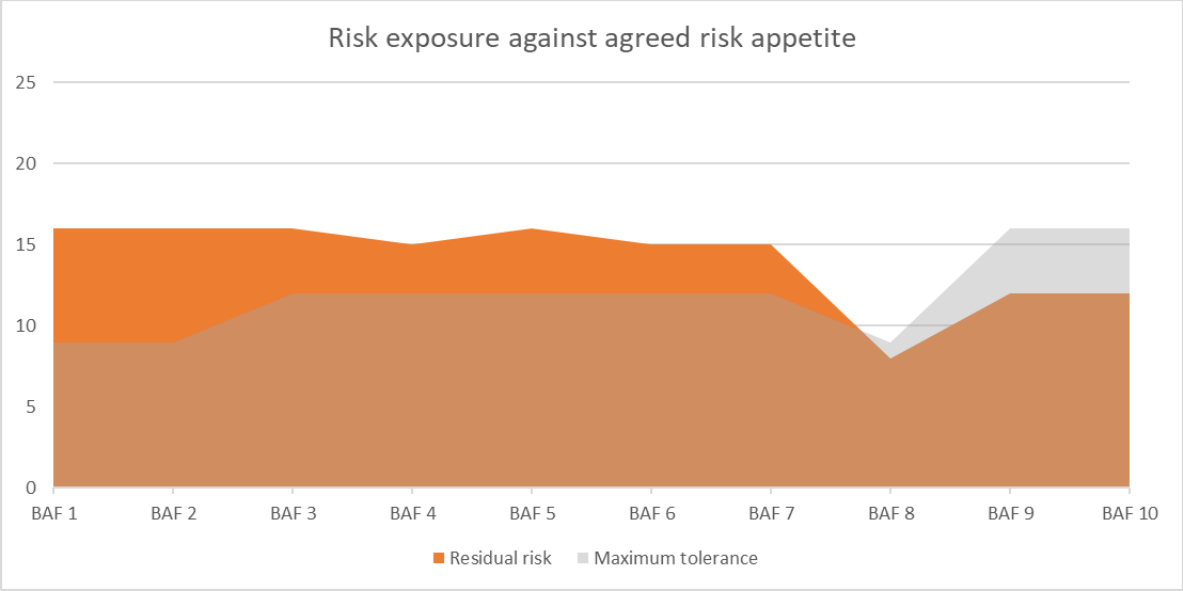
Alignment to strategic goals and objectives has been included within the BAF, with strategic objectives shaded within the key controls. The current risk exposure against the strategic goals is summarised below.

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 (including movement in residual risk scores since previous report)

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

- 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
- Continued focus on consistency of application of quality standards and expectations
- Continued focus on leadership development and culture

- Risk management improvements continuing to progress with a current focus the roll out of training
- Medium term integrated plan development including financial sustainability
- Digital and Data Strategy refresh and delivery of digital priorities
- Research strategy development and continued strengthening of research governance

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 Q3 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 • Patient and family engagement programme being developed
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 review and sign off • Clinical Strategy delivery and review of fragile services through CMPC • 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 (including medical staff) roll out • 5 year integrated plan development include narrative on workforce plans • Culture and leadership programme (design phase) • Training needs analysis
BAF5. Failure to deliver **financial plan** and underlying financial position could impact long term financial sustainability for the Trust and system partners	**16** ⟺	**12**	Partial	• Integrated medium term plan including financial sustainability • Grip and control • Delivery of CIP schemes and PDO support • Cash preservation and management
BAF6. Inability to achieve the **capital programme** within a challenging and uncertain operating environment and deliver an Estates Strategy	**15** ⟺	**12**	Partial	• Capital plan delivery 2025/26 • Capital planning for 2026/27 (3 year plan) • Continued RAAC failsafe and inspections continuing until final

Principal Risk	Current Risk Score	Target Risk Score	Assurance Level	Key Actions progressing
that supports the provision of our services				decant
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.	**15** ⟺	**12**	Partial	• Digital and data strategy publication • DSPT submission • Replacement of legacy network hardware • Cyber security protection plan delivery • National competency framework workstreams

(Note: movement in current risk score since the previous report has been included above. 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.

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. NHSE and Kings Fund culture and leadership programme, discovery phase complete and moved to design phase.
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. 5 year integrated plan being developed to include strategic narrative on workforce plans, and will need to be underpinned by Divisional workforce plans.
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 through CMPC.
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	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, with datix guidance published in December 2024 and training developed for roll out in Q4.

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. Integrated medium term plan including financial sustainability and 5 year deficit recovery plan to be submitted February 2026.
Advance digital solutions in support of transforming care	JB	Strategy has been reviewed by MIAA with a rating of substantial assurance. Strategy presented at December 2025 Finance & Performance Committee. DMA 2025 and EPR usability survey reports presented at December 2025 Finance & Performance Committee;
Develop and deliver the refreshed Green Plan.	JD	Completed.

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 January 2026.
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 CMPC and the development of a Provider Bluepint. 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 including Mental Health Services. TORs and joint working agreement approved by the Board in Sseptember 2025. Updates provided through the CEO report.
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. Place colleagues presented at the Board Development Day in December. New Cheshire West Health and Well Being strategy is in the final stages of development and will be presented at the Health and Well Being Board in April. Director of Strategy has been a core contributor.

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:** January 2026	**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***	***To be reviewed April 2026***
										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 - Cleaning standards compliance reports to Q&S Committee	CQC reports	*Partial*		Consistency of cleaning standards. IPC compliance assurance and improvements.	To continue to monitor consistency of cleaning standards and IPC compliance. **Action owner:** Director of Nursing and Quality **Due date:** Quarterly updates	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. UEC CQC action plan progress reviewed through comprehensive report to Quality and Safety Committee. UEC CQC report awaited. Full review of consolidated CQC action plan undertaken and proposal to be made to Board in January 2026 in respect of ongoing assurance.		
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:** January 2026	**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***	***To be reviewed April 2026***
									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. The impact of fast flow in ED on screening is being reviewed. NEWS trigger hard stop on EPR will commence in January 2026.		
			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 through CMPC.		
			C5) Mental Health service provision **Control Owner:** Director of Strategy and Partnerships	Exec to exec meetings with CWP.		*Acceptable*			Response to CQC Warning notice. Delivery of mental health 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 Mulit disciplinary Steering Group is 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. This group is working towards meeting the Core 24 mental health standards for urgent care. Governance of the steering group aligned with joint executive committee 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: Internal sources of assurance	Board Assurance: External sources of assurance	Board Assurance: Overall assurance level	Residual risk score (C x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score	Estimated date of achievement of target score
BAF3 Inability to deliver operational planning standards, inability to address the backlog of patients waiting could result in poorer patient outcomes, and result in financial consequences to the Trust. **Executive Risk Lead:** Chief Operating Officer **Assurance Committee:** Finance and Performance Committee **Last Update:** January 2026	**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 - Unable to accommodate all Non-RTT follow-up patient's within due date because of lack of capacity within some clinical services **Consequences:** - Increased patient waits for access to services impacting on patient safety, potential/ actual 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*			Gaps in validation (non RTT) and data quality issues remain. Long waits in Ophthalmology for Non-RTT patients who are overdue their follow up which can lead to patient harm.	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.		
									Long waits in Ophthalmology for Non-RTT patients who are overdue their follow-up which can lead to patient harm.	(i) Action plan to EDG on 14th January 2026. Weekly review of action plan to ensure progress. **Action Owner:** Chief Operating Officer **Due date:** Quarterly updates (ii) Harm review feedback to be shared at QGG/Quality Committee via Medical Director **Action Owner:** Medical Director **Due date:** Quarterly updates			

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:** January 2026	**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. 2026/27 plan submitted aligned to planning guidelines and expectations with a further submission planned for Feb 2026. Plan 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 commenced in November 2025.	***12***	***Review to consider reduction in March 2026***
									Workforce plan underpinned by service workforce reviews and plans.	Divisional 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. 5 year integrated plan being developed to include strategic narrative on workforce plans, and will need to be underpinned by Divisional workforce plans.		
			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.		
									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, discovery phase complete and moved to design 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 progressing.		
			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:** January 2026	**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. Integrated medium term plan including financial sustainability and 5 year deficit recovery plan to be submitted February 2026.	***12***	***March 2031 Risk Score to be reviewed November 2028 for progress and track record of delivery***
			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. Confirmation received that Q3/4 DSF withheld. Monthly distress cash applications are continuing and are being supported.		
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:** January 2026	**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. 2026/27 guidance moves to direct allocations to Providers, with a three year allocation expected.	***12***	***Risk score to be reviewed April 2026 following planning cycle***
			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 commenced 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. Action 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 deconstruction.		

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:** January 2026	**Cause:** - Failure to review and adopt innovative solutions to deliver value added digital transformation - impacting ability to support CoCH, ICB and NHSE / national 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. C3 - Data loss and regulatory sanctions if personal data is lost, financial consequences of losing access to systems and data. C4 - Reduced level of skills and or capacity 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 licence 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	(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:** Complete (ii) MIAA to conduct audit of Digital and Data Strategy. **Action Owner:** Chief Digital and Data Officer **Due date:** Complete (iii) Publication of Digital and Data Strategy. **Action Owner:** Chief Digital and Data Officer **Due date:** Q4 25/26	Strategy has been reviewed by MIAA with a rating of substantial assurance. Strategy presented at December 2025 Finance & Performance Committee. DMA 2025 and EPR usability survey reports presented at December 2025 Finance & Performance Committee;	*12*	***To be reviewed April 2026***
			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 MDE score	*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 2026	DSPT action plan is in progress - initial submission was completed in Dec 25		
										(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 review of data centres has been completed, report is currently being drafted. Expectation is significant assurance for main data centres, and moderate for data rooms. A programme of work is under way to replace legacy network hardware across the organisation following capital funding. Capital replacement programme is being finalised.		
										(iii) Deliver Cyber Security protection plan **Action Owner:** Chief Digital and Data Officer **Due date:** March 2026	Funding received to procure new proxy solution this financial year. Funding for replacement of Privileged Access Management solution has been approved for 26/27. 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 - procurement 26/27 - go live Q2 26/27 Business case for Chemotherapy Electronic Prescribing system by Mar 2026 CRV digitisation project in progress - programme starts Feb 26 AVT - 12 month pilot of regional AVT solution to start Q1 26/27 Patient flow solution review is taking place and will complete in Q4 25/26	eRS integration went live in Dec 2025, final services to be added in Jan 2026. Tools deployed for sepsis, emergency procedures, medical take deployed. Business case d for procurement of new Ophthalmology system was approved at Dec 25 Capital Management Group. 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:** Q4 25/26 - deadline updated due to reflect changes in ICB model and collabration opportunities.	Local Target Operating Model (TOM) is being developed following reduction in WTE inline with regional headcount reduction target. Discussions regarding regional collabration opportunities are in progress.		

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:** January 2026	**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 2 = 8***	**NO**	Assurance on the effectiveness of sub committee level and Divisional Governance. Delivery of the risk management improvement plan.	(i) To review and support effectiveness of Divisional governance organogram and embedding of the Accountability Framework. (ii) Embed risk management through delivery of risk management improvement plan. **Action Owner**: Director of Governance, Risk and Improvement **Due date**: Quarterly updates	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, with datix guidance published in December 2024 and training developed for roll out in Q4.	***9***	***Target Score Achieved (Jan 2026)***
			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 2026. NHSE undertakings align to delivery of established plans.		
			C3) Partnership Governance **Control Owner:** Director of Governance, Risk and Improvement	- CEO report	- CMPC updates throguh CEO report (joint working agreement and Leadership Board TOR approved)	*Acceptable*			Clarity of governance for emerging partnerships and collaborations.	To support collaborations and emerging partnerships with effective governance. **Action Owner:** Director of Governance, Risk and Improvement **Due date:** Quarterly updates	Support provided on discreet projects/ developments (e.g. Pathology South Hub). Engagement and contribution to collaboration governance through CMPC Director of Strategy and Company Secretary professional group.		
			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.	(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 now anticipated after Easter 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:** January 2026	**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 CMPC 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 reporting. **Action Owner**: Director of Strategy & Partnerships **Due date**: Quarterly updates	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. Health and Well Being Board are reviewing effectiveness and ways of working (Director of Strategy contributing).	***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.	Embed population health and health inequalities framework. **Action Owner:** Director of Strategy & Partnerships **Due date:** Quarterly updates	Board development session held in October - raising education and training awareness of health inequalities at a national, Core20plus5, regional (Marmot) and local level using CIPHA data. Roles and responsibilities of Board members discussed and self assessment undertaken. Place colleagues presented at the Board Development Day in December. New Cheshire West Health and Well Being strategy is in the final stages of development and will be presented at the Health and Well Being Board in April. Director of Strategy has been a core contributor.		
										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 approach to Health Inequalities has been developed and shared with local stakeholders who have endorsed the approach. Health inequality tools are deployed in community services through the CIPHA (data into action) when assessing likelihood of risk and admission to hospital		
			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*							
			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. Clinical 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 meeting 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: Cheshire & Merseyside).	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 CMPC and the development of a Provider Bluepint. 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 including Mental Health Services. TORs and joint working agreement approved by the Board in Ssseptember 2025. Updates provided through the CEO report.		

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:** January 2026	**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 - Alignment 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 bto be presented to the 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:** Quarterly update	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:** Quarterly update	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
27th January 2026

Report	**Agenda Item 10b.**	**High Risks Report**						
Purpose of the Report	Decision	**X**	Ratification		Assurance		Information	
Accountable Executive	Karan Wheatcroft			Director of Governance, Risk & Improvement				
Author(s)	Nusaiba Cleuvenot			Head of Corporate Governance				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **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 – 14th January 2026							
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 • On call model capacity
Recommendations	The Board of Directors is asked to consider and **agree** the current high risks in the context of 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	6
20	1
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
- On call model capacity

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 5th January 2026)

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 in place. An action plan has been developed to mitigate the risk and address the backlog with improvements to be embedded to ensure this does not reoccur.	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	Digital and Data Services	5x3	15	Data Security Protection Toolkit submission for 2026 is in progress, initial submission has been completed. MIAA are reviewing progress against action plan as part of annual review. Risk score remains at 15 whilst DSPT action plan is completed.	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
		have been raised for these areas and this risk is to hold the overarching risk of a Cyber attack.				Work continues to reduce our device exposure score (MDE), with current score 31 against a target of below 30. Windows 11 has now 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. National funding has been awarded for the purchase of a new internet proxy device. This will help to reduce the risk of malicious data exfiltration.			
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

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Lead Committee
06/04/2020	2385	Use of Siporex RAAC Planks in W&C's Building Roof	Corporate	3x5	15	Risk and mitigations being managed through Women & Children's Project Board. National RAAC board sign-off of current risk rating (reduced from 20).	May 2026	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 Q4 25/26.	March 2026	Karen Edge	Finance & Performance Committee
09/02/2023	2964	High numbers of Non-criteria to reside (NCTR) patients across both Trust sites	Therapies and ICC	4x4	16	Agreed to increase to a red risk of 16 at OMB due to affect of the high percentage of (NCTR) patients across the 3 adult bed owning divisions. Failing to reduce NCTR percentage of the acute bed base to 15% creates subsequent risk in patient flow resulting in delayed ambulance handover and increased number of patients being held in ED who should be transferred to ward areas. The number of NCTR patients also requires the Trust to maintain a high level of escalation capacity at additional cost.	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
						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 2025.			
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. Secondment of band 9 into Director of Delivery role and standing up of PDO function to lead delivery and accelerate implementation of CIP.	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
						Risk remains due to planned care funding being prioritised between resolving risk and 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 reliant on reduction in NC2R position.	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
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 the new Network	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 being reviewed with	March 2026	Jason Bradley	Finance & Performance Committee

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Lead Committee
		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.				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. Interim resource recruitment being finalised and then work will be scheduled. Division have reviewed risk an confirm it is still at 16.			
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
29/10/2025	3541	General Surgery on-call model lacks capacity and senior oversight for timely patient reviews	Planned Care	4x5	20	Divisional triumvirates have discussed this risk and will be reviewed in further detail at the next Risk Management Committee. Divisional Director attended EDG on 10th December and agreement to temporarily increase staff is under review.	January 2026	Cathy Chadwick	Finance & Performance

Committee Chair's Report

8th January 2026 at 9.30am in the Women & Children's Building Seminar Room

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

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

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

- Continued challenge in evidencing Sepsis compliance in line with NICE guidelines. The Committee received assurance on recognition in respect of NEWS scoring and training compliance. Further work needed on evidencing timeliness of clinical assessment and treatment. Impact of rapid assessment triage processes is being reviewed to ensure risk assessment compliance deterioration is addressed. Cerner NEWS Trigger hard stop to be implemented in January 2026. New NICE guidelines released November 2025 which are being assessed.

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

- Received an overview of the processes in place for safer mobility and falls prevention, including Datix reporting and learning; reduction in number of falls and harms from falls; and an improvement in falls assessment compliance.
- Good progress being made against the Internal Audit Action log with a number of adult review management actions now fully complete and closed including Data Quality Review – Emergency Department (ED) and Strategic Oversight Framework (SOF) Data Quality - Complex Patient Discharge.
- Urgent and Emergency Care Quality Committee (CQC) update with details of action delivery and outcomes. Key risk areas remain patient safety checklist compliance at all time points; and 4 hour A&E performance. Amber areas include metal health triage, Sepsis management, Infection Prevent & Control (IPC), Braden and MUST (Malnutrition Universal Screening Tool assessment) compliance, paediatric nursing in ED. Discussion included the need for continued assurance reporting.
- Integrated Performance Report (IPR) quality and safety metrics reviewed.
- Quality Governance Group (QGG) Chairs report providing assurance on a range of areas. Alerts on VTE, stroke, and mobility and falls with actions being taken and monitored.
- Striving for excellence amid year report with Zero platinum ratings, Nine gold ratings, Twenty-one silver ratings, One bronze rating and Zero white ratings. The report demonstrated that the ward accreditation processes have been strengthened and are now embedded and are driving improvements in standards.
- Cleaning standards monitoring report for August 2025 to November 2025 demonstrating high compliance in both Planned Care and Urgent Care. A small number of exceptions noted and when these occur the exceptions are managed through remedial cleaning, staff feedback and repeat monitoring, with escalation where improvement is not evidenced. It was recognised that vacancies and sickness absence has a significant impact.

- Maternity Incentive Scheme Year 7 compliance and assurance report providing assurance on all 10 safety actions, notwithstanding that there is an exception report for new resident doctor training compliance with the training now either complete or booked. Committee confirmed recommendation for Chief Executive Officer (CEO) to sign the report submission.
- Received a summary of the maternity survey results, feedback and areas for improvement. Action plan being developed further with Maternity and Neonatal Voices Partnership.
- Quality Impact Assessment (QIA) update providing assurance on the QIA process for the cost improvement programme.
- Medical devices gap analysis and action plan update. Gaps in process, assurance, compliance and risk were set out. Progress is being made to processes, procedures, training and awareness, with multidisciplinary work required to continue to take this forward. Agreed to continue to bring a quarterly update to the Committee.
- Resuscitation annual report received providing assurance on training, trolley checklist compliance, DNACPR. Report demonstrated improved training compliance with the team now keen to move this forward to increased numbers of staff receiving enhanced education.
- E'Discharge 24 hour compliance is improving but challenges remain in general surgery (this includes patients in SDEC). Further system development is underway to support sustained improvements going forward.
- Mortality report providing assurance on HSMI and SHMI levels. Committee requested more details on learning into action, recognising the Committee has a different role to Board.

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

- Not applicable.

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.

PUBLIC – Board of Directors
27th January 2026

Report	**Agenda Item 12.**	**Care Quality Commission (CQC) Improvement Plan including Well Led**						
Purpose of the Report	Decision	**X**	Ratification		Assurance		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 25th November 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. The Trust has continued to monitor progress against the action plans including a separate urgent and emergency care action plan assurance report to the Quality and Safety Committee. Significant progress has been demonstrated over this time against a wide range of actions. 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, we have undertaken a review of 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.							

This report sets out the proposal to step down a separate consolidated action plan on the basis that the outcomes of the remaining actions are included in our assurance reporting through the relevant governance structures, with escalations and assurance provided through the Board assurance committees including the AAA reports.

In summary the key actions continuing to progress include:

Actions	Lead Committee
The combined **UEC and patient flow** action plan is in place with delivery against 4 hour and 12 hour targets reported to the Board through the IPR.	Finance and Performance Committee
Out of date policy recovery programme continues to be tracked and reported.	Audit Committee
Staff survey and action plans continue to be monitored and will be further developed following the results of the annual survey.	People Committee
UEC CQC action plan continues to be reported in full. This includes sepsis management; e'discharge; medical devices; mental health services; UEC medical staffing.	Quality and Safety Committee
5 year financial plan development is now part of the 2025/26 planning framework.	Finance and Performance Committee
Risk Management improvement plan delivery continues to be monitored and reported.	Audit Committee
Mandatory training compliance.	People Committee

The following areas from the CQC action plan are included directly on the BAF with quarterly updates provided to the Board:

- Organisation learning policy (BAF 8)
- Health inequalities framework (BAF 9)

Following the review as set out within this paper, the proposal is to step down the separate consolidated CQC action plan reporting.

Recommendations

The Board of Directors is asked to consider and **Approve** the proposal to step down the consolidated CQC action plan and continue to monitor delivery through the relevant assurance committees.

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.

Care Quality Commission (CQC) Improvement Plan including Well Led

1. Introduction

The Trust has continued to monitor progress against the action plans including a separate urgent and emergency care action plan assurance report to the Quality and Safety Committee. Significant progress has been demonstrated over this time against a wide range of actions.

In November it was agreed that a review of the action plan would take place and a proposal brough to the Board of Directors on the future monitoring and reporting of remaining actions.

2. Purpose

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.

In addition, the report sets out the proposal to step down a separate consolidated action plan on the basis that the outcomes of the remaining actions are included in our assurance reporting through the relevant governance structures, with escalations and assurance provided through the Board assurance committees including the AAA reports.

3. CQC actions and assurance reporting

Progress against the extensive CQC action plans have continued to be tracked through the Board. During this time a significant range of actions have been delivered.

The remaining actions from the consolidated CQC action plan are set out in the table below along with the Lead assurance committee.

Requirement	Actions	Lead Committee
UEC OPERATIONAL PERFORMANCE Effective systems to ensure service users receive care without delay when compared to national and regional performance.	The combined UEC and patient flow action plan is in place with delivery against 4 hour and 12 hour targets reported to the Board through the IPR.	Finance and Performance Committee
POLICIES The Trust must ensure that policies and procedures are reviewed and follow national guidance.	Out of date policy recovery programme continues to be tracked and reported.	Audit Committee
UEC CQC ACTION PLAN Deliver the actions from the February 2025 assessment.	UEC CQC action plan continues to be reported in full. This includes sepsis management; e'discharge; medical devices; mental health services; UEC medical staffing.	Quality and Safety Committee
STROKE SERVICES	The service has been recurrently funded until midnight.	Quality and Safety Committee

Requirement	Actions	Lead Committee
The trust must ensure the risks presented by gaps in the out of hours stroke service are effectively assessed and mitigated.		
FINANCIAL STRATEGY Develop a five year financial strategy	5 year financial plan development forms part of the 2025/26 planning framework.	Finance and Performance Committee
RISK MANAGEMENT The trust must ensure risks in services are appropriately recorded, assessed, escalated to the trust's board where required, and regularly reviewed.	Risk Management improvement plan delivery continues to be monitored and reported.	Audit Committee
MANDATORY TRAINING Provide a trajectory plan trust wide (supported by divisions) for all areas to achieve trust targets for all of mandatory training. To be monitored through Operational Management Board. Mandatory training performance to achieve target.	Mandatory training compliance.	People Committee
TRANSCRIPTION The trust must assess and manage the risks relating to the electronic patient record system and transcription services. The trust must improve the quality of the services provided and ensure this did not impact on delays to patients care and treatment.	Voice Recognition/ Ambient Voice Technology. Typing KPIs monitored via Operations and Performance Executive Led Group.	Finance and Performance Committee
IMPROVEMENT STRATEGY The Trust must implement quality improvement systems and processes such as regular audits of the services provided and must assess, monitor and improve the quality and safety of services. The Trust needs to develop an improvement strategy.	Improvement team priorities being aligned with Director of Delivery through Program Delivery Office.	Finance and Performance Committee
TRANSLATION The trust should ensure that health promotion and information is available in all departments is available in languages other than English, in child friendly versions, and in alternative formats.	Translation and Interpretation reviewed, renewed and ratified. Awaiting update re regional review of service providers.	Quality and Safety Committee

Requirement	Actions	Lead Committee
CLEANING STANDARDS The trust must ensure the premises and environment are clean and maintained to prevent the spread of infection. This includes but is not limited to repairs to flooring, walls and door frames, plumbing / drainage, and food storage within patient's fridges.	Improvements demonstrated and assurance reporting on cleaning standards compliance and through PLACE reports in place.	Quality and Safety Committee
HEALTH AND SAFETY The trust must ensure that a robust system is in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and ensuring premises are safe and for their intended purpose.	Improvements demonstrated and assurance reporting on health and safety in place.	Finance and Performance Committee
CLINICAL REVIEW AND VALIDATION The trust must ensure patients waiting to receive treatment after a referral are clinically reviewed and validated.	Cancer harms reviews, A&E attendance waiting list harms, datix and audit reports.	Quality and Safety Committee
	Size of waiting lists and validation reports.	Finance and Performance Committee

4. Conclusion

The Trust has continued to progress delivery against the consolidated CQC action plans. Whilst further action is needed in some areas, these are now embedded within the assurance reporting to Committees. There is a risk of lack of oversight of the remaining actions but this is mitigated through the agreed assurance routes established and operating as set out above.

5. Recommendations

The Board of Directors is asked to consider and **Approve** the proposal to step down the consolidated CQC action plan and continue to monitor delivery through the relevant assurance committees.

PUBLIC – Board of Directors
27th January 2026

Report	**Agenda Item 13.**	**Maternity Incentive Scheme Year 7 Compliance and Assurance Report**						
Purpose of the Report	Decision	**X**	Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton			Director of Nursing and Quality / Deputy Chief Executive				
Author(s)	Natasha Macdonald Sara Brigham 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** **X** **X**	BAF 1 – Failure to maintain quality of care would result in poorer patient & family experience. BAF2 - Failure to maintain safety and prevent harm would result in poorer patient care and outcomes. BAF 3 – Inability to deliver operational planning standards, inability to address the backlog of patients waiting could result in poorer patient outcomes, and result in financial consequences to the Trust. BAF 5 Finance: Achievement of MIS standards supports the Trust's financial position through recovery of the MIS incentive.			
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 & Safety Committee – 8th January 2025							
Executive summary	The Trust has achieved full compliance with all 10 Safety Actions required for the Maternity (and Perinatal) Incentive Scheme (MIS) Year 7. Evidence has been reviewed and validated through internal governance processes, Local Maternity and Neonatal System (LMNS) oversight, and scrutiny by the Maternity and Neonatal Safety Champions during November and December 2025. The Board is required to confirm assurance prior to submitting the statutory declaration to NHS Resolution by 12 noon on 3 March 2026. Approval is therefore sought for the Chief Executive Officer to							

	sign the MIS Year 7 Board Declaration Form, enabling recovery of the associated financial incentive. The Quality and Safety Committee has reviewed this paper and is recommending approval to the Board of Directors.
Recommendations	The Board of Directors is asked to receive, discuss and approve this report, and specifically to: 1. Approve the final compliance position for MIS Year 7. 2. Authorise the Chief Executive Officer to sign the MIS Year 7 Board Declaration Form for submission to NHS Resolution.

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

Maternity Incentive Scheme Year 7 Compliance and Assurance Report

1. Introduction

This paper seeks Trust Board approval for the Chief Executive Officer to sign the Board Declaration Form confirming the Trust's compliance with the Maternity (and Perinatal) Incentive Scheme (MIS) Year 7 requirements, as mandated by NHS Resolution. The Board is asked to take assurance from the comprehensive evidence reviews undertaken through formal MIS oversight meetings and from the independent scrutiny provided by the Local Maternity and Neonatal System (LMNS), which has validated the submitted evidence.

Compliance with all 10 Safety Actions comprising approximately 90 standards remains a national requirement and enables the Trust to recover the 10% rebate and potentially receive a share of unallocated funds. Many of the standards require external verification through national reporting systems, including PMRT, MBRRACE-UK, the Maternity Services Dataset, Saving Babies' Lives Care Bundle Version 3, and NHS Resolution submissions.

In accordance with national guidance, Trusts must declare YES/NO/N/A for each sub-requirement. Boards must be fully assured of their compliance position before the Board Declaration Form is submitted to NHS Resolution by 12 noon on 3 March 2026. The declaration itself does not permit narrative or supporting documentation; therefore, all assurance must be gained from the evidence presented to the Board. NHS Resolution may request supporting evidence by exception.

2. Background

The NHS Resolution Maternity Incentive Scheme (MIS) aims to strengthen the safety and quality of maternity and neonatal care by requiring Trusts to demonstrate compliance with a defined set of safety standards. Year 7 continues to embed the improvements achieved in previous years and supports national ambitions to reduce stillbirths, neonatal deaths, maternal deaths and brain injuries.

Participating Trusts must evidence compliance with 10 Safety Actions, comprising approximately 90 standards across clinical governance, workforce, data quality, safety culture, learning and surveillance.

To support the assurance process, an extraordinary evidence review meeting was held on 9 December, during which senior leaders including the Director of Nursing, Sue Pemberton, and the Maternity Safety Champion and Non-Executive Director, Sarah Corcran reviewed and scrutinised the evidence for each Safety Action. This meeting supplemented the routine oversight provided through internal governance structures and the Local Maternity and Neonatal System (LMNS).

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info	Check Response	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	7	0	0	0	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	2	0	0	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	5	0	0	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	11	0	1	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	5	0	1	0	0
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes	5	0	0	0	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	6	0	0	0	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes	20	0	1	0	0
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes	9	0	0	0	0
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Yes	8	0	0	0	0

3. Current Compliance Position

The Trust has achieved compliance with all 10 Safety Actions required for MIS Year 7, evidencing adherence to approximately 90 national standards. Assurance has been obtained through established internal governance processes, LMNS review, and the extraordinary assurance meeting held on 9 December 2025.

All Safety Actions are fully met with the exception of Safety Action 8, for which a permissible exception is required in line with MIS Year 7 technical guidance. This relates specifically to rotational resident obstetric and anaesthetic doctors, whose training compliance is measured within six months of commencing employment with the Trust.

National guidance permits a lower compliance rate for rotational medical staff who commenced on or after 1 July 2025, provided that the Trust Board formally approves the exception and associated recovery plan and records this within the Board minutes. A clear trajectory to achieve ≥90% compliance within six months of each individual's start date must be demonstrated.

The full exception report was received and reviewed at the Quality and Safety Committee on 8 January 2026

Data for the reporting period 1 December 2024 – 30 November 2025 shows:

Fetal Monitoring Training

- Consultant Obstetricians: 100%
- Midwives: 99%

Resident Obstetric Doctors: 75% (three outstanding at the reporting point). All commenced after 1 July 2025 and completed training in December 2025, meeting the criteria for an allowable exception in line with MIS Year 7 technical guidance (Perinatal Exception Report).

PROMPT (Maternity Emergencies)

- All staff groups are compliant except anaesthetic resident doctors, who are currently at 83%, with four outstanding. All remain within the six-month compliance window and are scheduled to complete training by February 2026 (Perinatal Exception Report).

Outstanding Resident Doctors training
PROMPT
The 6-month grace period ends 1st February 2026 for the remaining resident doctors meaning they need to attend before 1st February 2026 (9th January is the next session)

Subject to Trust Board approval of the exception and recovery plan, as set out in MIS Year 7 technical guidance, the Trust is able to declare full compliance with MIS Year 7.

4. Recommendation

The Board of Directors is asked to receive, discuss and approve this report, and specifically to:

1. Approve the final compliance position for MIS Year 7.
2. Authorise the Chief Executive Officer to sign the MIS Year 7 Board Declaration Form for submission to NHS Resolution.

Appendix 1 – Detailed Submission

Safety action No. 1

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

From 1 December 2024 to 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 1 December 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose N/A)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 1 December 2024, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 1 December 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 75% of all reports completed and published within 6 months of death? MIS verification period: Dec 2024 to April 2025 60% of cases. 2 April 2025 to 30 Nov 2025 75% of cases	Yes
5	For a minimum of 50% of the deaths reviewed, was an external member present at the multi-disciplinary review panel meeting and was this documented within the PMRT? MIS verification period: 2 April 2025 - 30 Nov 2025	Yes
6	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 1 December 2024 including reviews and consequent action plans.	Yes
7	Were quarterly reports discussed with the Trust Maternity Safety and Board level Safety Champions?	Yes

Safety action No. 2

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

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No)
1	Did July 2025's data contain valid birthweight information for at least 80% of babies born in the month? This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405)	Yes
2	Did July 2025's data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes

Safety action No. 3

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

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are pathway(s) of care into transitional care in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice?	Yes
2	**Or** Can you evidence progress towards a transitional care pathway from 34+0 in alignment with the BAPM Transitional Care Framework for Practice, and has this been submitted this to your Trust Board and the Neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards?	N/A
Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation.		
For units commencing a new QI project		
3	By 2 September 2025, register the QI project with local Trust quality/service improvement team.	N/A
4	By 30 November 2025, present an update to the LMNS and Safety Champions regarding development and any progress.	N/A
Or **For units continuing a QI project from the previous year**		
5	Demonstrate progress from the previous year within the first 6 months of the MIS reporting period, and present an update to the LMNS and Safety Champions.	Yes
6	By 30 November 2025, present a further update to the LMNS and Safety Champions regarding development and any progress at the end of the MIS reporting period	Yes

Safety action No. 4

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

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing all short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 and before submission to Trust Board (select N/A if no short-term locum doctors were employed in this period): Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust ensured that the RCOG guidance on engagement of long-term locums has been implemented in full for employing long-term locum doctors in Obstetrics and Gynaecology, demonstrated through audit of any 6-month period from February 2025 to 30 November 2025 (select N/A if no long-term locum doctors were employed in this period)	Yes
3	**For information only:** RCOG compensatory rest (not reportable in MIS year 7) Have you met, or are working towards full implementation of the RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.	Yes
4	Is the Trust compliant with the Consultant attendance in person to the clinical situations guidance, listed in the RCOG workforce document: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. Trusts should demonstrate a minimum of 80% compliance through audit of any 3-month period from February 2025 to 30 November 2025.	Yes
5	Do you have evidence that the Trust position with the above has been shared with Trust Board?	Yes
6	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champ	Yes
7	Do you have evidence that the Trust position with the above has been shared with the LMNS?	Yes

b) Anaesthetic medical workforce		
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) Representative month rota acceptable for evidence.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	Yes
10	Is this formally recorded in Trust Board minutes?	Yes
11	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	N/A
12	Was the above action plan shared with the LMNS?	N/A
13	Was the above action plan shared with the Neonatal ODN?	N/A
d) Neonatal nursing workforce		
14	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of	Yes
15	Is this formally recorded in Trust Board minutes?	Yes
16	If the requirements are not met, has Trust Board agreed an action plan with updates on progress against any previously developed action plans? This should be monitored via a risk register.	
17	Was the above action plan shared with the LMNS?	N/A
18	Was the above action plan shared with the Neonatal ODN?	N/A

Safety action No. 5

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

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? (If this process has not been completed within three years due to measures outside the Trust's control, you can declare compliance but evidence of communication with the BirthRate+ organisation (or equivalent) MUST demonstrate	Yes
2	Has a midwifery staffing oversight report that covers staffing/safety issues been submitted to the Board every 6 months (in line with NICE midwifery staffing guidance) on an ongoing basis. This must include at least one report in the MIS period 2 April - 30 November. Every report must include an update on all of the points below: • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. • The midwife to birth ratio • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift. • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour • Is a plan is in place for mitigation/escalation to cover any shortfalls in the points above?	Yes
3	**For Information Only:** We recommend that Trusts continue to monitor and include NICE safe midwifery staffing red flags in this report, however this is not currently mandated, This includes: •Redeployment of staff to other services/sites/wards based on acuity. •Delayed or cancelled time critical activity. •Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). •Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). •Delay of more than 30 minutes in providing pain relief. •Delay of 30 minutes or more between presentation and triage. •Full clinical examination not carried out when presenting in labour. •Delay of two hours or more between admission for induction and beginning of process. •Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). •Any occasion when one Midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally.	Yes
4	Can the Trust Board evidence that the midwifery staffing budget reflects establishment as calculated? Evidence should include: • Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes

5	Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.	N/A
6	Where deficits in staffing levels have been identified must be shared with the local commissioners.	N/A
7	Evidence from an acuity tool (may be locally developed) that the Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
8	**For Information Only:** A workforce action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the workforce action plan will NOT enable the trust to declare compliance with this sub-requirement.**	
9	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Yes
10	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Development of the improvement plan will enable the Trust to declare compliance with this sub-requirement. This improvement plan does not need to be submitted to NHS Resolution**	N/A

Safety action No. 6

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

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3.2 is fully in place, and can you evidence that the Trust Board have oversight of this assessment?	Yes
2	Where full implementation is not in place, has the ICB been assured that all best endeavours and sufficient progress has been made towards full implementation, in line with the locally agreed improvement trajectory?	N/A
3	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 6, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 7 to track compliance with the care bundle? These meetings must include: • Initial agreement of a local improvement trajectory against these metrics for 25/26, and subsequently reviews of progress against the agreed trajectory. • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.	Yes
4	Following these meetings, has the LMNS determined that sufficient progress has been made towards implementing SBLCBv3, in line with the locally agreed improvement trajectory?	Yes
5	If the available Implementation Tool is not being utilised to show evidence of SBL compliance, has a signed declaration from the Executive Medical Director been provided declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB	N/A

Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not
1	Do you have evidence of an action plan co-produced following joint review of the annual CQC Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge	Yes
2	• Has progress on the co-produced action above been shared with Safety Champions?	Yes
3	• Has progress on the co-produced action above been shared with the LMNS?	Yes
4	**Do you have evidence of MNVP infrastructure being in place from your LMNS/ICB, in full as per national guidance, and including all of the following:** • Job description for MNVP lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost	Yes
5	**If MNVP infrastructure is not in place and evidence of an MNVP, commissioned and functioning in full as per national guidance, is unobtainable (and you have answered N to Q4):** Has this has been escalated via the Perinatal Quality Oversight Model (PQOM) at trust, ICB and regional level? In this event, as long as this escalation has taken place the Trust will not be required to provide any	N/A
6	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Terms of Reference for Trust safety and governance meetings, showing the MNVP lead as a quorate member of trust governance, quality, and safety meetings at speciality/divisional/directorate level including all of the following: •Safety champion meetings •Maternity business and governance •Neonatal business and governance •PMRT review meeting •Patient safety meeting •Guideline committee	Yes
7	**If MNVP infrastructure is in place as per national guidance (and you have answered Y to Q4):** Evidence of MNVP engagement with local community groups and charities prioritising hearing from those	Yes

NHS
Countess of Chester Hospital
NHS Foundation Trust

Safety action No. 8

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

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2025? Rotational medical staff in posts shorter than 12 months can provide evidence of applicable training from a previous trust within the 12 month period using a training certificate or correspondence from the previous maternity unit.		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2025) contributing to the obstetric rota? (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank midwives employed by Trust and maternity theatre midwives who also work outside of theatres)?	Yes
	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants?	Yes
6	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows,foundation year doctors and GP trainees contributing to the obstetric rota?	Yes
7	For rotational obstetric staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust?	Yes
9	90% of maternity support workers and health care assistants? (to be included in the maternity skill drills as a minimum).	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors?	Yes
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2025) including any anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This requirement is supported by the RCoA and OAA?	Yes
12	For rotational anaesthetic staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
13	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in any clinical area or at point of care during the whole MIS reporting period? This should not be a simulation suite.	Yes
	Neonatal resuscitation training	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2025) who attend any births?	Yes
16	For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	Yes
17	90% of neonatal nurses? (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)?	Yes
19	**For Information Only:** 90% of maternity support workers, health care assistants and nursery nurses? (dependant on their roles within the service - for local policy to determine)	Yes
20	90% of midwives? (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres), maternity theatre midwives and bank midwives employed by Trust)	Yes
21	In addition to the above neonatal resuscitation training requirements, a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations unsupervised must have a valid Resuscitation Council (RCUK) Neonatal Life Support (NLS) certification or local assessment equivalent in line with BAPM basic capability guidance? Staff that attend births with supervision at all times will not need to complete this assessment process for the purpose of MIS compliance.	Yes

Safety action No. 9

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

From 2 April 2025 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded with evidence of working towards the Perinatal Quality Oversight Model (PQOM)?	Yes
2	Has a non-executive director (NED) been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM/PQOM at least quarterly, and presented by a member of the perinatal leadership team to provide supporting context?	Yes
4	Does the regular review include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent?	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system LMNS/ODN/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM/PQOM?	Yes
6	Ongoing engagement sessions should be being held with staff as per previous years of the scheme. Is progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025?	Yes
7	Is the Trust's claims scorecard reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period 2 April - 30 November)?	Yes
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period 2 April - 30 November) and that any support required of the Trust Board has been identified and is being implemented? **Where the infrastructure is in place, this should also include the MNVP lead as per SA7.**	Yes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented?	Yes

Safety action No. 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?

From 1 December 2024 until 30 November 2025

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported of all qualifying cases to MNSI from 1 December 2024 until 30 November 2025?	Yes
2	Have you reported all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 until 30 November 2025?	N/A
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them?	Yes
4	For any occasions where it has not been possible to provide a format that is accesible for eligible families, has a SMART plan been developed to address this for the future?	N/A
5	Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes
6	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution?	Yes
7	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible with the SMART plan to address this?	Yes
8	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
9	When reporting EN cases, have you completed the field showing whether families have been informed of NHS Resolution's involvement? Completion of this will also be monitored, and externally validated.	N/A

Maternity Incentive Scheme - Year 7 Board declaration form

Trust name	**Countess of Chester Hospital NHS Foundation Trust**
Trust code	**T422**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	-		
Total sum requested			-	

Sign-off process confrming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.
* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2025/26) or the previous financial year (2024/25)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports must be brought to the MIS team's attention.
* If declaring non-compliance, the Board and ICS agree that any discretionary funding will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which will be escalated to the appropriate arm's length body/NHS System leader.

Appendix 2: 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.

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
27th January 2026

Report	**Agenda Item 14.**	**Maternity Survey Results 2025**						
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Sue Pemberton			Director of Nursing and Quality / Deputy Chief Executive				
Author(s)	Natasha Macdonald			Director of Midwifery				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X**	Supports triangulation against quality and safety BAF risks.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Quality & Safety Committee – 8th January 2026							
Executive summary	A total of 97 service users (38% response rate) participated in the 2025 CQC National Maternity Survey. The Countess of Chester's results are broadly in line with national peers, with most indicators rated "about the same." Key strengths include: • Labour and Birth: Strong performance in compassionate care, multidisciplinary teamwork, and partner involvement, with five questions scoring significantly above the national average. • Key improvement priorities include: • Antenatal Care: Lower scores for choice and personalized information, mental health support, and staff awareness of medical history. • Postnatal Ward Care: Challenges with partner presence, discharge processes, and access to staff and information.							

	These themes align with FFT feedback and internal quality intelligence. Actions are underway through the Maternity Quality Improvement Plan, with oversight via established governance structures. The new Women & Children's Building is already enhancing privacy, dignity, and family experience. A co-produced action plan with the Maternity and Neonatal Voices Partnership (MNVP) will further support delivery of improvements.
Recommendation	The Board of Directors is asked to: • Note the survey results and thematic learning • Note the identified areas for improvement and associated action plan • A co-produced action plan will be created with the MNVP

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

Maternity Survey Results (2025)

1. Introduction

The NHS Maternity Survey forms part of the national Patient Survey Programme and captures feedback from women and birthing people who accessed maternity services between January and February 2025. A total of 255 service users were invited, with 97 responses received, representing a 38% response rate.

The survey reports on experiences across the full maternity pathway, including antenatal care, labour and birth, postnatal ward care, postnatal care at home, triage, and complaints.

This paper provides an overview of the Trust's 2025 survey results, including national benchmarking, key themes, and the actions underway to address identified areas for improvement and strengthen patient experience.

2. Purpose

To provide the Quality Governance Group with:

- A summary of the Countess of Chester's performance in the 2025 Maternity Survey
- Comparison against national performance
- Key improvement themes and actions
- Oversight and governance arrangements

3. National Context

National findings from the 2025 NHS Maternity Survey indicate:

Variable antenatal experience across England, particularly relating to information provision and mental-health support

Stronger national performance in Labour & Birth, especially teamworking, communication and partner involvement

Ongoing challenges with postnatal ward pressures, including staffing availability, discharge delays, noise, and limitations of partner presence

These national themes align closely with the Trust's local findings and with wider national maternity safety and quality improvement programmes.

4. Countess of Chester – 2025 Results Summary

<u>Overall benchmarking position</u>

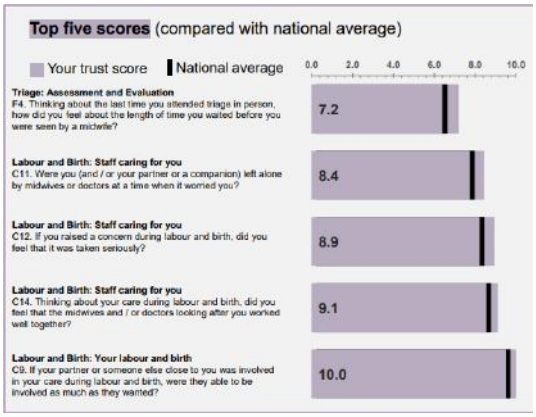
- Much better than expected: 1 question
- Better than expected: 2 questions
- Somewhat better: 0 questions
- About the same: 44 questions
- Somewhat worse: 5 questions
- Worse: 5 questions
- Much worse**:** 0 questions

Year-on-year change (2024–25)

- Significantly better: 2
- No change: 47
- Significantly worse**:** 4

Overall, the results demonstrate a largely stable position year-on-year, with limited areas of deterioration and some improvement.

Detailed Findings



Areas of Strong Performance

Labour & Birth – Staff caring for you

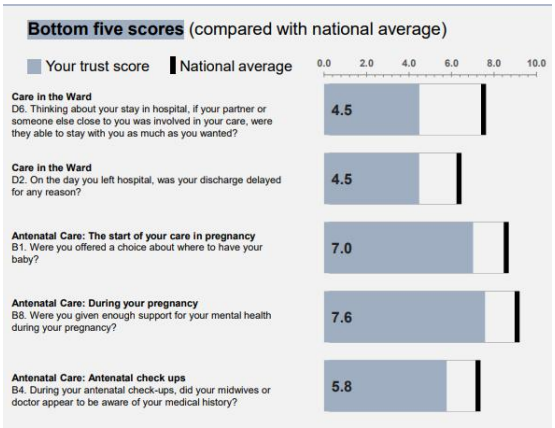
Rated above national average for:

- Feeling concerns were taken seriously (C12)
- Midwives/doctors working well together (C14)
- Not left alone at a worrying time (C11)
- Partner involvement (C9 – scored **10.0**, highest possible)
- Perception of pain management support (C8)

Communication & Respect

Antenatal and intrapartum communication scored strongly, with high confidence and trust in staff and consistent ratings for dignity and compassion.

Areas Requiring Improvement



1. Antenatal Care

Lowest performing indicators included:

- Choice of place of birth (B1) – Trust score 5.8 vs national 7.1
- Mental-health support (B8) – Trust score 7.6 vs 9.0
- Staff awareness of medical history (B4) – Trust score 5.8 vs 7

Themes reflect fragmentation of early pregnancy pathways, capacity challenges and variation in personalised care planning.

2. Postnatal Ward Care

This section showed the lowest overall section score (6.4 – worse than expected).

Key concerns:

- Partner ability to stay (D6) – one of the Trust's lowest scoring questions
- Discharge delays (D2) – worse than expected
- Access to staff and information needs improvement in parts

Actions Underway / Forward Look

The identified improvement themes are embedded within the Maternity Quality Improvement Plan and are being actively addressed through targeted workstreams.

Further assurance is provided through the move to the new Women and Children's Building, which has mitigated previously identified environmental constraints. All inpatients are now cared for in single en-suite rooms with pull-down parental beds, significantly enhancing privacy, dignity, partner presence and the overall family experience.

5. Conclusion

Overall, the Trust's maternity survey results place us in the mid-range nationally, with the majority of indicators performing in line with peer organisations, alongside areas of strong performance and a small number of clearly defined improvement priorities. The CQC does not publish an overall numerical ranking for the Maternity Survey; instead, performance is assessed using the "expected range" methodology, which determines whether results are statistically better than, worse than, or about the same as other NHS trusts.

The survey provides assurance of high-quality Labour and Birth care, while highlighting the need for focused improvement in Antenatal Care and Postnatal Ward experience, particularly in relation to choice, information provision, mental-health support and discharge processes.

Theme 1 – Antenatal Care

Theme	Actions	Monitoring
Choice & personalised information	Standardise booking information; implement digital personalised care plans; strengthen shared decision-making across pathways	Perinatal Assurance and Improvement Board (PAIB)
Mental-health support	Implement universal mental-health screening; improve referral pathways to PMH team	PAIB

Staff awareness of medical history	Optimise EPB/EMR prompts refresh antenatal documentation	PAIB

Theme 2 – Triage & Early Labour

Theme	Action	Monitoring
Timely assessment	Combined Maternity assessment areas	PAIB

Theme 3 – Postnatal Ward Care

Theme	Actions	Monitoring
Partner presence	New Build partner staying	Friends and Family. PAIB
Continuous listening	MNVP listening events staff feedback	PAIB

6. Recommendation

The Board of Directors is asked to:

- Note the survey results and thematic learning
- Note the identified areas for improvement and associated action plan
- A co-produced action plan will be created with the MNVP

Countess of Chester Hospital NHS Foundation Trust

Committee Chair's Report

18th November 2025 at 11am via Microsoft Teams

Committee	Finance and Performance Committee
Chair	Hasintha 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)*

- Deficit Support Fund (DSF) - The Trust is delivering in line with its financial plan and is forecast to deliver this with the exclusion of DSF.
- Cash at Month 7 (£17.6m) expected to cover only 16 days. This position is expected to get worse if cash support doesn't get injected in December 2025 and January 2026.

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

- The Chief Finance Officer assured that the Trust is managing its deficit within the pre agreed range of £13m, however the non-receipt of Deficit Support Fund (DSF) of £6.5m leaves the Trust at an adverse variance against the planned deficit of £19.5m.
- Trust is on track to deliver NHS England (NHSE) target of 30% reduction in agency spend.

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

- Budget setting principles and workforce management templates were getting developed with clear oversight from the respective Executive Committee members.
- High-level overview and Board assurance framework, including the maturity assessment gradings (Maturing, developing, not embedded) were discussed. Committee requested the Executives to provide timely updates with supporting evidence with the Board to ensure they have sufficient time to understand and provide robust feedback prior to signing the final Assurance statement.
- The Chief Finance Officer will provide monthly updates to the Board (until March 2026) on key milestones and any new developments/updates on the Planning process.
- Geothermal Bid Update was escalated to the Board given the size, complexity and financial commitment required for the overall project.

Risks discussed and new risks identified

- Continued impact due to non-receipt of DSF – impacting the overall external communication, including the communication with appointed third party Pricewaterhouse Copper (PwC) to assess Trust's performance.

Committee Chair's Report

17th December 2025 at 13.30 in the Boardroom, 1829 Building

Committee	Finance & Performance (F&P) Committee
Chair	Non-Executive Director, Ms H Gunawickrema

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)*

- Challenge of Cash deficit as we go into Quarter 4.
- Planning submission and assurance statements discussed with the Board with minor changes made to one assurance statement discussed reduced due to additional information regarding commissioning arrangements noting more work to do to understand this with the integrated Care Board (ICB) and an element of the operational gap was reduced - positive change to ensure target expectations met.

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

Financial Performance:

- Month 8 financial position with an adverse variance YTD of £8.2M driven by non-receipt of Deficit Support Funding. Earlier industrial action costs have now been absorbed. Under delivery of Cost Improvement Programme (CIP) £7.4M has been mitigated through non recurrent items. Likely forecast deficit is £33.8M (excluding deficit support funding) which is an improvement of £300k from Month 7.

Operational performance:

- Review of Integrated Performance Report (IPR) for operational (including referral to treatment (RTT), cancer and diagnostics) and financial performance. Committee noted improvements in Referral to treatments (RTT) in October and improvements within Emergency Department 4- and 12-hour performance metrics, Ambulance handover times and Corridor management.
  Based on the information shared relating to deterioration
- Diagnostics performance has declined, which has a direct link to the reduced ability to spend Elective Recovery Fund money.
- Ongoing risk flagged with Non Criteria to Reside (NCTR) remaining high. To further understand the wider impact of the current NCTR performance subject matter expert (Divisional Director, Therapies & Integrated Community care) were invited to join the next committee meeting to share further information on 'delay days incurred'.
- Details on Doctors strike and direct operational impact was discussed. Chief Operating Officer (COO) was requested to share a performance comparison between 'strike days' and 'business as usual (BAU) days.
- Challenges in sourcing agency staff has been flagged as a key driver for the long wait time for Echocardiogram Request was made to provide an update to the committee on the resource position.
- **Update on the digital and data strategic programme**, including ambient voice technology, Artificial Intelligence (AI) clinical coding solutions, Electronic Patient Record (EPR) integration and Regional order comms. Report also included NHS

Digital Maturity Assessment with a good score achieved by the Trust, and EPR usability survey where the Trust scored slightly higher than national average.
- Committee requested further updates on the following:
1) Cyber Business continuity plan
2) Update F&P Committee and the Board on the AI Policy and the assurance framework followed.
3) Assurance requested to confirm safety and functionality of integration project with blood transfusion prior to the old process gets switched off.

- **Senior Information Risk Owner (SIRO) report** providing assurance on cyber security activities, information governance and Data Security & Protection Toolkit (DSPT). Recognising some Freedom of Information (FOI) breaches with an interim solution on delivery of FOI and separately an outsourced solution for Information Governance.
- **Audit tracker** reviewed with updates against outstanding actions with dates agreed and internal audit review of progress planned to close actions (Estates, Cost Improvement Programme (CIP), IT infrastructure, Cerner lessons learned.
- **Health and safety** 6 monthly report providing an update on health and safety incidents, fire safety assurance, major capital programmes support, ligature reduction and other health and safety work.
- Estates and facilities update providing an overview of improvements in the environment, water safety and specialist compliance, policies, governance and reporting, reputation and stakeholder engagement, health and safety and security services, facilities and cleaning, clinical engineering and equipment management, financial performance and efficiency, future planning and priorities.
- Information Governance Annual Report providing an overview of the roles and responsibilities, Data Security and Protection Toolkit (DSPT) audit, FOI requests, training compliance, Information Commissioners Office (ICO) reportable incidents. The Information Governance (IG) service is currently outsourced to the Midlands and Lancashire Commissioning Support Unit to provide resilience and longer term view of the service is required.
- Thirlwall Inquiry financial spend update showing significant under spend year to date against the plan. In year forecast being revisited along with a view for 2026/26. NHS England have funded the Trust's response to the Inquiry to date.
- Chair reports received from a range of reporting Committees and Groups. Subject Access Requests (SARs) breaches noted and action being taken to increase resource to recover this position. Echo performance alerted from Operational Performance Executive Led Group (OPELG) as updated in the meeting.

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

- National cost collection complete with initial feedback showing an improvement and position positive to national average. Full update will be reported through F&P Committee in Quarter 4.
- Update on Digital and data strategy development with internal audit providing substantial assurance on the approach. Strategy to come back for review and approval. AI governance framework and/or policy requested for future review.

Risks discussed and new risks identified

- Reviewed relevant extracts of High risks and the Board Assurance Framework (BAF) in terms of operational effectiveness, finance and capital, digital and data

confirming position and alignment to Finance & Performance Committee agenda. As discussed at the Board, the Committee is keen to understand the trajectory for when risk scores are expected to reduce and/or meet the risk appetite.

- Strategic risks noted in health and safety report.
  1) Deconstruction of the old Women and Children's building
  2) Ageing fire alarm system – Potentially require additional funding from that which is already allocated.
  3) Temporary absence of a centralised Control of Substances Hazardous of Health (COSHH) management system.

Committee Chair's Report

Tuesday 9th December 2025 at 13.30 in the Boardroom, 1829 Building

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

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

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

- The People Committee received an update on the visa sponsorship situation and the Committee asked for a paper setting out the number involved, and the process taken to agree and implement the actions required.
- Action plan in respect of the sexual safety charter is progressing with planned completion by end March 2026; this continues to hold a national profile and there has been a recent NHS England letter to all Chief Executive Officers (CEOs) regarding the expectations

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

- Received a Chief People Officer (CPO) report to keep abreast of national and local updates.
- Received a chairs report from the Partnership Forum with no alerts noted. Update included band 2/3 resolution progress, partnership agreement review, and visa update.
- Received a chairs report from the People and Culture Sub Committee with no alerts noted. Updates included development of workforce metrics dashboard, turnover and leaver trends, sickness absence data and actions, return to work compliance, exit interview completion rates, staff experience action plans, implementation of the sexual safety charter, improving resident doctors working lives 10 point plan, and review of People related risk register.
- Received a chairs report from the Education and Learning and OD Committee with no alerts noted. Reference was made to the NHS England placement provider self-assessment which had been reviewed prior to coming to People Committee. Other updates included mandatory training, appraisals and apprenticeships, NETS 2025 survey, General Medical Council (GMC) trainee survey action plans and review of the People related risk register with a new operational risk scored at 9 to be added.
- Received a chairs report from the Workforce Committee with no alerts, although focus is on increasing attendance at meetings. Updates included performance against workforce plan, payroll overpayments, medical roster implementation, overdue policies, variable pay data, and review of people related risks.
- Workforce plan 25/26 position presented with actions being taken to improve the actual position in line with 'normalised' plan recognising that this is higher than the actual plan which was based on the 2024/25 month 9 position. This will continue to be discussed with Pricewaterhouse Coppers (PwC) at the FPRM.
- Culture and leadership update setting out how the actions we are taking align to the culture and leadership framework.

- People Promise paper with reference to flexible working campaign; staff experience action plans and response rates for the staff survey being 44% (subject to final data cleanse).
- Workforce metrics dashboard noting increase in sickness absence, staffing related Datix reporting with further work required on exploring the data.
- Audit tracker progress update with the outstanding action on medical staffing to be closed as superseded with the medical e'rostering system implementation.
- Sexual safety charter update including progress against the actions aligned to each principle of the framework. Actions will continue to be delivered with planned completion for all actions by the end March 2026.

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

- NHS England Self Assessment for Placement Providers provided to the Committee for information following submission in November 2025.

Risks discussed and new risks identified

- High risks reviewed including the microbiology cover, with an update that recruitment for one of the roles had progressed and would be in post in January 2026, a risk will remain, but the intention is to review with a view to reducing. A risk regarding medical cover and premium rates had been increased to a score of 16 and was included in the risks reported to the People Committee, with an update on the actions being taken to reduce gaps and be proactive in recruitment for future workforce gaps.
- Committee received the People extract of the Board Assurance Framework (BAF) for consideration alongside the People Committee agenda, noting this had been updated at Quarter 2 for the Board.

PUBLIC – Board of Directors
27th January 2026

Report	**Agenda Item 20. ***	**Annual NHSE Self-Assessment for Placement Providers**						
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Vicki Wilson			Chief People Officer				
Author(s)	Sallie Kelsey Liz Pritchard			Head of Education Deputy Chief People Officer				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X** **X** **X**	BAF impact is linked to contractual compliance with the Education contract between the Trust and NHS England.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X**
Previous considerations	Education, Learning and Organisational Development Sub-Committee – November 25 People Committee – December 25							
Executive summary	The purpose of this report is to provide information confirming the completion and submission of the NHSE Self-Assessment for Placement providers, demonstrating that the Trust is compliant with the standards set out in the national Education Contract with NHS England. The self-assessment report has been completed in line with NHS England requirements and provides assurance that the Trust continues to meet the Education Contract, including the obligations and KPIs of the Education Funding Agreement and the standards within the Education Quality Framework. The completed document demonstrates that the Trust is compliant with all areas of the Education Contract but acknowledges that there are elements that the organisation continues to find challenging (as referenced in section 4.2 of the report). These include access to training spaces and facilities,							

	increase in resident doctors working less than full time, and placement management and capacity. The Trust is aware of these challenges, has documented risks as appropriate, and is actively working to mitigate the impact of these in practice. Challenges (and any associated risks) are being managed via the Education Learning and OD Sub-Committee or the Workforce Sub-Committee. Examples of good practice have been provided throughout the submission (a sample of these is provided in section 4.2) that demonstrates the Trusts commitment to continuous improvement whilst also actively responding to feedback from learners. These include an exponential increase in collaborative working with University of Chester Medical School, most improved Trust in relation to Training Evaluation Form data via the Royal College of Obstetricians and Gynaecologists, and the introduction of a volunteer patient clinic as an example of innovative practice.
Recommendations	The Board of Directors is asked to note the contents of the report including - The completion and submission of the NHSE Annual Self-Assessment for Placement Providers, demonstrating the Trusts continued compliance with the standards set out in the National Education Contract with NHS England.

Corporate Impact Assessment	
Statutory/regulatory requirements	NHS England Education Contract
Risk	Failure to comply with the Education Contract could result in loss
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential

Annual NHSE Self-Assessment for Placement Providers

1. Introduction

The NHS England self-assessment is a process by which organisations who provide practice placements to learners, carry out their own quality evaluation against a set of standards, submitting their self-assessment to NHS England to confirm their adherence with the NHSE Education Contract.

2. Background

In accordance with the Care Act 2014, NHS England is responsible for the leadership of all healthcare education and training for those employed by the NHS and for those seeking NHS employment. NHS England also has statutory obligations for the quality of the services delivered that it funds, as well as for the safety and protection of students and patients.

The NHS Education Contract (2024-2027) requests all placement providers to fulfil the obligations of their roles and responsibilities set out in the NHS England Education Quality Framework and the Education Funding agreement, and to submit a self-assessment return to NHS England on their compliance with the contract annually.

3. Purpose

The purpose of this report is to provide information confirming the completion and submission of the NHSE Self-Assessment for Placement providers, demonstrating that the Trust is compliant with the standards set out in the national Education Contract with NHS England.

4. The Trust Self-Assessment 2025

4.1. Trust approach

The completion of the self-assessment has been led by the Head of Education, involving key education stakeholders from across the Trust. The completed self assessment has been presented to the members of the Education, Learning and OD Sub-Committee, who supported the content.

It has been signed off by the Chief People Officer acting as a Trust Board representative and is travelling to the People Committee for information following submission of the self-assessment in November 25.

This process adheres to the NHSE requirement of ‘Board level approval’ for the self-assessment.

4.2. Self- Assessment Content and Submission

The self- assessment is made up of twelve sections with a brief summary provided of each section below.

4.2.1. Section 1 – Placement Provider Challenges

The Trust is required to submit three challenges in relation to practice placements. The 2025 return included access to training spaces and facilities, increase in resident doctors working less than full time, and placement management and capacity. Additional detail on the challenges as submitted in the self-assessment are provided below, along with an brief update for the Board of Directors on action being taken.

Training Spaces and Facilities

'With the increasing number of undergraduate students attending practice placements across all programmes and from all education providers at the trust, space and facilities is becoming a challenge. The pressure is increasing with the introduction of Chester Medical School and will further increase with the introduction of the MPharm course from September 2026 at a local HEI. Specific challenges within the Education Centre are around IT facilities which are increasing due to many of the professions requiring training with the evolving electronic prescribing systems. The medical student mess space, training rooms, and simulation facilities availability and size are also becoming a challenge. Space within clinical practice is particularly challenging in clinic rooms where space to accommodate students has been raised. This is being addressed through provision of simulated consultations with volunteer patients and the review of the Education estate and development of a business case for a capital bid'.

Action being taken

The availability of training space and facilities is documented as a risk on the risk register (Risk ID 2030) with action being taken reported through the Education Learning and OD Sub-Committee. Action planned in the next 4 weeks as reported through the November Sub-Committee includes the finalisation of phase 1 of a capital funding business case with the aim of delivering improvements in year and the further progression of a phase 2 business case, seeking further estate development in 26/27.

Increase in Less Than Full Time (LTFT) and Reasonable Adjustments

'Increase in resident doctors working LTFT. The GMC NTS has shown that the proportion of LTFT resident doctors in the Health Education NW in 2025 stands at 28.1% (up from 14.9% in 2021). At the trust we have 30% LTFT resident doctors. This is challenging to cover curriculum requirements for the LTFT trainees and leads to less training opportunities. It also results in rota gaps (which can be expensive to cover at locum rates) as well as more time consuming rota writing due to the need for personalised work schedules for LTFT doctors.

Action being taken

The Trust continues to work proactively to forecast and plan for gaps in rotas due to this national trend, investing in locally employed doctors in 25/26 to mitigate the impact. The introduction of the recently procured medical roster will provide efficiencies in rota planning and support further proactive identification of gaps. The introduction of Education Medical Fellows in Sept 25 is enabling more flexible delivery of the curriculum, increasing training opportunities for LTFT resident doctors. Conversations are continuing with the NW Deanery to ensure more timely sharing of rota requirements to increase opportunity for local planning in advance of resident doctor rotations. This Trust challenge is linked to an existing Trust risk, Risk ID 3326 relating to medical gaps and safe staffing that will be reported through the Trusts Workforce Sub-Committee.

Following review in December 25, the People Committee requested a letter to be drafted from the Trust to the North West Deanery, expressing concerns in relation to LFTF, more timely notification of on call reasonable adjustments related to placements, and more timely notification of gaps in relation to placement provision. This is planned for action in January 26.

Placement Management/Capacity

'The NHS Long Term Workforce Plan 2023 outlined the plan to double medical students nationally by 2031/32 in order to train the required sustainable UK trained medical workforce, and these new numbers are preferentially going to new medical schools. Chester Medical School started with its first intake of MB ChB students in September 2024. Some of them will be starting their 2nd year placements at the Countess on 22nd September 2025. The University of Liverpool medical students will still be coming to the Countess for placements. This will lead to an overall increased number of students across the Trust. The University of Chester will be at "business as usual" with students from all 4 years on placements from September 2027, meaning a total of 160 medical students at the hospital over the year. The University of Chester Clinical Sub Dean and year 2 lead and the Undergraduate Medical Education team have put in a great deal of work to plan for the placements for year 2, and planning is in process for year 3 from September 2026 and then work for year 4 will begin. This increase in student numbers across all professions impacts on access to learning opportunities in clinical practice for all undergraduate health care programme students. We are providing clinical skills workshops and simulation sessions in order to reduce the pressures on clinical practice. The Trust is also experiencing an increase in the number of students requiring reasonable adjustments which is impacting placement capacity, especially in undergraduate nursing and AHP programmes where it becomes difficult to place students across the rota'.

Action Taken

To ensure continued access to learning opportunities, the Trust is implementing new ways of working, one of which have been referenced in section 2 of the self-assessment submission below, the introduction of Volunteer Clinics. In addition, the introduction of the Education Medical Fellows in Sept 25 has enabled more bespoke bedside training and increased clinical skills training capacity further supporting Medical Students with education aligned to reasonable adjustment plans. For nursing and AHP students requiring reasonable adjustment plans, Practice Education Facilitators liaise with the relevant Universities and Placement managers to ensure appropriate learning is available. An example of this is the facilitation of no night placement areas for students requiring this reasonable adjustment. This is an ongoing challenge with the current action mitigating any current Trust risk, however this will be reviewed and monitored via the Education, Learning and OD Sub-Committee.

4.2.2. Section 2 – Placement Provider Achievements.

The Trust is also required to submit three achievements in relation to practice placements. The 2025 return included an exponential increase in collaborative working with University of Chester Medical School, most improved Trust in relation to Training Evaluation Form data via the Royal College of Obstetricians and Gynaecologists, and the introduction of a volunteer patient clinic as an example of innovative practice. Additional detail on the achievements as submitted in the self-assessment.

Collaboration/Partnership

'There has been an exponential increase in collaborative working with the University of Chester Medical school - with the Clinical Dean, and year 2 and 3 leads in order to be ready for the roll out of the Chester Medical school programme. Following approval of a business case at the end of July 2025, 6 x 0.5WTE education fellows were appointed. Speciality leads for the year 2 placements have also now been recruited.

The pharmacy department at the Countess of Chester have partnered with Day Lewis Pharmacies to offer multi-sector Foundation Trainee Pharmacist provision for the first time. This has required joint design of four new individual programmes for learners. Joint assessment days will include quality review of programmes to identify any issues and ideas for improvements and will take place with trainees to support future programme design. In addition, this will also allow for joint standard setting and evidence review to provide assurance that both partner organisations are working to a single set of standards.

Quality - Improvement Initiatives, response to data, positive feedback

'The Specialty Education Advisory Committee at the Royal College of Obstetricians and Gynaecologists (RCOG) oversees the collection of training data nationally via the Training Evaluation Forms (TEF) which are completed annually as part of the ARCP process as a tool for the RCOG to monitor and improve quality of training. The Countess of Chester Hospital was awarded a certificate in July 2025 in recognition in the 2025 TEF results, commending Chester for being the most improved hospital out of 167 in the country, whose TEF scores across all indicators have improved the most since the 2024 TEF survey. In order to promote and share excellence, and as a highly performing unit the department at Chester were asked to provide some tips that could be shared more widely including on the RCOG website, as to how they have achieved this outstanding feedback. These findings are mirrored in the Chester Obstetric and Gynaecology departments GMC survey results in 2025, and similarly we have asked them to share their tips with other departments in Chester'.

Innovative Training / Course Development

'As a part of enhancing student learning experience at the Countess we have introduced a Volunteer Patient clinic. The aim for it is to mimic real clinic environment, where the student can examine the patient or take history in a safe environment and receive immediate feedback without added pressure on the clinical areas. The clinics are facilitated by one our senior doctors. We are planning to expand this project and hopefully run multiple clinics at the same time. Consultants from different specialties are asking some of their patients if they would be willing to be a part of this project. The Volunteers are recruited through the Trusts volunteer process and are not inpatients but actively attend routine outpatient appointments.
We believe this is beneficial not only to our students but also our patients, who are often elderly and appreciate being able to give something of value back to the Trust whilst also enjoying the social aspect of being part of this project. This in turn may lead to improved wellbeing.

For the first time the Trust is supporting two Clinical Scientist Graduate Programme students within the Pharmacy aseptic unit. Students are with the Trust for 3 years working alongside pharmacy staff in the unit to review and improve processes and learn about quality control and pharmaceutical production. We also plan to encourage our clinical scientists to contribute to the training of others in the department, including our trainee pharmacists and newly qualified pharmacists'.

4.2.3. Sections 3 – 7 – Placement Provider to provide assurance on compliance with standards.

A summary of the Trust position against each standard is provided in the below table.

Section No.	Section Description	Trust self-assessment position as reported.
3	Compliance with the NHS Education Funding Agreement	Compliant with all obligations and KPIs and provided additional comments to support response.
4	Compliance with Quality, provision of library services, reporting concerns and patient safety training obligations and KPIs of the Education Funding Agreement	Compliant with all obligations and KPIs and provided additional comments to support response.
5	Policies and processes in relation to Equality, Diversity and Inclusion (aligned to the Education Funding Agreement)	Compliant with all obligations and KPIs, providing additional comments to support response and information on good practice examples.
6 - 11	That the Trust meets standards from the Education Quality Framework	Compliant with all standards with no exceptions reported. Examples of good practice included across medical, nursing, and AHP professions.

5. Conclusion

The self-assessment report has been completed in line with NHS England requirements and provides assurance that the Trust continues to meet the Education Contract, including the obligations and KPIs of the Education Funding Agreement and the standards within the Education Quality Framework.

The completed document demonstrates that the Trust is compliant with all areas of the Education Contract but acknowledges that there are elements that the organisation continues to find challenging (as referenced in section 4.2 of the report). The Trust is aware of these challenges, has documented risks as appropriate, and is actively working to mitigate the impact of these in practice. Challenges (and any associated risks) are being managed via the Education Learning and OD Sub-Committee or the Workforce Committee.

Examples of good practice have been provided throughout the submission (a sample of these is provided in section 4.2) that demonstrates the Trusts commitment to continuous improvement whilst also actively responding to feedback from learners.

6. Recommendations

The Board of Directors is asked to note the contents of the report including:

- The completion and submission of the NHSE Annual Self-Assessment for Placement Providers, demonstrating the Trusts continued compliance with the standards set out in the National Education Contract with NHS England.