NHS
Countess of Chester Hospital
NHS Foundation Trust

Public meeting of the Board of Directors Agenda
(published items)
Tuesday 31st March 2026, 08.30 – 12.30
Women & Children's Building Seminar Room

Chair	Mr N Large, Trust Chair
Apologies	Ms H Gunawickrema, Non-Executive Director
In attendance	Ms K Adams, Chief Pharmacist/Controlled Drugs Accountable Officer (Item 15.)

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.	Patient Story (to be presented on the day)			
09.10	5.	Minutes of the previous meeting held on 27th January 2026 (attached)	Trust Chair	5 - 25	For approval
09.15	6.	To consider any matters arising and action log (attached)	Trust Chair	26 - 28	For noting
09.20	7.	Chief Executive Officer's Report (attached)	Chief Executive Officer	29 - 34	For noting
09.30	8.	Chair's Update (verbal)	Trust Chair		For noting
09.35	9.	a) Board Assurance Framework – 2025/26 Q4 Update (attached)	Director of Governance, Risk & Improvement	35 - 56	For approval
		b) High Risks Report March 2026 (attached)	Director of Governance, Risk & Improvement	57 - 67	For noting
Quality of Care					
9.45	10.	Quality & Safety Committee Chair's Report – 5th March 2026 (attached)	Chair Quality & Safety Committee	68 - 69	For assurance
9.50	11.	Freedom to Speak Up Report (FTSU) (attached)	Chief Operating Officer	70 - 76	For assurance & noting
10.00	12.	Guardian for Safer Working Report (to follow)	Medical Director		For assurance

10.10	13.	Safety Surveillance and Learning Report – Quarter 3 2025/26 (attached)	Director of Nursing & Quality / Deputy Chief Executive & Medical Director	77 - 86	For assurance & noting
10.20	14.	Quarter 3 2025-2026 Mortality Surveillance Report (Learning from Deaths) (attached)	Medical Director	87 - 97	For assurance
10.30	15.	Self-Assessment and Designated Body Controlled Drugs Accountable Officer (CDAO) Improvement Framework for 2026 (attached)	Chief Pharmacist / Controlled Drugs Accountable Officer	98 - 105	For decision
Comfort Break (10.40 – 10.45)					
Operational Performance					
10.45	16.	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
10.55	17.	Operational Management Board Chair's Report – 22nd January 2026 and 26th February 2026 (attached)	Chief Executive Officer	106 - 109	For assurance
Finance, Use of Resource and Performance					
11.00	18.	Finance & Performance Committee Chair's Report – 21st January 2026 and 25th February 2026 (attached)	Finance & Performance Committee Non-Executive Director	110 - 113	For assurance
11.05	19.	Audit Committee Chair's Report – 3rd February 2026 (attached)	Audit Committee Chair	114 - 115	For assurance

Strategic Change					
11.10	20*.	Cheshire and Merseyside 5 Year Strategic Commissioning Plan (2026-2031) (attached)	Director of Strategic Partnerships	116 - 149	For noting
11.13	21*.	Cheshire and Merseyside Population Health Improvement Plan (2026-2031) (attached)	Director of Strategic Partnerships	150 - 217	For noting
11.15	22.	Equality, Diversity & Inclusion Annual Report (attached)	Chief People Officer	218 - 242	For approval, assurance & noting
Leadership, Improvement Capability, Organisation Development and People					
11.25	23.	People Committee Chair's Report – 10th February 2026 (attached)	People Committee Chair	243	For assurance
11.30	24.	Standing Financial Instructions Review 2026 (attached)	Chief Finance Officer	244 - 246	For decision
11.40	25.	NHS Staff Survey 2025 – Results and High-Level Actions (attached)	Chief People Officer	247 - 257	For ratification, assurance & noting
11.50	26.	Sexual Safety Charter Framework Implementation (attached)	Chief People Officer	258 - 263	For assurance
Governance					
12.00	27*.	Council of Governors Report – February 2026 (attached)	Director of Governance, Risk, and Improvement	264 - 266	For noting
12.03	28.	Provider Licence Compliance 2025/26 (attached)	Director of Governance, Risk, and Improvement	267 - 270	For decision
12.08	29.	Code of Governance Compliance 2025/26 (attached)	Director of Governance, Risk, and Improvement	271 - 272	For decision
Items for noting					
12.12	30.*	Items for noting and receipt (attached): ***Sent under separate cover*:** **Minutes of Committee Meetings:** a) Approved minutes of the Quality & Safety Committee – 8th January 2026. b) Approved minutes of the People Committee – 9th December 2025. c) Approved minutes of the Finance & Performance Committee – 17th December 2025 and 21st January 2026. d) Approved minutes from the Audit Committee – 7th October 2025.	Trust Chair		For noting

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		Other items: e) Board of Directors Workplan 2025/26 and Draft Workplan 2026/27.			
Other items					
12.15	31.	Any Other Business (verbal)	Trust Chair		For noting
12.20	32.	Questions from Governors and members of the Public relating to items on the meeting agenda - ***Questions to be submitted in writing in advance of the meeting to:*** coch.membershipenquiriescoch@nhs.net ***by Thursday 26th March 2026*** **Future Dates:** 19th May 2026 21st July 2026 29th September 2026 24th November 2026 26th January 2027 16th March 2027	Trust Chair		For noting
12.30	33.	Closing remarks (verbal)	Trust Chair		For noting

Next Meeting: Tuesday 19th May 2026 at 8.30am, Women & Children's Building Seminar Room

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

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MINUTES OF THE PUBLIC BOARD OF DIRECTORS

Tuesday 27th January 2026, 08.30 – 12.00

Women and Children's Building – Seminar Room

Members	20/05/25	29/07/25	30/09/25	25/11/25	27/01/26	
Trust Chair, Mr N Large MBE	☑	☑	☑	☑	☑	
Chief Executive Officer, Ms J Tomkinson OBE	☑	☑	☑	☑	☑	
Non-Executive Director, Mr D Williamson	☑	☒	☑	n/a	n/a	
Non-Executive Director, Mr P Jones	☑	☑	☑	☑	☑	
Non-Executive Director, Mr M Guymer	☑	☒	☒	n/a	n/a	
Non-Executive Director, Mrs P Williams	☑	☑	☑	n/a	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	☑	☑	
Non-Executive Director, Ms A Simpson	n/a	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	☑	☑	☑	☑	☑	
Director of Delivery, Mr D Nash	n/a	n/a	☑	☑	☑	
Consultant Dermatologist/Skin Cancer Lead, Dr E Domanne	☑ (item 3)	n/a	n/a	n/a	n/a	
Healthcare Assistant, Ms M Facer	☑ (item 3)	n/a	n/a	n/a	n/a	
Director of Midwifery, Ms N Macdonald	☑ (item 11 and 12a)	☑ (item 4)	☑ (item 11)	n/a	☑ (item 13 and 14)	
Director of Clinical Research, Mr P Bamford	☑ (item 23)	n/a	n/a	n/a	☑ (item 18)	
Deputy Medical Director, Dr I Benton	n/a	☑	n/a	n/a	☑ (item 3)	
Maternity and Neonatal Voices Partnership Lead, Ms R El Boukili	n/a	☑ (item 4)	n/a	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	n/a	
Intensive Care Consultant and Organ Donation Clinical Lead, Mr D Zeinali	n/a	n/a	☑ (item 4)	n/a	n/a	
Safeguarding Lead, Ms J Cooper,	n/a	n/a	☑ (item 10)	n/a	n/a	
Deputy Chief Operating Officer, Mr S Brown	n/a	n/a	☑	n/a	n/a	
Freedom to Speak Up Guardian, Ms H Ellis	n/a	n/a	☑ (item 13)	n/a	n/a	
Named Nurse for Safeguarding Children, Ms L Ates	n/a	n/a	n/a	☑ (item 3)	n/a	

Head of Nursing - Infection Prevent & Control, Mr M Woodward	n/a	n/a	n/a	☑ (item 4)	n/a	
Associate Medical Director, Dr S Brigham	n/a	n/a	n/a	☑ (item 13)	n/a	
Head of Midwifery, Ms C Davies	n/a	n/a	n/a	☑ (item 14a)	n/a	
Deputy Chief People Officer, Mr P Marston	n/a	n/a	n/a	☑	n/a	
Programme Director/LMNS SRO, Women's Health and Maternity (WHaM), Ms C McClennan,	n/a	n/a	n/a	n/a	☑ (Item 13)	
Consultant, Mr S Sheppard	n/a	n/a	n/a	n/a	☑ (Item 3)	

Observers in attendance:

- Cheryl Finney - Staff Governor
- John Jones – Lead Governor
- Tracy Cunningham - Account Manager, Bridgehead
- Archie Maher – Healthcare Client Partner, Netcompany
- Mark Taylor – Sales Manager, Xyla

Agenda No.	Agenda item	Action
1.	**Welcome, apologies and Chair's opening remarks** Mr N large (NL), Trust Chair opened the meeting and welcomed Ms Angela Simpson, as the new University appointed Non-Executive Director. Apologies were noted from Mrs H Gunawickrema (HG), Non-Executive Director and Mr J Develing (JD), Director of Strategy and Partnerships.	
2.	**Declarations of Conflicts of Interest with agenda items** There were no declarations of interest to note.	
3.	**Service Showcase – Mortality and Stroke** Mr S Shepperd (SS), Stroke Consultant and Mr I Benton (IB), Deputy Medical Director attended to present the stroke and mortality service showcase. IB introduced the stroke service showcase and the context of mortality. SS provided an overview of stroke services, the results and demographics, performance against quality targets, timeliness of treatments, national and regional comparators. Improvements have included extension of stroke coordinator, dedicated trolley and now a new Stroke Unit. Board members queried scan delays, late presentations among older patients, and variation in regional performance. Explanations were provided	

	relating to atypical presentations, North West presentation patterns, and specialist centre effects. The Board sought assurance on collaboration with Aintree; and regular ISDN engagement was confirmed. A question was raised about emotional and psychological support for stroke patients; the Stroke Association and neuropsychology services were highlighted. The Board discussed HSMR vs SNAP methodology, noting limitations in national models and awaiting updated external mortality review data. The Board **noted** assurance that clinical care was of good quality. They recognised ongoing improvement actions, including pathway refinement, coding validation, and strengthening MDT and acknowledged external system influences (e.g. ambulance delays and specialist centre proximity). The Chair thanked SS and IB for the presentation. *SS and IB exited the meeting.*	
4.	**Staff Story** Ms V Wilson (VW), Chief People Officer, presented a staff story relating to a flexible working request. The request had initially been declined under the previous flexible working policy. Following the introduction of the updated policy, and with support from the HR Business Partner team, the case was revisited. A positive outcome was subsequently agreed. The review of the case highlighted inconsistencies in process, gaps in guidance, and limited awareness of the new policy. The staff member provided clear, constructive feedback, which informed improvements. As a result, enhanced guidance and manager training have now been implemented to strengthen the handling of flexible working requests. The Board thank VW and **noted** the staff story.	
5.	**Minutes of the previous meeting held on 25th November 2025** The minutes of the previous meeting held on 25th November 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 – IPR Trajectories.** Completed in part. RTT trajectories have been added to the Integrated Performance Report, with ED trajectories now incorporated. Work continues with operational and clinical teams as further trajectories are developed. **Action 2 – Closed.** Item is covered on the agenda. **Action 3 – Closed.** Addressed at the Board Development Day. **Action 4 – Closed.** Research Strategy included on today's agenda. **Action 5 – Closed.** Ms V Wilson (VW), Chief People Officer provided an update on the continuing impact of national immigration thresholds. Dialogue has taken place with Unison and a formal response from the Chief Executive and Chair has been provided, confirming limited flexibility within the national rules. The Trust will review any individual cases where staff feel their	

	circumstances have not been fully considered. Although only a small number of staff are affected, the Board acknowledged the significant personal impact. VW reported that despite recent national discussions, no relaxation of the rules is expected. The issue will also be escalated to the People Committee. Mrs W Williams (WW), Non-Executive Director recognised the distress caused but acknowledged that the Trust must comply with legislation. Ms S Pemberton (SP), Director of Nursing and Quality/CEO noted that ward teams are saddened at the loss of valued colleagues and highlighted broader challenges with recruitment and retention. VW referenced national conversations exploring potential career development pathways (e.g. into roles eligible for sponsorship) as part of future workforce planning. **Action 6 – Closed.** Item included on agenda. **Action 7 – Trainee Rotas and Less-Than-Full-Time Working.** Dr N Scawn (NS), Medical Director met with the Regional Postgraduate Dean to discuss the issue of trainees working less than full time while occupying full-time rota slots. The Dean was sympathetic but reported no progress on a regional solution. Some larger trusts have moved to appointing trainees on 0.8 WTE contracts. The Chair suggested this is an option worth exploring locally to address rota gaps. NS agreed that this may be beneficial in larger specialties where LTFT working is more prevalent and proposed evaluating the model and associated costs. **Action:** VW and NS to explore 0.8 trainee contracts through Medical Staffing. **Action 8 – On track for March** **Action 9 – Echo Action Plan.** Progressing through OPELG and scheduled for Finance & Performance Committee. **Actions 10 & 11 – Due in March.**	**VW/NS**
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: • Sustained OPEL 4 pressures with escalation into all hospital areas; ward decant and escalation use of Ward 41 adding strain. • Significant impact on staffing with increasing gaps emerging. • Non Criteria to Reside (NCTR) patient numbers continues to be highly challenging due to flow and discharge constraints. • Despite pressures, elective activity continues; Referral to Treatment (RTT) and financial risks remain key considerations. • Current ICB contract is due to be signed off this week but the current offer is not acceptable given the level of activity and required targets. • Regional feedback on the initial planning submission (December) highlighted strengths and areas requiring further refinement, which are being worked through by the teams.	

	• It has been announced that the Crown Prosecution Service has decided not to pursue further criminal charges against Lucy Letby. The investigation into potential gross negligence manslaughter is ongoing. The Trust will continue to support ongoing investigations. • Mr J Develing, Director Strategy and Partnerships is representing the Trust at a mandatory Leadership Away Day today. • Dame Jenny Harries is opening the new Medical School today. The Board **noted** the CEO's update.	
8.	**a) Chair's Update** The Chair, opened the item by expressing significant concern regarding ongoing challenges in Urgent Care, noting that despite focused work, the Trust is not seeing the level of improvement required. He highlighted weekend discharge as a critical issue affecting flow and stressed the continuing pressures linked to NCTR. The Chair suggested that the Board may benefit from a dedicated paper on discharge to support a fuller understanding of the constraints and opportunities for improvement. **ACTION:** Report on discharge process to be shared with the Board. Reflecting on recent discussions, he commented that the Board is managing a wide range of strategic and operational issues. He raised the question of how the Board can better prioritise its time, ensuring meaningful space to work together as a team while remaining focused on the priorities that will have the greatest organisational impact. The Chair cautioned that while strategy is important, the Trust risks losing strategic autonomy if it fails to address its immediate operational challenges. The Chair also welcomed the arrival of the newly expanded Non-Executive Director team, noting the valuable breadth of skills and experience this brings to the Board. This aligns with the Trust's updated NED structure and enhanced composition as described in the *Non-Executive Director Roles* report, which outlines the recent recruitment of two new NEDs and the appointment of a University-nominated NED and the update to NED portfolios. **b) Non-Executive Director Roles** The Chair continued by referring to the paper on NED roles. The Board reviewed and discussed the updated portfolio allocations set out in the paper. The Chair confirmed that Mrs H Gunawickrema (HG), Non-Executive Director will take on Transformation as an additional champion role, which will be added to the updated NED role table. Dr N Scawn (NS), Medical Director raised the issue of the Doctors' Disciplinary process, noting that the Maintaining High Professional Standards (MHPS) framework requires independent NED oversight. He explained that Prof A Hassell (AH), Non-Executive Director currently supports this area but highlighted that sitting on the Responsible Officers Advisory Group (ROAG) may be perceived as to being more difficult to	**NS**

	maintain an impartial perspective. NS suggested that the Board consider whether another NED should take on this responsibility. The Chair sought clarification from AH, who confirmed that his role for MHPS relates to oversight of the process rather than involvement in operational decision-making. AH stated that he does not personally feel conflicted but acknowledged that a consultant involved in the process might perceive a conflict. He added that NED training on MHPS would be beneficial. Mrs K Wheatcroft (KW), Director of Governance, Risk and Improvement reminded the Board that the adoption of NED champion roles stems from NHSE guidance, which aims to strengthen governance and oversight arrangements. VW questioned whether the doctors disciplinary should be referred to as MHPS and questioned whether a NED is required to sit on ROAG, as the MHPS oversight function is a specified requirement. After further discussion, the Chair proposed that AH remain as the MHPS lead, with the matter to be discussed further with the full NED group to ensure consensus. Mr P Jones (PJ), Non-Executive Director highlighted his role as the Anchor Institution Champion and requested that this also be included in the updated NED roles table. **Action:** Update NED roles table to reflect, HG as Transformation Champion, PJ as Anchor Institution Champion and change Doctors Disciplinary to MHPS. The Board **noted** the overview of NED responsibilities presented in the report, including committee membership and champion roles, and agreed that the role descriptions should be updated to reflect the amendments discussed.	**NC**
9.	**NHS England Enforcement Notice** The Board received an update on the NHS England enforcement notice. The report outlined that the enforcement undertakings had been formally signed by both the Trust and NHS England on 28 November 2025. This was following earlier discussions at the Board Development Day in October 2025 and a further review at the private Board meeting on 25 November 2025. The paper confirmed that the Trust already had a number of action plans in place including the financial plan and CIP, the Urgent and Emergency Care Improvement Plan, and the CQC Section 29a action plan all of which align closely to the Board Assurance Framework (BAF) and had been subject to regional scrutiny through the System Oversight Group. Mrs S Corcoran (SC), Non-Executive Director asked whether the enforcement notice would be added to the BAF or the corporate risk register. Ms J Tomkinson (JT), Chief Executive Officer responded that the constituent elements of the notice are already reflected within the BAF, given their connection to quality, safety, operational, people and financial risks, all of which are already monitored through existing risks and actions. Mrs K Wheatcroft (KW), Director of Governance, Risk and Improvement confirmed that key elements captured in the enforcement notice were already incorporated within the BAF prior to receipt of the formal notice. She added that the Audit Committee is scheduled to review Provider Licence compliance the following week, and that this compliance mapping will include	

	direct correlation to the NHS enforcement notice, BAF and associated action plans. The Board **noted** the NHS England enforcement notice which had been accepted by the Trust and the action plans already in place to deliver the improvements required.	
10.	**a) Board Assurance Framework – 2025/26 Q3 Update** Mrs K Wheatcroft (KW), Director of Governance, Risk and Improvement, presented the Q3 Board Assurance Framework (BAF) update, noting that the BAF had been fully reviewed by Executive colleagues with updates made across actions and risks. She highlighted that the Executive Summary sets out risks that remain above appetite, consistent with the strategic nature of the issues, and that whilst progress continues, some improvements will take time to fully embed. She also noted a reduction in the Corporate Governance (BAF8) risk score, now within appetite, as work in this area continues to be strengthened. KW explained that the BAF actions correlate closely with the Trust's NHSE enforcement notice action plans, with clear alignment visible across risk themes and mitigation plans. She drew the Board's attention to the progress against strategic objectives, summarised in the report, covering RTT, UEC, leadership, culture, workforce, digital, and research. The Chair asked how the organisation sets out and determines its risk appetite. KW explained that the Board holds annual development sessions to discuss appetite levels, thresholds, and tolerance for risk exposure. She acknowledged that many risks currently sit above appetite, reflecting the Trust's operating environment and challenges, but emphasised that the Board should not increase appetite simply because risks are challenging to mitigate. A further risk appetite session is planned for April, at which the BAF will be reset. She added that target scores are derived from appetite levels, and it is unusual to set a target that differs from the agreed appetite. KW acknowledged the need to revisit the target score for quality and safety, which is higher than in many other NHS organisations and something the Board had discussed at the last development session. Mrs S Pemberton (SP), Director of Nursing and Quality/ Deputy CEO expressed concern regarding patient flow and escalation, describing it as one of the Trust's most critical risks and warning that risk scores could not be reduced at this point. She noted that current pressures are contributing to patient harm, referencing pressure ulcers as an example. The Chair asked whether there was a meaningful distinction between a 'target' and an 'ambition' score. KW agreed this would be something to discuss when the Board revisited the risk appetite and reset the BAF for 2026/27. Mrs S Corcoran (SC), Non-Executive Director highlighted the importance of articulating the estimated timeframe for when risks might realistically reduce. She stated that the BAF has matured significantly but does not yet include a trajectory for risk reduction. She suggested the need for realistic forecasting for each risk area. KW agreed and noted that this had been considered during the Q3 review and will be built into the April Board session; the finance risk was cited as an example where trajectory modelling is already	

	clear. SC also proposed including bold statements acknowledging that patient safety risks cannot always be fully controlled or predicted, given the current pressures. Mrs W Williams (WW), Non-Executive Director queried the Digital risks (BAF7), noting that while good progress is being made, the positive direction does not appear to be fully reflected in the BAF rating. Mr J Bradley (JB), Chief Digital and Data Officer responded that cyber security remains the key underlying driver pushing the score above appetite and that work underway will be reviewed in April to determine whether the risk can be lowered once more evidence of delivery is available. The Chair concluded that any changes to the BAF or risk appetite will be considered as part of the April review, in order to allow sufficient time for engagement and completion of key pieces of work. The Board **noted** the Q3 BAF update. **b) High Risks Report** KW presented the High Risks Report, with the paper outlining the 13 risks currently scoring 15 or above on the Datix Risk Register. She reported that work continues to strengthen risk management practice Trust-wide, supported by the Risk Management Committee, which is now meeting regularly and progressing the Risk Improvement Plan, including Datix updates and improved risk management training. KW advised that the number of high risks had reduced, with improved focus being made on the most critical areas. She noted that the latest Risk Management Committee (RMC) meeting showed stronger triangulation between divisional reports and corporate risk themes, indicating improved consistency in reporting. She confirmed that further improvements are expected by April as part of the refreshed corporate risk register for corporate teams. Mr P Jones, (PJ) Non-Executive Director welcomed the direction of travel and commented that the report was beginning to evolve into an assurance document, helping the Board understand the effectiveness of mitigating actions. The Chair added that the role of the Board's assurance committees is crucial in providing assurance against these risks and confirming the robustness of controls and mitigations. Prof A Hassell (AH), Non-Executive Director emphasised the importance of recognising the interdependencies between committees and risks, particularly where risks span multiple operational and strategic domains. It was noted that the assurance committees continue to receive high risk reports. The Board **noted** the high risk report and continued action to strengthen risk management.	
11.	**Quality & Safety Committee Chair's Report – 8th January 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 Board was alerted to the significant improvement in sepsis screening and management acknowledged, with further improvement needed, particularly in the Emergency Department and also across inpatient areas. A Cerner hard-stop for NEWS triggers is being implemented this month; impact to be reviewed at the next Q&S. Progress in UEC noted, though some metrics remain below target. Ongoing attention required to maintain and embed improvements. • Strong assurance received on cleaning standards with a small number of exceptions which were responded to rapidly. • Assurance received on the Cost Improvement Plan (CIP) Quality Impact Assessment (QIA) process. Positive development noted: inclusion of post-implementation audits to ensure no unintended harm. • Improvements seen with e'discharge, but progress has plateaued in General Surgery. Work continues to support further system improvements • Committee noted the assurance within the mortality report. A key area for development remains strengthening evidence of learning and demonstrating actions taken. 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), Director of Nursing and Quality/ Deputy CEO, presented an update on the the Trust's CQC Improvement Plan including well led. She noted that the review of the action plan had been undertaken in November, led by K Wheatcroft (KW), Director of Governance, Risk and Improvement. SP highlighted that many actions within the plan are now embedded within assurances through existing Board assurance committees. The report demonstrates how the remaining actions have now been mapped to the appropriate committees, ensuring clear ownership and alignment with the Trust's broader Improvement work and BAF assurances. The Board of Directors considered and **approved** the proposal to step down the consolidated CQC action plan and continue to monitor delivery through the embedded reporting to the relevant assurance committees.	
13.	**Maternity Incentive Scheme Year 7 Compliance and Assurance Report** Ms N Macdonald (NM), Director of Midwifery presented the MIS Year 7 Compliance and Assurance Report, seeking approval for the Chief Executive Officer to sign the Board Declaration Form confirming compliance for submission to NHS Resolution. NM outlined the background to the MIS scheme, confirming that all evidence had been uploaded and externally validated through Local Maternity and Neonatal Systems (LMNS) review, internal governance processes, and the extraordinary evidence review meeting held in December 2025. The Trust has achieved full compliance with all ten Safety Actions, with the exception of Safety Action 8, where a permissible national exception applies for rotational resident doctors who started after 1 July 2025 and had not yet reached the required 90% mandatory training compliance within the	

	reporting window. NM confirmed that all outstanding training for individuals has since been completed. Mrs S Corcoran (SC), Non-Executive Director noted that a rigorous evidence review session had been held with the Maternity Team, confirming confidence in the robustness of the evidence. Ms J Tomkinson (JT), Chief Executive Officer thanked NM, Catherine McClennan (LMNS), and Clare Fitzpatrick (LMNS) for their work. She reflected on the Trust's previous experience, where compliance standards changed after submission, and asked whether the team was assured that this year's submission would be fully retained. NM provided clear assurance that the Trust is fully compliant, noting that while last year a query was raised, no funds were reclaimed, and this year's evidence position is stronger and has been externally validated. CM (LMNS) advised that although LMNS does not review Safety Actions 1, 2, and 10, all other actions had been reviewed, showing full compliance. She noted that, compared to last year, the Trust had "done really well," with only the expected caveats due to the areas LMNS does not validate. NM added that the team now uses the Perinatal Review Tool, and early evidence shows compliance for Safety Actions 1 and 2, with Safety Action 10 (MNSI) demonstrating timely referrals and full compliance. All three of these are being reviewed externally as part of national processes. The Board **approved:** • The final compliance position for MIS Year 7; and • Authorisation for the Chief Executive Officer to sign the MIS Year 7 Board Declaration Form for submission to NHS Resolution *CM and CF exited the meeting.*	

14.	**Maternity Survey Results 2025**
	
	Ms N Macdonald (NM), Director of Midwifery presented the maternity survey results highlight report. A total of 97 responses were received, representing a 38% response rate. NM highlighted that the overall Trust performance was broadly in line with national peers, with 44 out of 57 questions rated "about the same" as other trusts.
	
	Strengths identified included:
	• Strong Labour & Birth experience, with several indicators scoring above the national average, including:
	  ○ Concerns being taken seriously
	  ○ Multidisciplinary teamwork
	  ○ Not being left alone at worrying times
	  ○ Partner involvement, scoring 10.0
	
	Areas requiring improvement aligned with national themes and included:
	• Choice of place of birth, mental health support, and personalised antenatal care information	

	• Postnatal ward experience, particularly delays in discharge, partner presence, and access to staff NM emphasised that many areas identified in the survey were already being addressed prior to receiving the results. Work had commenced on: • Induction process improvements • Revised discharge processes • Implementation of the LMNS booklet • Strengthened perinatal mental health support • Combining maternity assessment areas to improve timeliness and responsiveness These actions are consistent with the Maternity Quality Improvement Plan and triage/early-labour developments described in the report. Mrs S Corcoran (SC), Non-Executive Director noted that discussions within safety meetings and with the Maternity and Neonatal Voices Partnership (MNVP) reflected a shared view that maternity services were progressing well. SC was confident that the improvements underway would result in a measurable shift in next year's survey results. A staff governor in attendance asked if the 38% response rate could be improved. NM agreed that increasing response rates was a priority and that more internal promotion of feedback opportunities could support this. Ms S Pemberton (SP), Director of Nursing and Quality/ Deputy CEO thanked NM for her leadership and acknowledged the contributions of Clare Fitzpatrick (CF) and Catherine McClennan (CM), whose support had been instrumental in progressing the maternity improvement work. CM recognised the significant investment made by the Trust, particularly noting the impact of the new Women & Children's Building, which has significantly enhanced privacy, dignity and partner presence via single en-suite rooms. She expressed her satisfaction with the progress made and emphasised the importance of sustaining this trajectory. The Board of Directors: • **Noted** the survey results and thematic learning • **Noted** the identified areas for improvement • **Noted** a co-produced action plan will be created with the MNVP	
15.	**Integrated Performance Report (IPR)** **Operational Performance** Ms C Chadwick (CC), Chief Operating Officer provided an update on operational performance. In summary: • 62-day cancer performance above target; 31-day standard met. • 28-day cancer Faster Diagnosis Standard (FDS) slightly under the 80% target but remains the strongest performance for some time. • Significant increase in suspected skin cancer referrals linked to the introduction of AI triage, though with a low conversion rate. This has	

	created pressure on FDS and Referral To Treatment (RTT) pathways. CC confirmed the Trust is not in tiering for cancer. • English and Welsh RTT waiting lists reducing, with a *sustained downward trajectory* aligned with the RTT report graphs. • SPRINT validation: Trust paid £33 per case for additional validation and clock-stops. Trust performing above Cheshire & Merseyside average, supporting improved triage through Consultant Connect. • 18-week performance: slightly off trajectory in December but 52-week waits continue to reduce. CC referred to further provider collaborative funding opportunities to support recovery and indicated the December flatline in performance is expected annually. Additional plans are being developed to return to 60% compliance, with further investment in Consultant Connect to enhance referral vetting and advice/guidance. • UEC: Significant increase in non-elective attendances, with January 2026 showing a trajectory of 900+ more attendances in comparison to January 2025. • 4-hour UEC performance remains significantly below plan. • 12-hour performance improved against plan but remains far from target • Ambulance handovers: o Historically strong but beginning to deteriorate; January 2026 average now 48 mins vs 31 mins in December 2025. o Despite this, NHSE benchmarking places the Trust in the top 10 most improved Trusts year-on-year. o Corridor care had improved earlier but worsened slightly in January 2026. • CC noted significant progress in reducing bed occupancy bottlenecks, but operational pressures remain with high use of escalation beds. Mr P Jones (PJ), Non-Executive Director asked about learning from the doctor strike periods and whether improved ED performance could be attributed to different staffing models. CC noted that attendance patterns vary greatly. During strikes, senior decision makers are more present, increasing discharge rates and lowering admissions. Dr N Scawn (NS), Medical Director reiterated that performance improvements stemmed from increased senior clinical decision making but emphasised existing rota gaps and concerns about replicating intensified decision-maker models sustainably. PJ queried whether the strike-period model should be adopted. NS and CC responded that workforce constraints and affordability limit replicability. Recruitment challenges remain; even if funded, the Trust may struggle to fill posts. Ms S Pemberton (SP), Director of Nursing and Quality/ Deputy CEO emphasised the need to modernise the model of care, reflecting what worked effectively during strike periods and encouraged defining what the future model of care should look like for patients and staff.	

	Ms W Williams (WW), Non-Executive Director raised feedback from doctors stating stronger standard operating procedures (SOPs), especially around *discharge before escalation*, and improved training, would be helpful. Ms V Wilson (VW) agreed that strike-period service model is not sustainable long-term; however, encouraged exploring skill-mix changes and new models of care, alongside challenging existing practice that sits outside agreed models. Mrs K Edge (KE), Chief Finance Officer supported redesign of operational models and encouraged innovative thinking. SC stressed the need for consistent behaviours across all teams to support decision making and clinical models. The Chair described the Trust's operational position as requiring radical action with some operational metrics providing limited assurance. The majority of issues originate in urgent care, creating hospital-wide impact. He suggested learning from other organisations and a refreshed approach to planning, assumptions and urgent care management. Prof A Hassell (AH), Non-Executive Director asked about the contribution of GIRFT (formally ECIST) in shaping models of care. Mr D Nash (DN), Director of Delivery noted ongoing GIRFT engagement including work on length of stay, outpatients transformation, and acute medical model. The NHS Model Health System benchmarking is also being used to support redesign. AH queried whether GIRFT had visited the emergency department. CC confirmed GIRFT have undertaken tests of change and continue to offer regular support. CC and SP are reviewing discharge functions and potential economies of scale arising from GIRFT recommendations. Ms J Tomkinson (JT), Chief Executive Officer suggested inviting the GIRFT team to present to the Board as they had to the Executive Team at a recent meeting. She noted that despite significant improvements delivered through intensive support, this is not reflected in the performance within the league tables. **ACTION:** CC to arrange for GIRFT to present to Board regarding their work in UEC. Mr P Williams (PW), Non-Executive Director emphasised the need to examine what elements of the strike model could realistically translate into everyday practice, suggesting dedicated Board time to explore future operational models. **Quality** Ms S Pemberton (SP), Director of Nursing and Quality/ Deputy CEO presented the Quality update: • No Serious Incidents (StEIS-reportable) were recorded in December 2025. • Increase in overall falls including four falls with harm, each resulting in fractures and occurring across four separate clinical areas. SP emphasised that all pressure ulcer and fall incidents receive in-depth review. • SP reported concerns regarding pressure ulcers originating in ED. There had been a rise in hospital-acquired pressure ulcers (PU) and a rise in	**CC**

	pressure ulcers present on admission. ED is a priority focus, with weekly pressure ulcer reviews and emphasis on early skin inspection and mattress allocation. • C'Difficile remains below trajectory and all cases are reviewed and monitored. • There has been a reduction in open complaints, though many originate as concerns and escalate. SP highlighted strong performance in the inpatient survey, whereas ED complaints frequently relate to waiting times and impacts the overall experience for patients. SP acknowledged poor patient experience in ED but emphasised that ward-based care is consistently rated positively. • SP explained that the Trust's external Friends and Family Test (FFT) provider has stopped analysing postcard feedback, causing delays in data processing. Internal solutions are being explored to support and improve feedback capture. • SP confirmed that the Trust is still awaiting the outcome of the recent CQC inspection. Mrs S Corcoran (SC), Non-Executive Director raised concerns about reconciling poor ED experience data with GIRFT observations. SP responded that quality indicators improve when flow is steady. When attendances surge, operational pressure redirects focus to discharge and flow, impacting quality indicators. Work is also ongoing to support the matron role being refocused on quality and safety. Mrs W Williams (WW), Non-Executive Director asked about the pressure ulcer specialist team and if there was an increased focus on ED. SP confirmed there are ED focused meeting and teams understand what needs to be done, but demand and time pressures reduce feasibility. It is understood that prevention is key. **Safety** Dr N Scawn (NS), Medical Director presented the Safety update: • Although significant work was undertaken last year to improve e-discharge timeliness, progress had plateaued. Following re-implementation of the process, compliance has now increased to 76%. General Surgery and Acute Medicine remain the most pressured specialties. A new multidisciplinary working group has been established involving GPs, clinicians and pharmacists to ensure discharge summaries consistently meet end-user needs. • Overall Trust mortality remains within expected parameters, but Stroke remains an intermittent outlier as presented earlier in the meeting. • NS noted the positive impact of the Cerner "hard stop" for sepsis, which now requires mandatory completion of key steps before clinicians can progress in the record. This has significantly improved compliance with sepsis bundles. The Chair commended the positive progress with sepsis.	

People

Ms V Wilson (VW), Chief People Officer presented the People update:

- Sickness has increased over winter, though not to the levels seen in previous years. Sickness is mainly short-term, with cold/flu and anxiety key causes; overall the largest driver remains stress and anxiety.
- Turnover is below the Trust's 10% target with the exception of Healthcare Assistants (HCA)
- Appraisal compliance is achieving target and mandatory training remains above 90%.
- Positive position on agency spend, particularly in nursing.

The Chair asked about comparison to other trusts with regards to sickness. VW stated COCH remains one of the better performing trusts, though continued reduction is a priority.

WW raised concerns about persistent stress/ anxiety despite wellbeing support being in place but recognised that external pressures also impact staff. VW noted much long-term sickness is related to local factors and confirmed a new Sickness Absence Policy has been agreed, including tools and supportive conversations to help reduce duration.

PW asked whether stress/ anxiety was concentrated in any service. VW confirmed it is spread across the Trust.

PW further asked about managerial support. VW confirmed that People Services and the wellbeing team provide structured support for managers.

Ms A Simpson (AS), Non-Executive Director asked whether there is a link between sickness and staff being moved between wards. VW noted no formal data, but strong staff feedback that frequent movement is unpopular and impacts on absences. SP corroborated that this is a significant contributor to sickness, noting operational pressures often force staff redeployment, and that sickness management sometimes becomes de-prioritised when balancing safety and flow. SP is developing a proposal to be reviewed through the Executive Director Group regarding staffing escalation areas.

Finance

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

- KE reported a £24.6m deficit against a planned deficit of £14.4m, a £9.8m adverse variance.
- She reminded the Board that Deficit Support Funding (DSF) is only provided where the Trust is delivering its plan.
- Excluding DSF, the Trust is on plan although at Month 9 there is slower-than-required progress in identifying and transacting CIP schemes. The overall financial position has been supported by non-recurrent measures, including technical opportunities and positive VAT rebate income, but the underlying requirement remains to deliver CIP recurrently.

	• Capital spend is on plan at Month 9, with the Trust expecting to fully deploy its operational capital allocation. An additional £2.4m capital allocation has been received to support replacement of LED lighting across the estate; deployment is underway by the Estates team. There are no concerns regarding the ability to deliver the capital plan. • Cash remains stable, supported by access to distressed cash funding via Department of Health and Social Care cash support. Earlier distressed cash funding applications were challenged, but the last three applications have been approved, enabling the Trust to maintain minimum liquidity. • The Trust is operating at minimum cash levels, and Better Payment Practice Code (BPPC) compliance has slipped slightly, but the team is ensuring small suppliers are prioritised. SC queried why the cash RAG rating shows green. KE clarified that this reflects that the Trust is currently receiving the cash support required and agreed to confirm the underlying parameters of the RAG ratings at the Finance & Performance Committee. The Chair highlighted emergency medicine performance as a major contributor to quality, safety, morale and financial pressure. He emphasised the need for clear plans for next year, particularly around redesigning how emergency and urgent care services are delivered, given their system-wide impact. The Board **noted** the integrated performance report.	
16.	**Operational Management Board (OMB) Chair's Report – 22nd January 2026** Ms J Tomkinson (JT), Chief Executive Officer provided a verbal update, as the OMB had only met on the previous Thursday. The full Chair's AAA Report will be submitted to the next Board meeting. She referred to an alert regarding the backlog on the ophthalmology waiting list. An action plan is being finalised and will be presented to Executive Director Group this week. The focus is on understanding the clinical risk, validating trajectories, and ensuring that any growth in the backlog is controlled. The situation is expected to improve with the introduction of the Ophthalmology Patient Referral system, which will enhance pathway oversight. JT reminded members that the OMB is fundamentally an assurance forum, with each clinical division presenting updates to review performance, risks and mitigations. The most recent meeting included a robust discussion on the High Risk Report, with attention given to escalation themes and cross-divisional risks. The Board **noted** the verbal OMB Chair's report.	
17.	**Finance & Performance Committee Chair's Report –18th November 2025 and 17th December 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. In the absence of the Finance and Performance Committee Chair, Mrs K Wheatcroft (KW), Director of Governance, Risk and improvement highlighted the following: • The Board were alerted that the Trust is delivering in line with its financial plan and is forecast to deliver this with the exclusion of Deficit Support Funding (DSF) and that the cash at Month 7 (£17.6m) was expected to cover only 16 days. • The Board were also alerted to the amendments to the Board Assurance Statements which was discussed in depth separately on the Board agenda. • Significant progress in Health & Safety, referring to improvements highlighted. • Estates and Facilities continue to be monitored via the Finance and Performance Committee. KW noted the Committee received a strong and positive update, with continued oversight in place. • KW drew attention to FOI and SAR breaches, noting the high volume and complexity of requests. The Trust has strong legal advice in place to support handling and ensure compliance. The Board **noted** the Finance and Performance Committee Chair's reports.	
18.	**a) Research Update** Mr P Bamford (PB), Director of Clinical Research attended to present the Research Update and confirmed that the Research Strategy had been circulated to the Board with the papers. The strategy sets out four strategic goals: Research accessible to all, capacity and capability, partnerships, and working with life sciences. PB outlined how the strategy directly aligns with National Institute for Health and Care Research (NIHR) national priorities, including capacity building, multiple long-term conditions research, and addressing underserved areas. Ms A Simpson (AS), Non-Executive Director commented positively and welcome the new strategy. PB reported that funding reduces year-on-year, requiring strategic alignment and diversification. The presentation outlined the three major NIHR regional funding categories: 1. Research Delivery Funding 2. Regional Research Delivery Network (RRDN) team funding including Agile Research Delivery Teams 3. Strategic funding PB added that the Hospital Delivery Budget is nationally calculated using a 50% historical, 30% activity, and 20% performance model. Recruitment weighting has been updated. Information governance limitations have caused delays in some studies. The Trust is in a safe funding position,	

	supported by additional strategic funding. £1.3m capital funding has been secured for a new cytotoxic unit. New Band 7 team leaders have been appointed to strengthen commercial research, with 10 commercial opportunities currently in progress. PB also outlined the 150-day NIHR target. PB presented the key strategic priorities: • Building research capacity and capability • Improving lives for people with long-term conditions • Bringing trials to underserved areas He highlighted opportunities to work more closely with primary care and shared early success in collaborative projects. PB shared a live example of innovation: A baby gut microbiome research grant was submitted to Innovate UK in collaboration with university partners. PB welcomed the opportunity to work more closely with the University of Chester. Ms J Tomkinson (JT), Chief Executive Officer described research as critical to the Trust's ambition to be outstanding, stressing the importance of Board understanding and support. She highlighted the commercial research opportunity as a potential "invest to save or generate" model. JT strongly supported strengthening ties with the University of Chester, citing benefits for staff, trainees and city-wide academic growth. PB agreed, emphasising the strong focus on the Trust's ambition to become a teaching hospital, as reflected in the strategy and the need for clear mechanisms to identify interested academic partners and develop joint appointments. AS welcomed the ambition and acknowledged the complexity of operationalising a renewed academic partnership. Mrs W Williams (WW), Non-Executive Director referred to the complexities of commercial research infrastructure and the ethical challenges that may arise with certain industries. She asked what support the Board could offer. PB responded that the research department will need contracting and legal entity support. The infrastructure in place over recent years should now support regional delivery. The Trust sits uniquely as the only Commercial Research Delivery Centre (CRDC) network combining primary and secondary care. WW requested short, medium and long-term planning; PB confirmed they currently hold a one-year plan and forecasting can take place as studies arrive. The Chair referred to a governor with a research background and suggested connecting with him. The Board **noted** the Research Update and **approved** the Research Strategy. *PB exited the meeting.*	
19.	**People Committee Chair's Report – 9th December 2025**	

	The Board received the People Committee Chair's report which included areas to Alert to the Board, areas where Assurance had been received, areas to Advise the Board and any new risks discussed. Mrs W Williams (WW), Non-Executive Director, presented the following highlights: • The Committee had received the latest visa sponsorship update as shared with the Board earlier in the meeting under the action log update. • WW reported that the Sexual Safety Charter will be presented to the March Board and will return to the next People Committee for further oversight. VW shared that following a recent increase in national cases reaching the media, elevating scrutiny, NHS England has issued a letter outlining expectations and resources, although the Trust has not yet received further clarification. The Trust continues to progress its local action plan, with planned completion by March 2026. • WW noted that several reports were received from People sub-committees, which she described as now functional and maturing. The Board **noted** the People Committee Chair's report.	
20.*	**Annual Health Education England Quality Self-Assessment Audit** Ms V Wilson (VW), Chief People Officer presented the Annual Health Education England (NHSE) Quality Self-Assessment Audit, confirming that Board oversight is required, and that the report had already been reviewed at People Committee. She highlighted the growing expectation nationally for Boards to maintain direct sight of key education and quality assurance processes and emphasised the need to balance the level of detail provided with ensuring appropriate Board awareness. The Board of Directors **noted** 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.	
21.*	Items for noting and receipt: ***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)	

22.	**Any Other Business** There was no other business to raise.	
23.	**Questions from Governors and members of the Public relating to items on the meeting agenda** There were no questions raised.	
24.	**Closing remarks** The Chair thanked everyone for their contributions and closed the meeting.	
	Future Dates: 31st March 2026 19th May 2026 21st July 2026 29th September 2026 24th November 2026 26th January 2027 16th March 2027	

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

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

Countess of Chester Hospital NHS Foundation Trust

Public Board of Directors Action Log

Updated March 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** – Mr 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 the Emergency Department (ED) trajectories added for the December Integrated Performance Report (IPR). **Update 24th March 2026** – There will be an end of year review of the IPR and additional trajectories implemented as we move into the new year based on the medium term plan submission.	Sept -25	**Open**

Action No.	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/ Outcome	Due Date	Status
3.	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. **Update 18th March 2026** – Learning is identified and detailed within the report.	~~Jan – 26~~ Mar-26	**Closed**
4.	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.	Added to board development plan 2026/27.	Mar-26	**Closed**
5.	25th November 2025	Director of Governance, Risk and Improvement	21.	People Committee Chair's Report – 14th October 2025	Equality, Diversity & Inclusion (EDI) to be added to the Board development plan 2026/27	Added to board development plan 2026/27.	Mar-26	**Closed**
6.	27th January 2026	Medical Director/Chief People Officer	6.	Action arising from previous action (action 7 on action log from 27.1.26)	Ms V Wilson and Dr N Scawn to explore 0.8 trainee contracts through Medical Staffing.		Jun-26	**Open**
7.	27th January 2026	Medical Director	8.	Chair's Update	Report on discharge process to be shared with the Board.	**Update 24th March 2026** – Further update to be confirmed following the Getting It Right First Time (GIRFT) Urgent Emergency Centre (UEC) visit on 25th March 2026.	TBC	**Open**

Action No.	Meeting Date	Allocated to	Agenda Item Number	Issue/Action Raised	Action Details	Action Update/ Outcome	Due Date	Status
8.	27th January 2026	Head of Corporate Governance	8.	Non-Executive Director Roles	Update Non-Executive Director (NED) roles table to reflect, Ms H Gunawickrema as Transformation Champion, Mr P Jones as Anchor Institution Champion and change Doctors Disciplinary to Maintaining High professional Standards (MHPS).	NED portfolio table updated locally.	ASAP	**Closed**
9.	27th January 2026	Chief Operating Officer	15.	Integrated Performance Report	Ms C Chadwick to arrange for Getting It Right First Time (GIRFT) to present to Board regarding their work in the Urgent Emergency Centre (UEC).		May-26	**Open**

PUBLIC – Board of Directors
31st March 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 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.

NHSE has also developed a new National quality and outcomes committee which will oversee the development of Modern Service Frameworks (MSFs) that promote new service standards for safe, effective and good patient experience. With the intent of addressing safety in respect of falls, pressure ulcers, deep vein thrombosis and the deteriorating patient, three frameworks are due for publication in this year including:

- Cardiovascular Care
- Sepsis
- Children and Young People

These will be followed by:

- Mental Health
- End of Life
- Frailty and dementia

2. Regional Updates

The Integrated Care Board (ICB) has established a new executive team and published a revised operating model reflecting the National blueprint and move toward strategic commissioning.

Considering the new fixed management cost envelope the ICB will have five core functions including:

- Clinical leadership and quality
- Health and integrated care commissioning
- Finance and commissioning
- Corporate services and governance
- Strategy and Transformation

Priorities for the ICB going forward include:

- Improving outcomes in population health
- Enhancing productivity and value for money
- Help the NHS support broader social and economic development
- Tackle inequalities in outcomes, experience and access

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

6th February 2026

The CMPC Leadership Board met on the 6th February 2026. The meeting included:

- Updates regarding the appointments to the Cheshire and Merseyside Integrated Care Board (ICB) Executive Team and the ICB operating model including strategic commissioning.
- An overview of the draft Cheshire and Merseyside ICB 5 year integrated plan with the following priorities:
    - Neighbourhood Health
    - Population Health
    - Maternity and Neonatal Care
    - Children and Young People
    - Mental Health
    - Neurodiversity
    - Frailty and Falls Prevention
    - Palliative and End of Life Care
- Transformation updates covering best value community offer, productivity opportunity around UEC (unwarranted variation), and capital prioritisation.
- Financial position, system deficit and risks, contract offers, CMPC blueprint opportunities and cost improvement planning.

18th February 2026

Chairs and CEOs attended the Leadership Board on 18th February 2026. This meeting included:

- Provider priorities ahead of the March strategic discussions with the Cheshire and Merseyside ICB and NHS England.
- The final CMPC Provider Blueprint was endorsed, confirming five strategic priorities: fragile services; financial sustainability; community offer standardisation; economies of scale; and corporate service consolidation.
- The updated CMPC governance arrangements including strengthened arrangements for Professional Groups, and key workstreams.
- Progress in respect of the blueprint workstreams.
- Financial planning across the system, the scale of the recurrent financial challenge and CIP requirements across providers.
- Digital investment updates.

4. Cheshire West

The Cheshire Health and Well Being Board has been working with partners to develop a new Health and Well Being strategy for 2026 - 2030.

The Vision for the strategy is to reduce inequality, increase years of healthy life and promote improved mental and physical health and wellbeing for everyone in Cheshire West and Chester. Priorities include

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention
- Tackle racism, discrimination and their outcomes
- Pursue environmental sustainability and health equality together

5. Cheshire and Warrington Devolution

The Parliamentary Order for the new Cheshire and Warrington Combined Authority has now been signed off by Minister Miatta Fahnbulleh MP, which means the Authority is officially up and running. A Mayor will be elected in May 2027, and the Authority will be responsible for at least £650 million of funding over the next 30 years.

Its first meeting is planned for April 2026, with local Council Leaders acting as the Board until the Mayor is in post.

Devolution is intended to bring decisions closer to home, support local businesses, attract talent and drive investment. Over the next year, the focus will be on bringing in investment, creating jobs, and improving transport to help build a sustainable, inclusive economy by 2045. This puts Cheshire and Warrington alongside other northern areas already benefiting from devolution, with a stronger voice both regionally and nationally.

Nick Walkley, previously Chief Executive of Homes England, has been appointed as Interim Chief Executive of the new Authority.

6. NHS England Letter regarding Corridor Care

NHS England wrote to all Trusts on the 4th March setting out the additional actions needed to eradicate corridor care. The Trust supports these actions and is committed to working with partners to ensure sustainable improvements can be made to eradicate the need for escalation beds in corridors.

7. NHS Oversight Framework (NOF)

NHS England published the NHS Oversight Framework segmentation and rankings for Q3 on the 18th March 2026. We are pleased to note the improvement in ranking for the Countess of Chester Hospital NHS Foundation Trust in the acute and specialist league table from 132/134 to 122/134. While league tables only tell part of the story, progress and accountability matter. The improvement reflects the hard work of our teams in tackling the long-standing challenges the Trust faces.

8. GIRFT Streaming Case Study

NHS England Getting it Right First Time team have commended the Trust on the improvements made through introduction of streaming for urgent and emergency care, with a case study published to demonstrate the achievements.

The Trust introduced Streaming and Rapid Assessment Triage (RAT) on 24th November 2025 for walk-in adult patients, which has led to improvements in time to initial assessment, resulting in a significant reduction in median time to initial assessment, as well as earlier decision making and clear safety benefits.

Whilst there is clearly more to do to improve waiting times within our emergency department this is a clear example of our commitment to improving the services for our patients.

9. PLACE Report

The outcomes of the 2025 Patient-Led Assessment of the Care Environment (PLACE) undertaken across Trust sites on 31st October 2025 demonstrate sustained improvement across most of the domains, with the Trust performing above the national average in the majority of PLACE indicators.

Performance at the Countess of Chester Hospital site in particular shows consistent improvement across all domains, reflecting the impact of the Trust's multidisciplinary approach to maintaining high standards in the patient care environment.

A small number of areas remain below national averages, primarily relating to organisational food provision and environmental accessibility at Tarporley War Memorial Hospital. Targeted improvement actions have been developed and will be monitored through the PLACE governance structure.

The PLACE programme operates as a continuous improvement feedback loop, incorporating assessment, learning, action planning and re-assessment through PLACE-Lite reviews and the PLACE Committee. This approach provides ongoing assurance that environmental quality and patient experience risks are identified, managed and improved.

10. NHS England Education Quality Assessment

The Trust has received a draft report from the NHS England Education Quality Assessment visit in November 2025. The report concludes

> *"We found no major concerns and identified no patient safety risks. The learning environment within the emergency department has dramatically improved, with learners consistently reporting a significantly better experience than previous cohorts. All doctors in emergency medicine training posts stated they would recommend the placement, describing a positive culture and strong individual support. These findings were triangulated with nursing staff, educators and governance leads, who similarly described an increasingly supportive and collaborative environment".*

The Trust had responded to stakeholder concerns through the leadership of the Director of Medical Education, addressing any gaps and improving the experience of training at the Countess of Chester Hospital NHS Foundation Trust.

11. COCH Planning Briefing Sessions

In March 2026, I held a number of briefing sessions for senior leaders across the Trust to speak candidly about where we are as we approach year end, and importantly, where we are going next.

We now have a clear and detailed five-year plan which is grounded in the NHS 10 Year Plan and aligned to national expectations. Built on a realistic assessment of our current performance and financial position, it is ambitious, but it is also deliverable - and it will require sustained focus.

This has been a challenging year, and we are not yet where we need to be, however there has been great progress. We are on track to deliver our financial plan, including £28 million in savings. We have continued to reduce waiting times by increasing activity and maintaining focus on our Urgent and Emergency Care services. There is more to do, but the direction of travel is positive.

We are also seeing meaningful improvements in patient safety. Falls have reduced, alongside reductions in pressure ulcers and infections, and we are now consistently assessing patients for their risk of developing DVT. This reflects our approach to prevention which we are continuing to take into the community.

This progress has been driven by the collective effort of colleagues across the Trust.

12. Board Leadership update

We are delighted to confirm the appointment of Mr Dan Nash as the new Director of Transformation and Productivity to the Board of Directors. This is a critical role in leading the Trust’s transformation programmes and addressing the underpinning challenges.

PUBLIC – Board of Directors
31st March 2026

Report	**Agenda Item 9a.**	**Board Assurance Framework – 2025/26 Quarter 4 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 Q4 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 the previous quarterly update: • BAF1 - quality of care (16) • BAF2 - safety and harm (16) • BAF3 - operational planning standards (16) • BAF4 - workforce (15) • BAF5 - financial plan (16) • BAF6 - capital programme (15) • BAF7 - digital transformation and infrastructure resilience (15) • BAF8 - corporate governance (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. Additional narrative has been provided regarding the trajectory for reduction and further development of this will be considered as we reset the BAF for 2026/27. 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 resetting of the patient flow group and action plan • 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 and independent internal audit review underway • Medium term integrated plan developed including financial sustainability • Digital and Data Strategy refresh and delivery of digital priorities • Research strategy developed and continued strengthening of research governance A full reset of the BAF is planned for 2026/27 taking into account the 5 year integrated plan priorities, collaboration and partnership developments, and the shift to transformation. A Board session will be held to shape this along with a review and refresh of the Risk Appetite Statement. This will be aligned to annual strategic objectives for 2026/27.
Recommendations	The Board of Directors is asked to: (i) **approve** the updates to the 2025/26 Board Assurance Framework (ii) **note** the update on progress in delivering strategic objectives

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 Q4 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.

A full reset of the BAF is planned for 2026/27 taking into account the 5 year integrated plan priorities, collaboration and partnership developments, and the shift to transformation. A Board session will be held to shape this along with a review and refresh of the Risk Appetite Statement. This will be aligned to annual strategic objectives for 2026/27.

2. BAF RISKS ALIGNED TO STRATEGIC GOALS

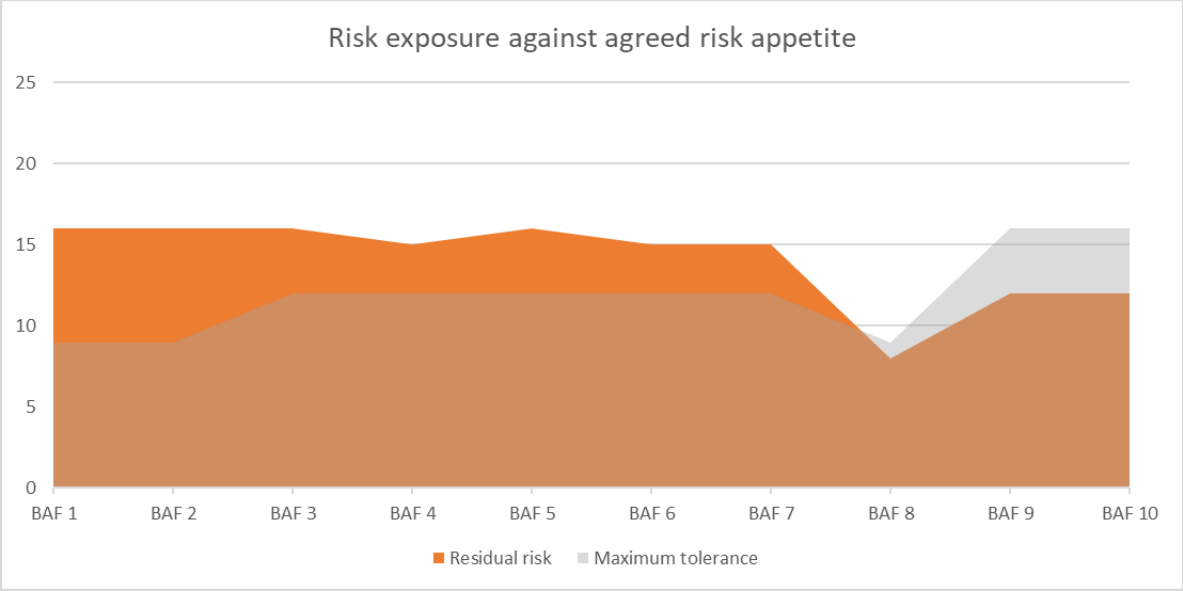
Alignment to strategic goals and objectives has been included within the BAF, with strategic objectives shaded within the key controls. The current risk exposure against the strategic goals is summarised below.

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 ⟺

7 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. Additional narrative has been provided regarding the trajectory for reduction and further development of this will be considered as we reset the BAF for 2026/27.

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

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 resetting of the patient flow group and action plan
- 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 and independent internal audit review underway
- Medium term integrated plan developed including financial sustainability
- Digital and Data Strategy refresh and delivery of digital priorities
- Research strategy developed 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 Board Assurance Framework

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

Appendix A – Summary of strategic risks above risk appetite

7 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. Additional narrative has been provided regarding the trajectory for reduction

Principal Risk	Current Risk Score	Target Risk Score	Assurance Level	Key Actions progressing	Trajectory Narrative
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 • Patient and family engagement programme being developed	**To be reviewed in 2026/27.** Reduction would be based on sustained improvements across quality and safety metrics; awaited CQC report; and roll out of Trust wide patient experience improvement framework and patient engagement events.
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	**To be reviewed in 2026/27.** Reduction would be based on sustained improvements across quality and safety priorities including sepsis.
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 • Revised governance for patient flow and reset of the action plan • Non RTT validation (including use of AI)	**March 2028.** Risk Score to be reviewed April 2027 for progress and track record of delivery of UEC target improvements. The 5 year integrated plan has been submitted with a trajectory to meet these in year 3 (28/29), but not yet accepted. The score

Principal Risk	Current Risk Score	Target Risk Score	Assurance Level	Key Actions progressing	Trajectory Narrative
					is unlikely to reduce until we can demonstrate that performance is consistently improving towards the UEC targets.
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 developed including workforce plans • Culture and leadership programme (design phase) • Training needs analysis • Talent and succession planning	**To be reviewed in 2026/27** Reduction not expected until end March 2027 given the nature of the actions and the impact needed on culture.
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 • Identification and delivery of CIP schemes, transformation and PDO.	**March 2031.** Risk Score to be reviewed November 2028, with reduction to be based on progress and track record of delivery.
BAF6. Inability to achieve the **capital programme** within a challenging and uncertain operating environment and deliver an Estates Strategy that supports the provision of our services	**15** ⟺	**12**	Partial	• Capital plan delivery 2025/26 • Capital planning for 2026/27 and future years	**2026/27.** Risk score to be reviewed April 2026 following capital planning cycle.
BAF7. Failure to deliver transformative **digital and data** solutions and performant, secure and resilient infrastructure could impact on patient	**15** ⟺	**12**	Partial	• Digital and data strategy publication • DSPT final submission • Replacement of legacy network hardware	**2026/27** The driver of the residual score is the cyber element of the risk and some key actions being driven in Q4 25/26 would be reviewed in early 26/27 to consider

Principal Risk	Current Risk Score	Target Risk Score	Assurance Level	Key Actions progressing	Trajectory Narrative
and staff experience and organisational productivity.				• Cyber security protection plan delivery • National competency framework workstreams	whether risk could be reduced (notwithstanding the nature of cyber risk being unpredictable).

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 and bi-monthly review of progress with leads. An update on progress against the Quality and Safety Strategy priorities was reported to the Quality and Safety Committee in March 2026. 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 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 has been re- aligned with a new meeting, with each area identifying priorities and taking a focus on assessing the impact of the actions taken. To ensure the whole Trust Board is aware of progress for UEC, RTT and Cancer there have been presentations at Board development sessions.
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 for roll out in 2026/27.
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 new organisational leaning policy captures all these opportunities, and considers how sharing of learning can continue to be maximised. Policy planned to be reviewed and approved through QGG in March 2026.

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 results received and action plans being developed.
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 includes 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 taking place alongside collaboration agenda through CMPC, with data collection in progress (February/ March 2026).
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 results awaited 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. Plans in place to attend Divisional forums in Q1 2026/27. 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 (likely to be delayed into Q1 2026/27). Internal audit review in progress as at Q4 2025/26.

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). 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 2025). Integrated medium term plan including financial sustainability and 5 year deficit recovery plan submitted February 2026, awaiting NHSE final review and acceptance.
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. Digital Maturity Assessment 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 approved by the 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:** March 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 and bi-monthly review of progress with leads. An update on progress against the Quality and Safety Strategy priorities was reported to the Quality and Safety Committee in March 2026. Accreditations are demonstrating improvements with the majority of areas now accredited at Silver and some at Gold.	*9*	***To be reviewed in 2026/27*** ***(reduction would be based on sustained improvements across metrics)***
									Structured approach to patient and family engagement.	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 for roll out in 2026/27.		
			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	The Trust is seeing some reductions across HCAIs. IPC compliance has improved, as supported by audit outcomes. Continuous focus is required to sustain the improvements.		
			C4) CQC regulatory compliance **Control Owner:** Director of Nursing and Quality	- Consolidated CQC and Well Led Action Plan reported to each Board of Directors - Quality and Safety Committee - Quality Governance Group via Q&S Committee - Ward accreditation reporting via Q&S	Commissioner reviews of quality (quarterly). CQC reports.	*Acceptable*		UEC CQC inspection findings and response.	(i) To deliver the warning notice action plan. **Action owner:** Director of Nursing and Quality **Due date:** Q2 (ii) To respond to the findings of the CQC report. **Action owner:** Director of Nursing and Quality Due date: Quarterly updates	Comprehensive action plan developed. 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. Full review of consolidated CQC action plan complete and remaining actions agreed by the Board as BAU (January 2026). CQC report awaited for inspection of UEC, end of life care, and acute medicine.		
BAF2 Failure to maintain safety and prevent harm would result in poorer patient care and outcomes **Executive Risk Lead:** Medical Director **Assurance Committee**: Quality and Safety Committee **Last Update:** March 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 quality and safety improvement outcomes (falls, pressure ulcers). **Action owner:** Medical Director **Due date:** Quarterly updates	Continued updates to Quality Governance Group.	*9*	***To be reviewed in 2026/27*** ***(reduction would be based on sustained improvments across metrics)***
									Evidence of consistent application of standards for Sepsis.	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 commenced in January 2026 and has shown improvements in compliance for this aspect of the metric.		
			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:** Q4	The Trust has developed a range of organisational learning through PSIRF, learning from deaths, national inquiries, clinical audit, patient safety summits etc. The new organisational leaning policy captures all these opportunities, and considers how sharing of learning can continue to be maximised. Policy planned to be reviewed and approved through QGG in March 2026.		
			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 taking place alongside collaboration agenda through CMPC, with data collection in progress (February/ March 2026).		
			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 (monthly) 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. Exec to exec meeting deferred from March 2026 (TBC).		

Risk Theme: Operational Effectiveness

RISK APPETITE: OPEN - Upper tolerance limit 12

LINKS TO STRATEGIC GOALS: SG4: Adding Value

Risk description & information	Causes & consequences	Inherent risk score (C x L)	Key controls	Board Assurance: Internal sources of assurance	Board Assurance: External sources of assurance	Board Assurance: Overall assurance level	Residual risk score (C x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score	Estimated date of achievement of target score
BAF3 Inability to deliver operational planning standards, inability to address the backlog of patients waiting could result in poorer patient outcomes, and result in financial consequences to the Trust. **Executive Risk Lead:** Chief Operating Officer **Assurance Committee:** Finance and Performance Committee **Last Update:** March 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 opening hours less than 24/7.	(I) ED - Whole system approach to hospital avoidance and supported primary care function. (ii) ED - Continued MADE (weekly) super MADE (bi-monthly) multidisciplinary discharge events. (iii) 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 has been re- aligned with a new meeting, with each area identifying priorities and taking a focus on assessing the impact of the actions taken. To ensure the whole Trust Board is aware of progress for UEC, RTT and Cancer there have been presentations at Board development sessions.	*12*	***March 2028*** ***(Risk Score to be reviewed April 2027 for progress and track record of delivery of UEC target improvements)***
			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.	Increased focus on Non RTT follow up data quality, clinical validation and delivery **Action Owner:** Chief Operating Officer **Due date:** Quarterly updates	C&M resources secured and have supported validation. Continue to focus on non RTT follow up and report through OPELG. The AI validation tool has been procured and implementation deferred to Q1 2026/27.		
									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 with 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	Action plan for Opthalmology reviewed at EDG and Division progressing actions with weekly review by the COO. Incident review processes continue. To ensure the whole Trust Board is aware of progress for UEC/ RTT and Cancer there have been presentations at Board development sessions.		

Risk Theme: Workforce

RISK APPETITE: OPEN - Upper tolerance limit 12

LINKS TO STRATEGIC GOALS: **SG2: People and Culture**

Risk description & information	Causes & consequences	Inherent risk score (I x L)	Key controls	Board Assurance: Internal sources of assurance	Board Assurance: External sources of assurance	Board Assurance: Overall assurance level	Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions: Planned action	Actions: Progress update	Target risk score	Estimated date of achievement of target score
BAF4 Challenges in ensuring a high quality, engaged, diverse and inclusive workforce and culture would affect our ability to deliver patient care. **Executive Risk Lead:** Chief People Officer **Assurance Committee:** People Committee **Last Update:** March 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. 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 phased implementation continues with expected completion by December 2026.	*12*	***To be reviewed in 2026/27*** ***(Reduction not expected until end March 2027).***
									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 includes 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 results received and action plans being developed.		
									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.	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 with clarity of the action required for 2026/27.		
			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 results awaited 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:** March 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**: Complete	Conclusion of 2025/26 annual planning process (May 2025). 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 2025). Integrated medium term plan including financial sustainability and 5 year deficit recovery plan submitted February 2026, awaiting NHSE final review and acceptance.	*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. Escalation capacity cost pressures continue but are mitigated in year by non-recurrent measures. PWC have completed a grip and control review and Trust leads were 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. CIP workshops held and schemes for 2026/27 captured. Approach to transformation being developed. Director of Transformation and Productivity recruited (March 2026).		
			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 DSF withdrawal (Q2) established. Cash preservation plan developed. Monthly updates to Board and plans in place to year end. Monthly distress cash applications are continuing and are being supported. Confirmation of DSF now received in Q4.		
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:** March 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 four year allocation advised.	*12*	***2026/27*** ***(Risk score to be reviewed April 2026 following capital 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**: Complete	Annual assessment completed Jan 2025. No further exceptional work required, with failsafe and inspections continued until decant. Full decant now achieved. Plans 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:** March 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*	***2026/27*** ***(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:** March 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. Plans in place to attend Divisional forums in Q1 2026/27. 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 (likely to be delayed into Q1 2026/27). Internal audit review in progress as at Q4 2025/26.	***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 assurance 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 2026/27. NHSE undertakings align to delivery of established plans and have been mapped to Provider licence compliance (which will be revisited at year end).		
			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. Leadership role taken on as the Convenor of the CMPC CoSec Group from March 2026.		
			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:** March 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). Health and Well being board strategy to be published in April 2026 Neighnbourhood health workshop attended	*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 Dicksion - 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. Joint Committe will consider implications from the CMPC Blueprint.		
									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 Sseptember 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:** March 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**: Complete	Research ambitions to support strategy development being aligned to the clinical strategy. Research Strategy approved by 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 processes in place to support timely mobilisation of research studies. Further work to streamline this to meet new 150 targets from NIHR which wil be integral to funding going forward. List of Standard Oprating Procedures (SOPs) in place and team engaged in further review and development including new consent SOP. Progress made to develop 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 - with increased commercial growth and income intention to have a research governance/ finance role embedded in the department.		
			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 encouraged including Trust wide engagement in system led Innovation fortnight (November 2025) and shift to transformation programmes planned for 2026/27.		

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
31st March 2026

Report	**Agenda Item 9b.**	**High Risks Report (March 2026)**						
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Karan Wheatcroft			Director of Governance, Risk & Improvement				
Author(s)	Nusaiba Cleuvenot			Head of Corporate Governance				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X** **X** **X** **X** **X** **X** **X** **X**	Potential to link to all BAF risk areas.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X** **X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Not applicable							
Executive summary	Work is ongoing to further strengthen and embed risk management across the Trust, together with a refreshed Risk Management Policy. The Risk Management Committee is now established and is working to drive risk management improvement plan actions. The current focus is on Datix reporting and alerts and reviewing Risk Management Training for roll out across the Trust. Whilst the improvement plan is progressing, the reporting of high risks continues as per the Datix system with review and update by Executive Directors. This paper sets out the current risks with a residual score of 15 or over and these risks include: • 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 • Lack of vascular hybrid theatre
Recommendations	The Board of Directors is asked to consider and **note** 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 (March 2026)

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

The High Risk Register details risk with a residual risk score of 15 and above and is scored in the following way:

Score	Count
15	5
16	7
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:

- Glaucoma waiting lists and overdue follow ups (residual score of 20)
- 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
- Lack of vascular hybrid theatre

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 9th March 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
31/12/2025	3584	Overdue Glaucoma Follow Up Patients in Ophthalmology	Planned Care	4x5	20	Risk of delayed appointments for Glaucoma patients due to lack of adequate administrative and EPR processes t o validate waitlists, and capacity to accommodate all patients waiting, within the date they are due to be reviewed. Mitigations: Full project plan developed focussing on Validation, Workforce, Capacity and EPR Improvements. This is monitored and reviewed bi weekly by clinical, administrative, digital, and operational staff, with oversight by the COO, OPELG, Finance and Performance Committee and Trust Board. Actions to date include • Failsafe Officer to validate all patients “unlisted” • Divert of all overdue glaucoma patients to the virtual glaucoma clinic.	TBC	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
						• Increase in diagnostic capacity • Development of validation scripts • Patient communication			
24/01/2025	3398	Multiple factors that could result in a Cyber Attack- several separate areas of risk that could contribute to a Cyber attack. Separate risks have been raised for these areas and this risk is to hold the overarching risk of a Cyber attack.	Digital and Data Services	5x3	15	Data Security Protection Toolkit submission for 2026 is in progress, initial submission has been completed. MIAA are reviewing phase 1 evidence with outcome expected this month (March 2026). Risk score remains at 15 whilst DSPT action plan is completed. Work continues to reduce our device exposure score (MDE), with score hitting a record low 29 against a target of below 30. National funding has been awarded for the purchase of a new internet proxy device. Supplier demonstrations have taken place and procurement process has started.	March 2026 (in line with DSPT action plan)	Jason Bradley	Finance & Performance Committee
10/06/2024	3260	Risk to patient safety due to lack of adherence to NHSE 4 hour Emergency	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	Sept 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
		Department standard				significantly improved during February 2025 and this has remained consistent. Work continues to reduce the waiting times for a bed to under 12 hours.			
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.	Sept 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
						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. Risk remains due to planned care funding being prioritised between resolving risk and CIP. No further	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
						update although overall Trust CIP risk has been mitigated through non-recurrent measures in 2025/26.			
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 30-90 patients daily. Potential for worsening position due to closure of beds in September 2025. Highly reliant on reduction in NC2R position.	Sept 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. Distress cash funding has been received during the year and the Trust is also receiving remaining deficit support funding for 25/26 due to forecast delivery of the financial plan and compliant 26/27 financial plan.	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
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 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.	Diagnostics and Clinical Support	4x4	16	The mitigation is to develop integration between the Microbiology Telepath system and the Cerner EPR. There is an underlying issue with technical support for Microbiology which is being reviewed with WUTH. Long term solution is the move to the ICS wide single pathology system. Approval has been given for short term resource from WUTH to work with us to develop the microbiology integration between Telepath and our Cerner EPR. Development work has completed and has been tested and go live expected during March 2026. Division have reviewed risk an confirm it is still at 16.	March 2026	Jason Bradley	Finance & Performance Committee
01/01/2024	3255	Dialysis machine past the recommended life span resulting in more frequent repairs.	Urgent Care	3x5	15	Dialysis machines have been included and prioritised in the 2026/27 capital programme. Procurement activity will commence beginning of April with expectation of delivery by end of Q2.	Q2 2026/27	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
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 Less Than Full Time 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	4x4	16	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.	Q2 2026/27	Nigel Scawn	Finance & Performance
22/12/2025	3581	Lack of Vascular Hybrid Theatre impacting on both staff and patient safety	Planned Care	4x4	16	Review of led gowns in progress. Theatre development work continues to ensure all funding streams explored.	TBC	Nigel Scawn/Jon Develing	Quality & Safety

Countess of Chester Hospital NHS Foundation Trust

Committee Chair's Report

5th March 2026, 9.30am – 122.30pm, 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)*

- Performance against Urgent Emergency Care (UEC) constitutional targets and the impact of demand on the emergency department. There is a continued focus on UEC Care Quality Commission (CQC) action plan and consistency of performance metrics including risk assessments.
- Two areas of sustained good performance worthy of highlight:
  - Perinatal services quarterly report providing assurance on continued compliance with the Maternity Incentive Scheme (MIS) safety actions as well as Perinatal and Maternity Review Tool (PMRT) and Saving Babies Lives.
  - Safeguarding and complex care quarter 3 report providing assurance on ongoing compliance with legal requirements and regulatory standards. Significant increase in complexity and increases in both child and adult referrals noted in quarter 3.

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

- Overview of coronial inquest learning and how this is being developed, recognising there is more to do to fully implement this.
- The Emergency Department (ED) resuscitation space risk assessment provided, with a request for assurance on mitigations to the next committee meeting.
- UEC CQC assurance report providing an update on the action plan delivery, gaps and performance indicators.
- Integrated Performance Report (IPR) demonstrated ongoing improvements in several key quality metrics as well as highlighting persistent challenges in sepsis screenings, pressure ulcer prevention, risk assessment compliance, and complaints management. Patient flow and emergency department performance continues to be highlighted as an area of concern. Discussion included level of concerns and themes of communication with patients, with the Patient Engagement Portal being discussed as an opportunity to improve this.
- Quality Governor Group (QGG) providing an overview of the work of the committee, with alerts on Venous thromboembolism (VTE) compliance; performance against quality and safety priorities; and transfusion compliance.
- Progress against quality and safety strategy priorities.
- Safety surveillance report proving an overview and learning from incidents, complaints and concerns, learning from deaths and coroner's inquests, and Patient Safety Incident Investigations (PSIIs).

- Paper on discharge summaries within 24 hours setting out the improvement but recognising the need for further digital developments to improve this further and ensure this is sustained.
- Sepsis compliance update with screening compliance improved to over 90% following implementation of hard stop on Cerner. Timeliness of antibiotics continues to be an area requiring improvement.
- Assurance on National Institute for Healthcare and Excellence (NICE) guidance update, review and actions.
- Cancer Services Group Chair's report including cancer reviews as an alert but provides some assurance on the reduction in the outstanding cancer harms reviews.
- Ionising Radiation (Medical Exposure) Regulation (IRMER) update including number of reported incidents (all low or no harm), CQC reportable incidents, and governance.
- Patient Safety Incident Response Framework (PSIRF) Mersey Internal Audit Agence (MIAA) action plan update confirming progress against audit recommendations.
- Paediatric ED update providing an update on actions from the CQC feedback and a wider overview of compliance with the Royal College of Paediatrics and Child Health (RCPCH) standards, gap analysis and action plan.

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

- The new Maternity Outcomes Signal System (MOSS) is now live. The system developed by NHS England provides near-real-time oversight of maternity outcomes and identify emerging risk signals. We are now using MOSS with senior clinical oversight and assurance through established maternity governance arrangements.
- Liberty Protection Safeguards (LPS) are a planned legal framework to replace Deprivation of Liberty Standards in England and Wales for people 16+ who lack mental capacity to consent to care arrangements (early 2026).
- The trust is struggling to move forward with patient safety partners

Risks discussed and new risks identified

- Reviewed the Board Assurance Framework (BAF) and high risk report in context of quality and safety agenda. Risks continue to be scored above risk appetite.

PUBLIC – Board of Directors
31st March 2026

Report	**Agenda Item 11.**	**Freedom to Speak Up Report (FTSU)**						
Purpose of the Report	Decision		Ratification		Assurance	X	Information	X
Accountable Lead	Cathy Chadwick			Chief Operating Officer				
Author(s)	Helen Ellis			Freedom to Speak Up Guardian				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			X X X X	BAF impact is that the Freedom to Speak Up Vision and Strategy offers a supportive framework to 'speak up' about issues in the workplace. This will contribute to the Trust's work to improve culture, morale and provide learning on how the Trust can improve services.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							X X X
CQC Domains	Safe Effective Caring Responsive Well led							X X X X X
Previous considerations	People Committee – Tuesday 10th February							
Executive Summary	This report provides assurance to the Board that the Freedom to Speak Up (FTSU) arrangements at the Countess of Chester Hospital NHS Foundation Trust continue to reflect national best practice and support a culture of openness and psychological safety. Key highlights include: • **Staff engagement:** Nurses remained the most active group, • 96% of concerns were raised by colleagues in non-management positions. Champions report that more colleagues, including managers, are sharing concerns, however there are a number of these colleagues that do not wish to take their concerns any further once they have had a chance to discuss them with a Champion. From April 2026 the FTSU Guardian will be attending Operational and Performance Executive Led Group (OPELG) each quarter to discuss any themes with the Divisional Directors and Divisional leaders and pick up on how changes are being communicated. • **Quarter 1-3 update**: Eighty-five concerns were raised, an 11% reduction on the same period last year. Patient and staff safety are							

	cited as key themes. No concerns cited sexual safety. All concerns are concluded. • **Governance and leadership**: Strong executive oversight continues, with regular reporting to the Board and sub-committees. All thirty-five actions within the FTSU Action Plan have been completed. • **Training compliance**: Most staff groups exceed the ninety percent compliance target for mandatory FTSU modules, Medical and Dental are slightly below the threshold for 'Listen Up' whilst Estates and Facilities although continuing to improve remain below on both modules. • **Champion network**: Over sixty champions support staff across the Trust, with newly developed divisional hubs providing greater peer support, improved learning and clearer identification of localised trends and themes. • **Education and Training**: FTSU is now embedded within both the Essential Managers and Aspiring Leaders programs. There are also established links with Chester University's Nursing Course. The FTSU Action Plan remains a key driver for ongoing development, improvement, and embedding best practice across the Trust.
Recommendations	The Board of Directors is asked to **note** the report and receive assurance that local FTSU arrangements are in place and continue to meet best practice.

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

Freedom to Speak Up Report (FTSU)

1. Introduction

This paper provides the Board with an update of the work of the Freedom to Speak Up (FTSU) Guardian and Champions in supporting the safety culture within the Trust, reflect on the progress made by the FTSU Network in empowering staff to speak up freely and to encourage ongoing positive cultural change. An overview of data for Q1-3 2025/6 compared to the previous year will be provided in line with National Guardians Office (NGO) recommendations. An update on the progress of the FTSU Action Plan and mandatory training compliance together with information on the future of the NGO will be included.

2. Background

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

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

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

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

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

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

3. Purpose

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

4. National Guardians Office

The National Guardian's Office is an independent, non-statutory body with the remit to lead culture change in the NHS in England and sponsored by the Care Quality Commission, NHS England and NHS Improvement. In July it was announced that as part of the 10 Year Health Plan for the NHS the NGO is to be abolished. Currently it is anticipated that the office will remain open until June 2026 and continue to undertake its full function. Further updates will be shared as they are announced.

5. Overview of FTSU concerns 2025-26 Q1-3

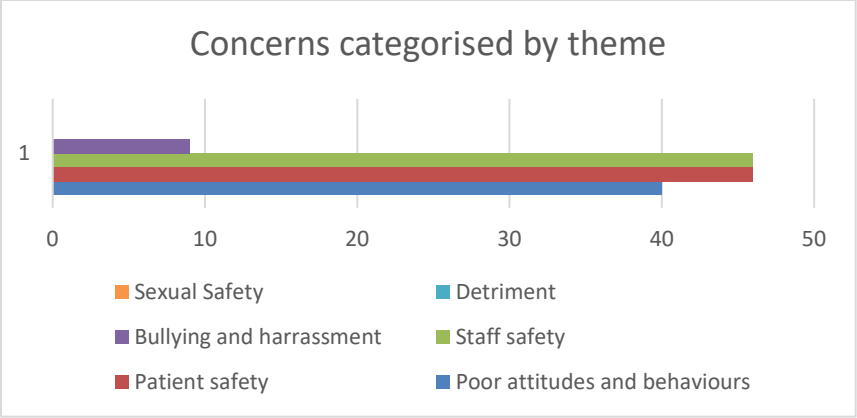
The trust has several safety reporting channels such as speaking directly to line managers, incident reporting and team and trust safety huddles. Issues raised in other channels are not logged as FTSU unless referred to or raised directly to the FTSU Guardian or champions.

During the reporting period 85 concerns were raised, a reduction of 11% for the same period last year.

Of those reporting concerns over 96% were raised by colleagues in non-management positions. 87% of those colleagues reported that they were satisfied with the support offered through FTSU, however this does not indicate satisfaction with the outcome. The remaining 13% did not respond to the survey.

Q3 saw the highest number of concerns (41), however 16 of those related to the same concern. In Q1 76% of concerns were raised by colleagues in non-clinical posts, whilst in Q2 and Q3 only 10% were raised by the same cohort.

Concerns are categorised in line with NGO recommendations. It is important to recognize that most concerns contain more than one element.



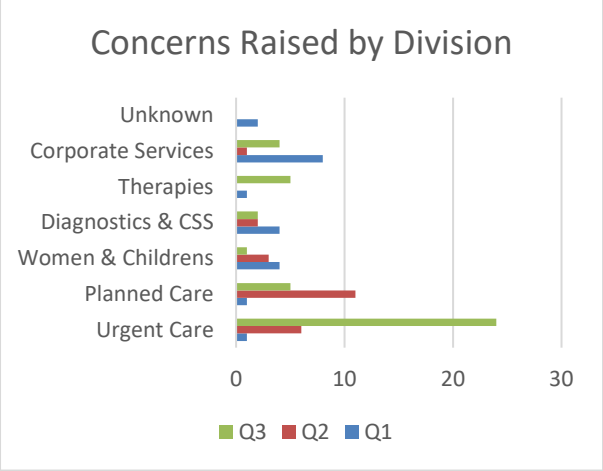
This year concerns that report an element of sexual safety are now recorded. This data feeds into the People and Culture Sub-committee.

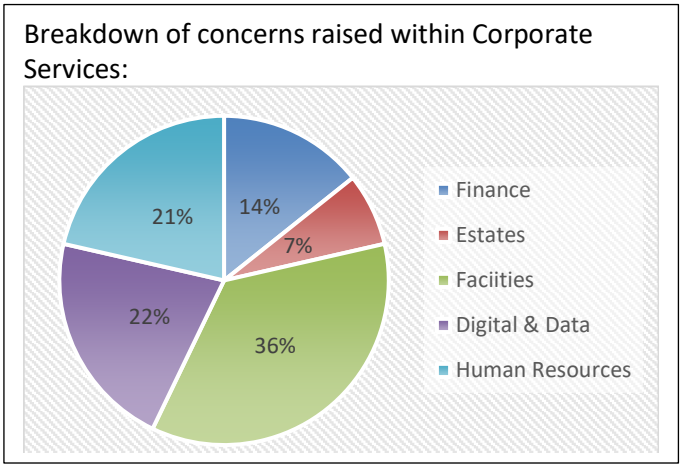
Themes :

There are six main themes that have been identified including:

1. Delays in HR processes with perceived lack of updates and support.
2. Concerns raised through management structure with colleagues feeling they have not been listened to and agreed action not being taken. Limited if any, feedback or monitoring.
3. Changes to structure/ staffing that is perceived to negatively impact on patient and staff safety. All these have previously been raised with little or no response from managers.
4. Poor behaviours, including bullying that have not resulted in improvement.
5. Continuation of concerns received from colleagues from within one department regarding staff and patient safety issues.
6. Increase in patient acuity, lack of staff and inadequate skill mix.

Data is now categorised by Division, which will be shared with senior leaders to support triangulation of local information and support greater dissemination of learning. Progress of this approach will be reported in September.





Other key Observations:

- All concerns during this period have been concluded with agreement from those that raised the concern.
- Nurses and clinical support staff raise more concerns than any other staff group, a similar pattern to other years.
- Only 3 concerns were reported anonymously, a reduction of 2 from the previous year.
- Champions report that more colleagues, including managers, are sharing concerns, however there are number of these colleagues that do not wish to take their concerns any further once they have had a chance to discuss them with a Champion. From April 2026 the FTSU Guardian will be attending Operational and Performance Executive Led Group (OPELG) each quarter to discuss any themes with the Divisional Directors and Divisional leaders and pick up on how changes are being communicated.

7. Progress on Internal Assessments and Governance

Cathy Chadwick, Chief Operating Officer and Paul Jones Non-Executive Director continue to have executive leadership for FTSU. The Executive lead, Chief People Officer and the Guardian convene meetings when complex cases of concern involve HR services. Support and service review meetings between the Executive lead and Guardian are held monthly as a minimum.

The FTSU policy has been reviewed, and it is currently subject to the trust governance forums for sign off.

FTSU reports are also submitted to the Trust Board bi-annually, People and Culture Sub-Committee quarterly and the Audit Committee and Quality and Safety Committee annually.

8. Freedom to Speak Up Action Plan:

The Trust Board approved an updated FTSU Action Plan in January 2025 and continues to act as a driver for further service development and improvement. Progress has been overseen by the People Committee, with progress reported to Board. All actions have now been completed. Following the Board's FTSU bi-annual self-assessment due to be completed later in the year any further actions identified will form part of an updated plan.

9. FTSU Mandatory Training

'Speak Up' is now at 95.99% with only Medical and Dental (92.54%) and Estates and Facilities (78.57%) recording less than 95%. 'Listen Up' has reached 92.15% an increase from 89.94% when last reported. Medical and Dental and Estates and Facilities compliance has significantly increase however still do not meet the target of 90% set within the FTSU action plan. 'Follow Up' mandated for Board members currently stands at 100% compliancy.

10. Freedom to Speak Champions Network

The network of over sixty champions continues to provide an alternative for colleagues wanting to either raise a concern or just understand more about Freedom to Speak. In addition, champions are a voice within their own teams, taking time to share information at local meetings and during new staff inductions. Champions training is held three times a year and facilitated by the FTSU Guardian.

Nine Divisional Hubs have been established, bringing together champions working in similar areas. This strengthens peer support, local knowledge and learning. Hub details have been shared with Divisional Directors for dissemination and uploaded onto the FTSU intranet page.

Data relating to concerns within each division will be shared quarterly with Directors to help triangulate themes, trends and learning with those concerns shared with managers.

The network continues to represent diversity and works collaboratively with the EDI agenda. Champions are working towards 100% compliance with Sexual Safety training by the end of

February. Data is now collected from individuals who speak up regarding gender, disability and ethnicity and this will be shared quarterly with the EDI lead.

10. Education and Learning

FTSU sessions are now included within the Managers Essential and Aspiring Leaders programs with an additional offer of FTSU workshops for managers on request. The Guardian continues to hold workshops for students and new nurses to the trust throughout the year. Annual sessions are delivered at Chester University during the student nurse induction period prior to clinical placement.

11. Outcomes and Learning

Following the People Committee meeting in February 2026 it has been agreed that a small group of colleagues, including the FTSU Guardian, will triangulate outcomes from FTSU concerns and other ways in which concerns are raised to give an overview of outcomes and learning. These will be added to future FTSU reports.

12. Conclusion

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

The FTSU Guardian, supported by the network of champions, continues to maintain engagement with colleagues across the organisation to raise the FTSU profile, support staff who have raised concerns, record and follow-up cases raised and wherever possible identify and disseminate learning. Quarterly data will continue to be submitted to the NGO until further guidance on new reporting channels is published.

Monthly FTSU blogs continue to be posted to all staff. The FTSU Action Plan will continue to be the driver for ongoing development and improvement.

The champion's network continues, providing colleagues with greater choices on how to raise concerns.

The FTSU guardian will continue to provide reports to the Board of Directors and its associated committees. The FTSU guardian will continue to maintain engagement with regional networks.

13. Recommendation

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

PUBLIC – Board of Directors
31st March 2026

Report	**Agenda Item 13.**	**Safety Surveillance and Learning Report – Quarter 3 2025/26**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	**X**
Accountable Executive	Sue Pemberton			Director of Nursing and Quality / Deputy Chief Executive				
Author(s)	Fiona Altintas			Deputy Director of Nursing, Quality & Governance				
Board Assurance Framework (BAF)	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X**	This assurance paper has a positive impact on BAF 1, 2 and 8			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Quality and Safety Committee 5th March 2026							
Executive summary	The purpose of this paper is to inform and provide assurance that the Trust is a learning organisation and has robust governance and assurance structures in place to identify and highlight risk, identify themes and present changes in practice where progress can be monitored and any concerns escalated. The Trust continues in its journey with PSIRF, reviewing and changing processes as required. In Quarter Three, the Trust reported 3042 incidents. This is an increase in the number of incidents compared to the previous quarter. No and low-level harm incidents make up 93% of all incidents reported, with 5% being moderate incidents and 1% being severe and catastrophic. The Trust has seen an increase in moderate harms in the last quarter, however, there has also been a reduction in severe and catastrophic harm incidents.							

	Progress of review of moderate and above-patient safety incidents are managed through the weekly Patient Safety Oversight Meeting. In 2025/26 to date, the Trust has reported 7 incidents to StEIS and patient safety incident investigations (PSIIs) are progressing, including a Never Event reported in January 2026. The Trust has seen a reduction in the number of reportable StEIS incidents this year, compared to the previous year. Work is ongoing to increase the number of incidents reported through the national LFPSE processes. Process and governance surrounding coroners' inquests continue to improve, including preparation and oversight. Priority is being given to reduce the backlog of mortality reviews, which is being led by the Deputy Medical Director. The Quality, Safety and Experience Strategy will further support the quality, safety and experience culture in the Trust by providing clarity on the priorities with the first assurance report presented to the Quality and Safety committee in March 2026.
Recommendations	The Board of Directors is asked to: • **Note** the assurance that the Trust is continuing to report and review incidents and promote a learning culture with evident and measurable actions to improve patient safety. • **Note** the improvements and sustainability in governance and oversight within the Countess of Chester Hospital • **Note** further improvement workstream in progress regarding Learning from Deaths and Mortality Review • **Note** the status of all StEIS/PSII reportable incidents

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

Safety Surveillance and Learning Report – Quarter 3 2025/26

1. Introduction

The Trust has recently reviewed and updated Its Patient Safety Incident Response Framework policy and plans. The Trust can demonstrate significant oversight and assurance regarding incident management, oversight and learning through a variety of forums.

In the Learning and Sharing forums, an overview of incidents and learning is presented by all divisions, learning from complaints, Trust oversight and triangulation of themes, and an overview of medication incidents, learning and improvement workstreams.

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

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

The new Quality, Safety and Experience Strategy has 26 priorities identified through data collection and analysis of patient and staff surveys, complaints and concerns and

patient safety incidents. Updates are received from these through a variety of routes and assurance committees and are presented at the newly formed Quality, Safety and Experience Strategy monthly meeting.

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

2. Background

The Trust is strengthening its governance and assurance as it continues to embed the Patient Safety Incident Response Framework (PSIRF) A fully established governance forum is the weekly Patient Safety Oversight Meeting. This provides scrutiny and oversight at an Executive level of learning responses of moderate and above harms. A monthly learning and sharing forum allows divisions and teams to present learning from incidents, identifying themes and improvements in patient care. Subsequent learning responses are shared, which guide and provide direction to changes in practice. This promotes patient, families and carers and staff safety and overall experience and in turn, reduces patient and staff safety risk. It also provides a trust wide forum for learning to be shared.

3. Purpose

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

4. Safety Surveillance Quarter Three 2025/6

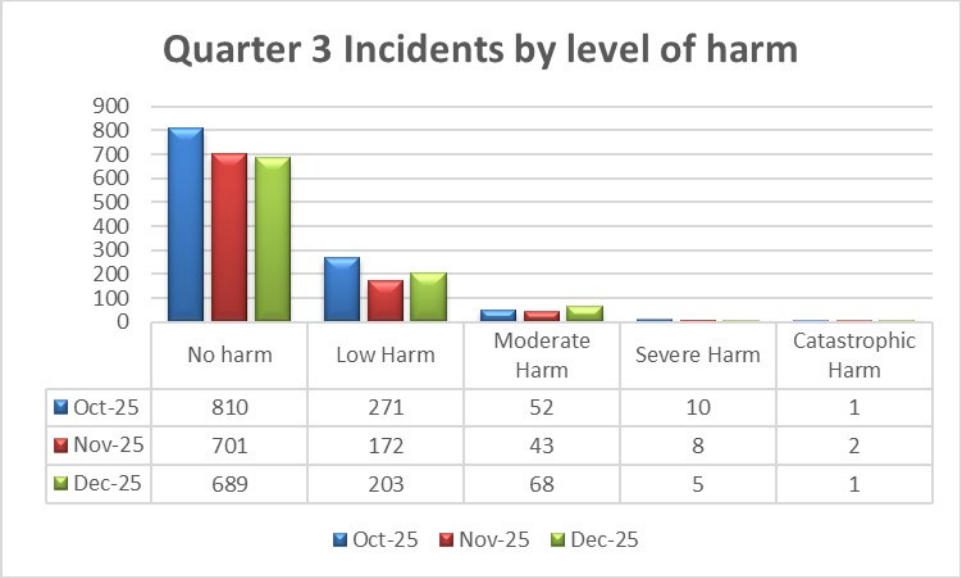
Incident Analysis

In Quarter Three, the Trust reported 3042 incidents. This is an increase from the previous quarter. No and low-level harm incidents make up 93% of all incidents reported, with 5% being moderate incidents and 1% being severe and catastrophic. This is demonstrated in both Graph 1 and Graph

2. We have seen an increase in moderate harms, but a reduction in severe and catastrophic harm incidents.

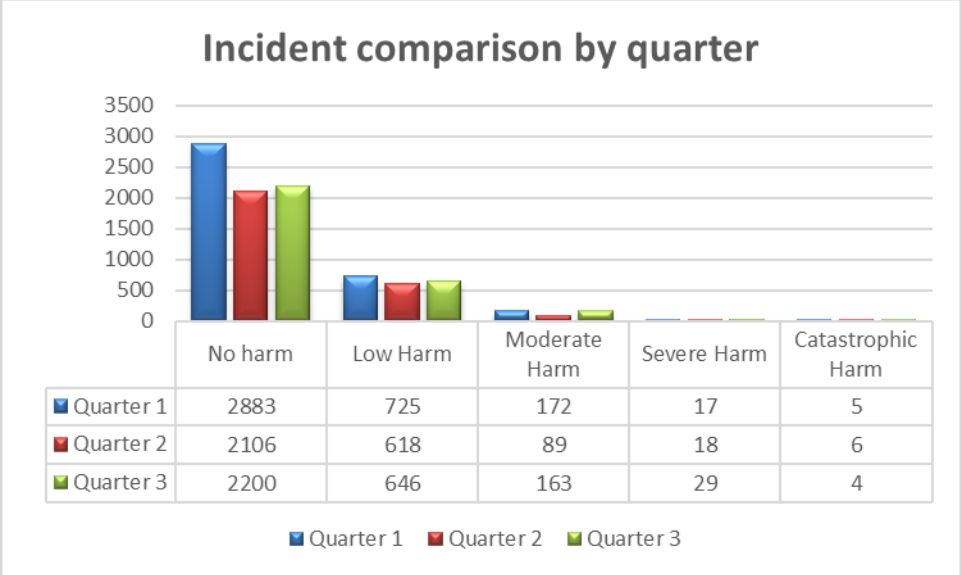
Variance is monitored and themes identified. and there are a variety of reasons that can be articulated to explain this variance, e.g. months with Bank Holidays, peaks of high annual leave (i.e. summer holidays) and there are some departments that submit many incidents at one time – e.g. pathology, catering and pharmacy, all which can all have an impact on overall reporting numbers.

Graph 1



	No harm	Low Harm	Moderate Harm	Severe Harm	Catastrophic Harm
Oct-25	810	271	52	10	1
Nov-25	701	172	43	8	2
Dec-25	689	203	68	5	1

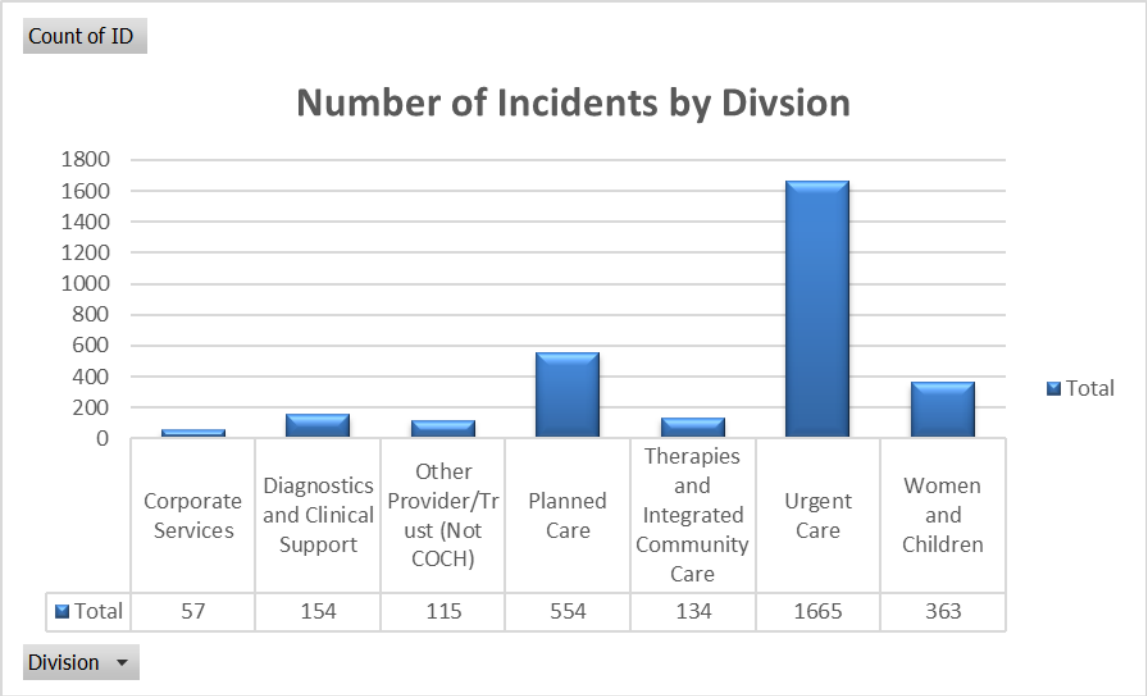
Graph 2



	No harm	Low Harm	Moderate Harm	Severe Harm	Catastrophic Harm
Quarter 1	2883	725	172	17	5
Quarter 2	2106	618	89	18	6
Quarter 3	2200	646	163	29	4

Urgent Care is the highest reporter of incidents, with Planned Care second. The number of incidents reported by division can be seen in Graph 3.

Graph 3



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

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

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

Moderate harm incidents

Interrogation of moderate incidents in quarter three demonstrates that there were 18 categories of moderate harm reported. Most categories have 1-3 incidents reported for each category, however the categories with the highest numbers of incidents were:

1. Skin Integrity (74)
2. Healthcare Associated Infections (HCAI) (32)
3. Unexpected Events (13)
3. Treatment (9)

These are the same as the previous quarter, with the addition of the unexpected events category. These top 4 categories of incidents make up 78 % of all moderate incidents reported.

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

There were 4 Catastrophic incidents reported. One incident was downgraded as it was not a patient safety incident- it was a clinical event. One has been reported as a Patient Safety Investigation (PSII) where a patient suffered a catastrophic event following surgery. The other two included a potential missed diagnosis of a Pulmonary Embolus (PE) and the second was regarding a deteriorating patient. All have either undergoing a PSII or an After-Action Review learning response.

There were 29 severe incidents, 24% were present on admission pressure Upulcers and 20% were for ophthalmology delays. There were 3 delays in diagnosis and 3 misdiagnoses and 2 falls. Overall Incident Themes:

The top 5 reported incidents in Quarter Three were:

- Skin Integrity – 16%
- Medications – 10%
- Slips, trips and Falls – 8%
- Staffing – 7%
- Bed Management – 5%

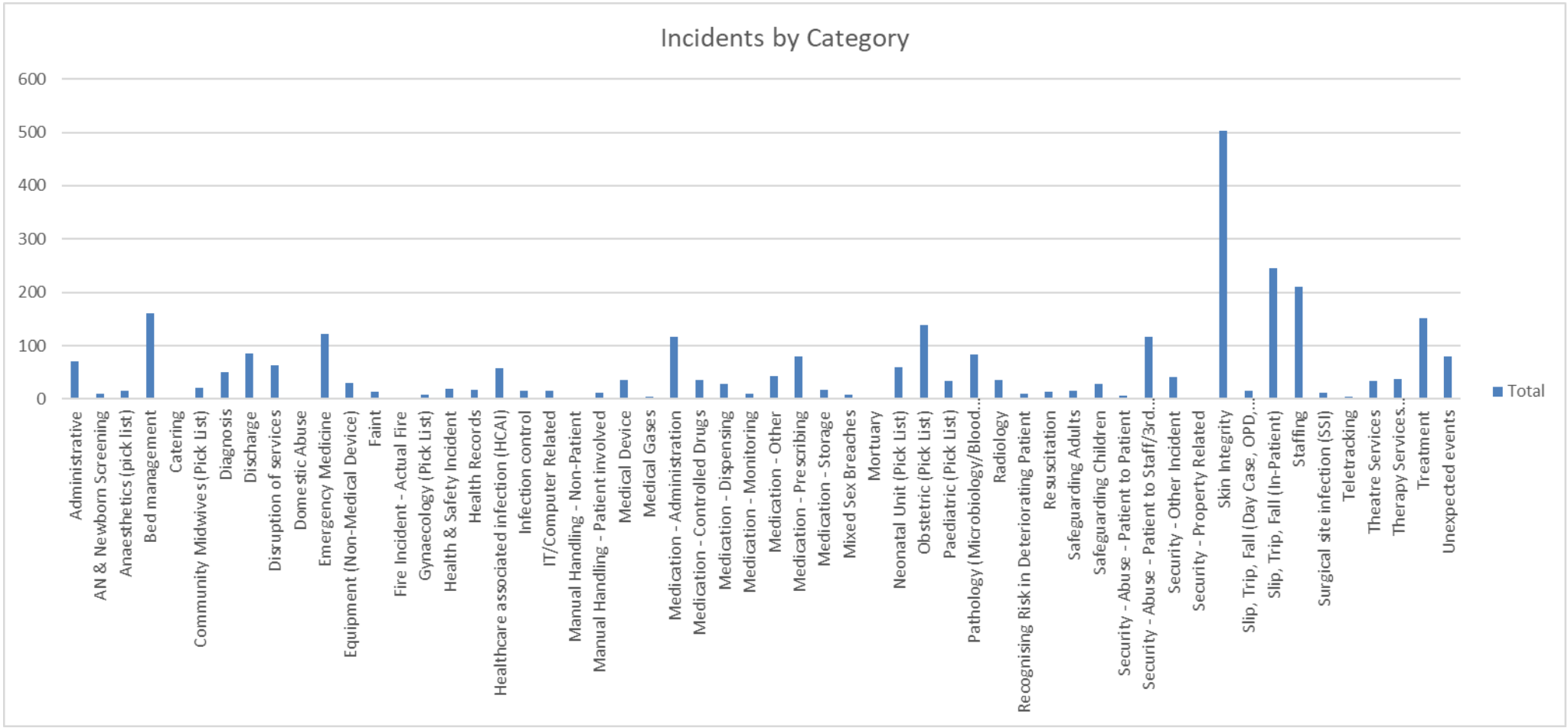
The full range of incidents by category can be seen in Graph 4

The Quality, Safety and Experience Strategy has been launched with 26 priorities identified. The priorities are split into three categories:

- Core Priorities
- Corporate Priorities
- Divisional Priorities

Several of the priorities were determined following a review of incidents- highlighting themes and trends that have led to improvement workstreams. These include pressure ulcers, falls, violence and aggression, medication safety and staff training. Pressure ulcer, falls and medication safety quarterly reports are also prepared for Quality Governance Group.

Graph 4 – Incidents by Category



Complaints and Concerns
Across services in quarter three, communication issues, delays in access to care, and administrative errors remain the most prevalent concerns across both complaints and informal queries. Full details of complaints and concerns can be seen in the complaints and concerns quarterly report.

Learning from complaints during this quarter has led to several service improvements across the Trust:

- In Ophthalmology, the risk of incorrect antiseptic use has been mitigated by removing 0.5% chlorhexidine from injection areas, introducing clear visual alerts, and ensuring all patients with iodine intolerance are clearly flagged in their records.
- In Vascular services, missed results were identified as being linked to reliance on a single consultant inbox; this has been addressed through implementation of a shared inbox to reduce the risk of future omissions.
- In SDEC, gaps in nurse rounding documentation were identified and feedback has been shared to improve compliance with timely care and comfort rounds.
- In Plastics, learning focused on the need for improved coordination and clearer communication between services, particularly for cross-border patients requiring funding approval.
- Within the Emergency Department, multiple actions have been taken to improve patient safety and experience, including enhanced recognition and management of adrenal crisis, strengthened senior leadership presence, IPC support, environmental improvements, improved care and comfort rounds, and Trust-wide action to address gaps in chaperone availability

Learning forums
The learning and sharing forum covers a variety of topics with all sessions recorded and available on the Trust Intranet. Topics included in quarter 3 were:

- IPC – antimicrobial stewardship
- Medical devices
- Learning from incidents
- Infection Prevention Audit
- Safeguarding decision tool
- ETOC – Enhanced Therapeutic Observations of Care
- AMU – Falls Improvement – following PSII
- Bladder washout
- Sepsis Screening
- Safety Surveillance – divisional thematic review and learning

Patient Safety Summits
Patient safety summits were held as below and covered various topics

- Patient Safety Summit – October 25- Complications following an elective AAA repair
- Patient Safety Summit – November 25- Learning from a formal complaint
- Patient Safety Summit – December 2025- Learning from Non-Invasive Ventilation PSII – including new COCH NIV guidelines

All patient Safety Summits are recorded alongside other learning forums on the trust intranet for staff who were unable to attend to watch and learn. Each week, a weekly learning bulletin is shared trust wide. These are also available on the Trust Intranet.

Learning from Deaths/Coroner Inquests
Every death in the Trust is now scrutinised by the Medical Examiner. Any death raising a concern or where learning has been identified, a Mortality and Morbidity (M&M), or Structured Judgement Review is undertaken.

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

Examples from Learning from Deaths can be summarised below:

- Implement a default CT head display profile at system level with quick toggles for brain / SDH window / bone – Complete – default display protocol for CT head scans has now been amended
- Anonymised case to be added to the radiology teaching file. Targeted REALM (radiology events and learnings meeting) to include thin SDH recognition and bias mitigation. – completed – presented several times to ensure shared widely.
- Incidents shared at Learning and Sharing Event – completed
- To implement a targeted falls awareness month focusing on both falls' prevention and post falls management. This initiative will include staff education on neurological observations and the use of rambleguards in bathrooms – completed in November
- Develop an ED abdominal pain pathway for the initial assessment of patients attending with abdominal pain (to include suggested investigations e.g. bloods, CXR, urine dip) – target date for completion 30/1/26
- Yellow form the potential for Mounjaro to have caused his death – completed
- Actions plans are monitored through weekly risk meetings with divisional triumvirates and risk team

This is also improving the preparation for coronial inquests ensuring investigations are initiated, completed with PSOM oversight received. A coroners database has been developed and is now in place, including a section for learning post inquest, however this requires some additional work. No Regulation 28 (Prevention of Future Deaths) have been issued to the Trust. Where a patient safety learning response has been written, for example an After-Action Review we ensure that this is shared with the family prior to the inquest, and an offer of a family meeting to go through the report. A weekly update is provided to the Executive Directors group of upcoming coroners inquests and outcomes of the previous week coroners conclusions.

Learning From Patient Safety Events (LFPSE)
The Trust is currently being highlighted as a low reporter and a lagged reporter to LFPSE as staff are selecting NO rather than yes in what are Patient Safety Incidents.

The LFPSE service defines a patient safety incident as: something unexpected or unintended has happened, or failed to happen, that could have or did lead to patient harm for one or more person(s) receiving healthcare'.

It is thought that due to the DATIX reporting system becoming extremely lengthy to complete – staff are choosing 'No' to the questions is this a patient safety event, due to the number of questions involve so the DATIX team and Deputy Director of Nursing are reviewing the system and streamlining the process.

Patient Safety Incident Response (PSII)
In Quarter One of 2025/26 we reported three incidents to StEIS. These can be seen in table 5. Two are Never Events, both relating to a retained object (both guidewires). In Quarter Two we reported one PSII to StEIS and in Quarter 3 we reported three incidents including a third Never Event. Progress of any PSII is managed through the weekly Patient Safety Oversight Meeting.

We have good engagement from Cheshire West Place with an oversight of our completed PSIIs and they are invited to attend our weekly Patient Safety Oversight Meeting when a PSII is to be presented.

Table 5 - The current position of the Trust PSIIs 2025/26

Incident	Lead Division	Incident report date	Status
Retained Object – NG Guidewire	Urgent Care	April 25	PSII complete and presented at PSOM with ICB in attendance ***COMPLETE***
Retained Object – Midline Guidewire	DCSS	April 25	PSII complete and presented at PSOM with ICB in attendance ***COMPLETE***
TTP	Urgent Care		PSII complete and presented at PSOM with ICB in attendance ***COMPLETE***
Death 2 days post discharge	Urgent Care	June 25 (identified PSII October 2025)	AAR complete Coroner's Inquest complete – conclusion natural causes ***Closed in the Trust awaiting ICB oversight***
Fall resulting in acute subdural haemorrhage (missed diagnosis on CT scan	Urgent Care	Agreed PSII 3/11/25	AAR complete Coroner's Inquest complete – conclusion – narrative conclusion with reference to neglect regarding adherence to policy. ***Closed in the Trust awaiting ICB oversight***
Delay in rectal cancer due to missed opportunities	Planned Care	Agreed PSII 31/10/25	
Never Event	Planned Care	Agreed PSII 13/1/26	

5. Conclusion

The Trust continues in its journey with PSIRF, reviewing and changing processes as required, including the additional Quality, Safety and Experience strategy and subsequent oversight meeting. This will further support the quality, safety and culture experience in the Trust.
There are a variety of forums where learning is shared, and an Organisational Learning policy has been developed and is awaiting ratification. The Trust will continue to build and strengthen its learning from all patient related events to improve the safety and quality of care for patients.

6. Recommendations

The Board of Directors is asked to:

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

PUBLIC – Board of Directors
31st March 2026

Report	**Agenda Item 14.**	**Quarter 3 2025-2026 Mortality Surveillance Report (Learning from Deaths)**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Dr Nigel Scawn			Medical Director				
Author(s)	Dr Ian Benton			Deputy Medical Director				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X**				
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X**
Previous considerations	Quality Governance Group (QGG) – February 2026							
Executive summary	The purpose of this report is to provide ongoing assurance as to the Trust's structures, processes and oversight of mortality. This report confirms that Mortality Indicators continue to remain within 'as expected' range: • Summary Hospital-level Mortality Indicator (SHMI) for September 2024 – August 2025 is 89.53 ('as expected' range) • Hospital Standardised Mortality Ratios (HSMR) for October 2024 – September 2025 is 95.83 ('as expected' range) A review of all stroke deaths in 2024/5 has been undertaken due to two episodes of statistical outlier status. No significant pathway changes were identified. There were two known cases that had been reviewed separately and identified as a Patient Safety Incident Investigation (PSII) due to the regional pathways for thrombectomy and the multifactorial elements affecting timely care.							

	There is an improving picture of the back log of specialty mortality reviews. Further work is being undertaken to improve the reporting and capturing of quality care and avoidability of death assessments within mortality reviews. A review of the platform for recording mortality reviews is also underway to allow easier tracking of learning.
Recommendations	The Board of Directors is asked to note the **assurance** that learning from mortality and morbidity is improving across the organisation within the learning and safety meeting structures / groups reaching multiprofessional audiences.

Corporate Impact Assessment	
Statutory/regulatory requirements	Legal and regulatory requirements.
Risk	BAF 2 and BAF 8.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential

Mortality Review	Mortality Rate (SHMI / HSMR)
• 275 patients died (inpatient) in the Trust between 1st October 2025 – 31st December 2025. 445 community deaths were reported. • 100% were scrutinised by the Medical Examiner's (ME) Office • 47 patients were identified by the ME's for further mortality review (HM Coroner referral, learning, family/staff concern or Governance) • There was 2 reported deaths under LeDeR criteria (1 was a notification from August 2025)	• SHMI for Aug 24 – Jul 25 is 89.53 ('as expected' range) • HSMR for Oct 24 – Sept 25 is 95.83 ('as expected' range) • All mortality measures have been within expected range for the last 6 quarter reporting periods.

Medical Examiners Activity					
Month	Total Adult (inpatient) Deaths	Number reviewed	Mortality review requests	HM Coroner referral	Deaths that occur in patients with a Learning Disability
October 2025	90	90	13	13	1 *notification for Aug 25
November 2025	85	85	19	17	0
December 2025	100	100	15	11	1 (child)

Medical Examiners Updates

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

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

- Review of care leading to degradation of pressure sore.
- Review the need for catheter in end of life patient. Wouldn't have contributed to death but may have improved symptoms.
- Complex vascular case will need anaesthetics and vascular M&M review. Death likely to have been unavoidable.
- Delay in IV access.
- Review decision for investigations in final days of life. Review the value in requesting the extensive tests with someone approaching the end of their life.
- Delay being seen in ED (incident reported). 41hour stay in ED. This did not affect outcome but would have had a negative experience on patients' quality of care.
- Timely review of patient with sepsis. F2 commended for management. Requested review due to timeliness of senior review.
- Thoracic Injury pathway not followed.
- Iatrogenic C Diff which may have contributed to death (incident reported).
- Lengthy admission. Given frailty, comorbidities and length of stay review needed as to whether palliation could have commenced earlier.

Feedback to Medical Examiner's office

All feedback received by the MEO is forwarded to the respective leadership team / ward area. Where relatives raise comments or concern, they are signposted to PALS:

- Exceptional care received on ward 45 all staff Drs nurses and domestics treated patient and her family like their own personal families, they felt loved by the staff, looked after and always doing all they could
- Fantastic care received a Ward 51
- Nurses on ward 51 were exceptional and kind to patients and family. They would have liked to have had a side room but knew the reasons why
- Palliative care nurses were very good (ED)
- Staff on Stroke ward were exceptional, wonderful care provided from the minute he arrived at COCH
- Nothing but high praise for all the staff at the hospital care was outstanding and food was amazing
- Excellent care received (Ward 44)
- Ward 53 staff are a bunch of angels!

- Drs and staff in ED and AMU were fantastic. Highly complementary to the MEO take the call from NOK for empathy and compassion
- Extremely impressed by the speed in which the documentation has been prepared and very grateful (ward 50)
- Amazing care by the whole teams on RSU. Every member of staff was wonderful
- ED was amazingly quick and very professional

Learning themes from Mortality reviews

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

Good care	Gaps in care / Learning identified
Timely and appropriate initial assessment Rapid recognition of patients poorly condition. Advanced care planning and communication with family Sensible and timely clinical plans Appropriate management of C Diff. Consistent themes of: • Good clinical management • Early ceilings of care established • Good family communication • Good use of MET call / team • Recognition of deteriorating patient • Referral to safeguarding teams Excellent open and honest discussions with patient and family Family felt listened to Chaplaincy support	Prolonged inpatient stay due to social barriers. Limited documentation of ceilings of care Good clinical reviews but delayed due to acuity of unit Delay in escalation (individual learning, feedback and reflection) Limited review of previous admission and advice / plans documented Limited safety netting advice (ED education forum) Documentation (signature/delegation) of health care practitioner not identifiable (reminder email sent to all staff re – naming convention / record standards) Multiple ward moves may have exacerbated delirium. (feedback to Clinical site coordinator/ bed team) Protracted length of stay due to social circumstances Identification / consideration of hypoglycaemia (Ward training has happened as a result)

Input from C.diff review team Patients' preference for discharge was taken into consideration	Review lacked clarity regarding capacity assessments. (feedback to ED team to incorporate into next teaching session)

Outlier diagnosis groups

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

In year we have undertaken reviews for the diagnosis groups: Fracture of upper limb, diabetes with complications, 'other screening for suspected conditions', infective arthritis, sand cerebrovascular disease, as these groups were alerting on the Early warning tool as approaching statistical significance. The groups contained low numbers so are strongly influenced by a small number of observed deaths than expected. There were no significant concerns raised from these reviews.

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

A comprehensive mortality review of all Stroke deaths in the period March 2024 – March 2025 has been undertaken, comparing the quality indices that define optimum Stroke care as measured by SSNAP Audit (The Sentinel Stroke National Audit Programme).

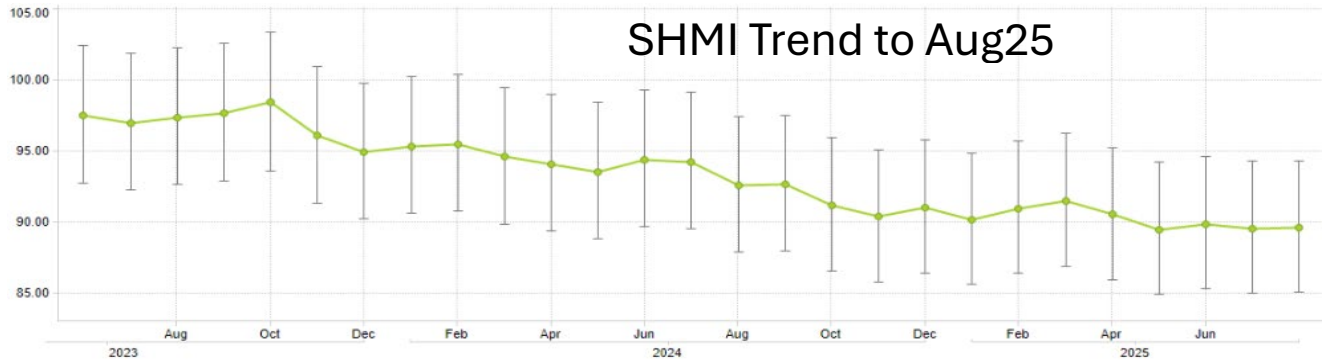
This review was presented to the Mortality Surveillance Group and the Board in January 2026. No significant explanations were found to account for the higher observed number of deaths, when comparing stroke severity, treatments offered, clinical outcomes and timeliness of interventions. There were 2 cases that had already been reviewed locally and regionally through established M&M processes. One was part of a PSII (Patient Safety Incident Investigation) due to the complexities of stroke care across the region.

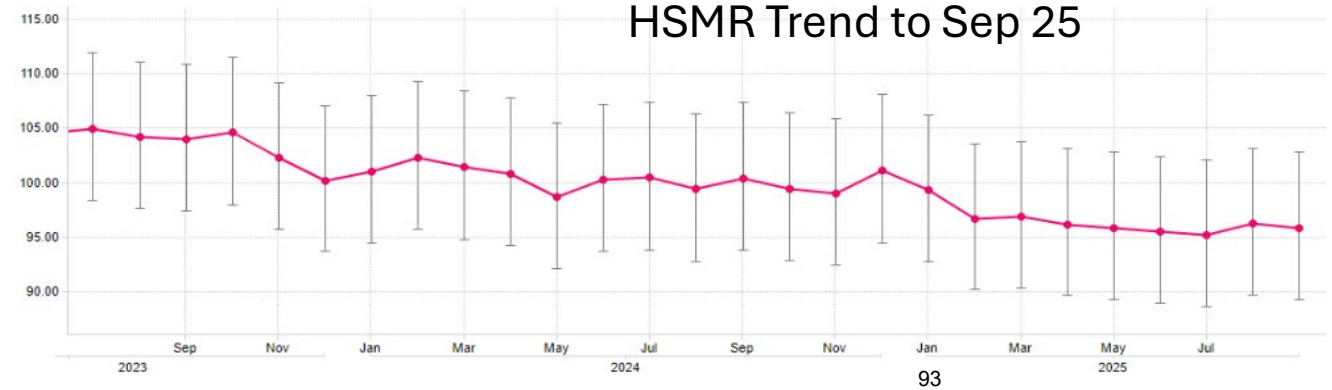
The summary of the review found:
1. The report does not find a significant difference between compliance with quality markers between the deceased patients and the total stroke figures
2. Comparing our figures to regional and national data also does not show us to be a significant outlier and does not account for the difference in mortality

3. No significant issues found with complications for acute interventions such as thrombolysis, thrombectomy and acute management of Intracerebral Haemorrhage patients

Points / learning outcomes that were noted were as such:
1. Patient mortality cohort had significant co-morbidity and poor prognostic markers at admission (79% of cohort)
2. There were minimal patients who did not have satisfactory explanations for their mortality and any patient that I flagged as requiring further review into their mortality during this report had already had a robust review either through M+M meetings or DATIX process
3. There are areas where we have room for improvement in meeting SSNAP quality markers and work is under way in this regard
4. Only 40% of deceased patients who had been given thrombolysis had been reviewed in the Thrombolysis M+M meeting, this will be fed back to the department

Mortality Data





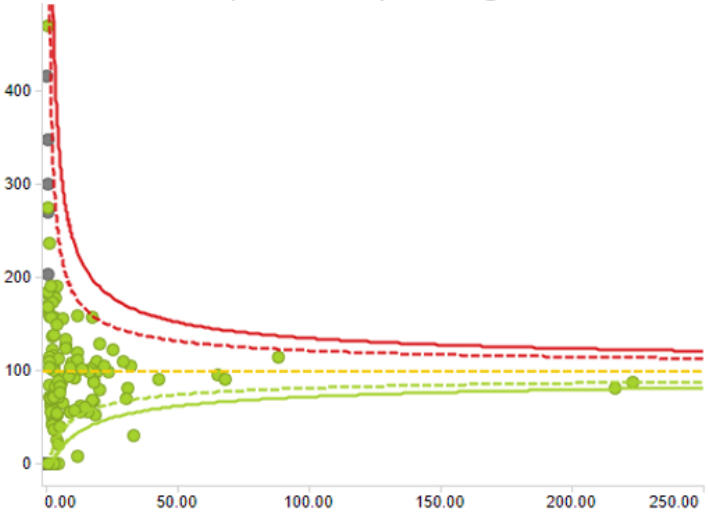
Both the rolling HSMR and SHMI trends show the last 24 data periods reporting within the expected

Statistical outliers – diagnosis aggregate level

Countess of Chester Hospital NHS Foundation Trust

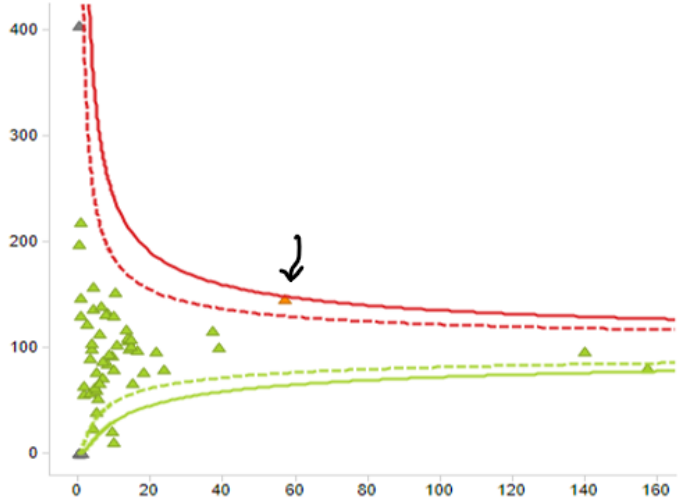
Data type: HES SHMI & HES HSMR

SHMI funnel plot for Sep24-Aug25



There are no statistical outliers at diagnosis group level.

HSMR funnel plot for Oct24-Sep25

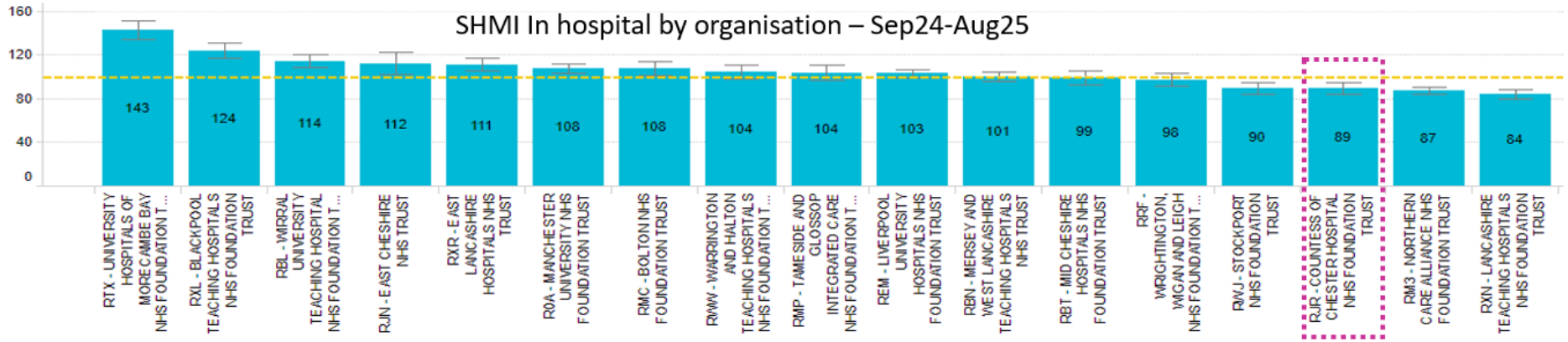


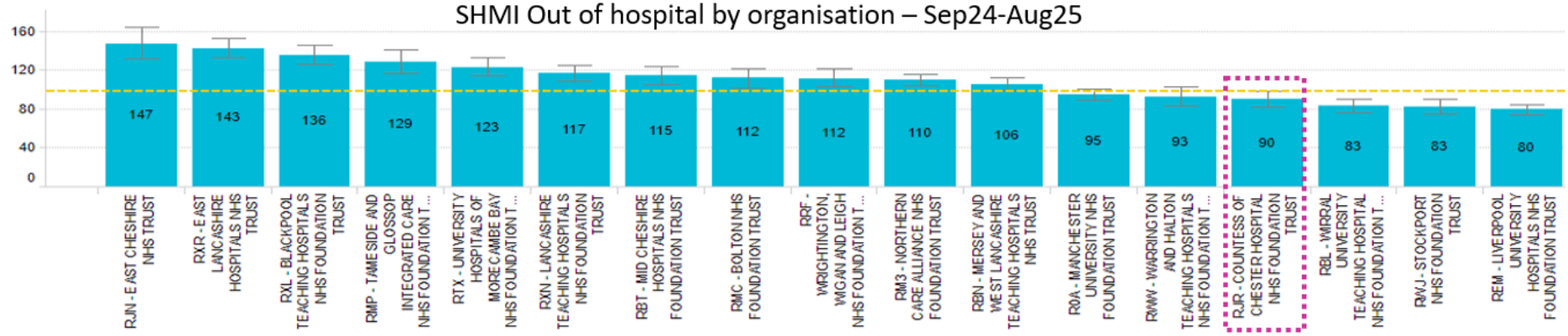
There is one statistical outliers at diagnosis group level – Acute Cerebrovascular Disease

In / out of hospital

NHS
Countess of Chester Hospital
NHS Foundation Trust

Data type: HES SHMI





Deep dive – Acute Cerebrovascular Disease

Countess of Chester Hospital NHS Foundation Trust

Data type: HES HSMR

Deaths and % Rates by Month Oct24 – Sep25

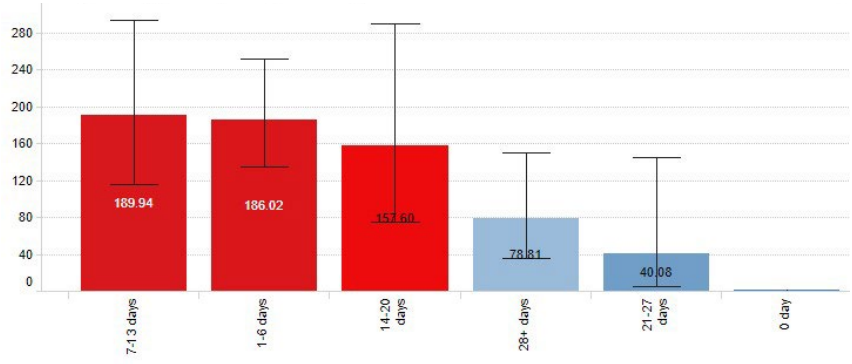
Month (of discharge)	HSMR	Number of provider spells with palliative care coding	Number of observed deaths	Expected number of deaths	Expected rate (%)	Crude rate (%)
October 2024	153.67	1	8	5.21	9.82%	15.09%
November 2024	195.08	3	15	7.69	13.49%	26.32%
December 2024	170.02	3	9	5.29	15.12%	25.71%
January 2025	88.62	2	4	4.51	12.20%	10.81%
February 2025	146.85	1	5	3.40	9.46%	13.89%
March 2025	203.60	3	14	6.88	12.50%	25.45%
April 2025	54.31	2	2	3.68	10.83%	5.88%
May 2025	126.44	3	6	4.75	12.83%	16.22%
June 2025	181.26	1	6	3.31	8.07%	14.63%
July 2025	108.48	4	6	5.53	10.44%	11.32%
August 2025	112.51	2	4	3.56	9.36%	10.53%
September 2025	119.86	2	4	3.34	11.92%	14.29%
Grand total	145.24	27	83	57.14	11.34%	16.47%

High crude rates Nov24, Dec24 & Mar25, Low crude rate Apr25. These are similar to fluctuations in HSMR. Jun25 has a high HSMR, but average crude rate. These 5 months are likely to be the best place to focus any reviews on.

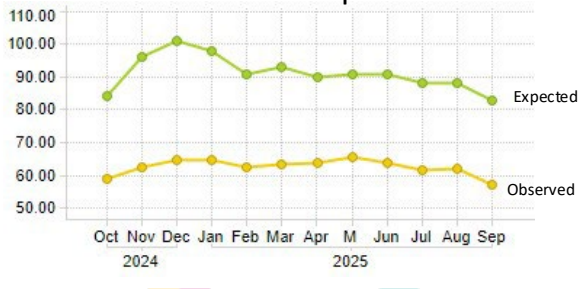
Deaths by Weekend/Weekday Oct24 – Sep25

Weekday/Weekend Admission	Number of observed deaths	Expected number of deaths
Weekday	61	44.32
Weekend	22	12.82
Grand total	83	57.14

HSMR by LOS Oct24 – Sep25



Number of Expected deaths v Number of Observed Deaths Oct24 – Sep25



Notes / Glossary

The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in hospital deaths (multiplied by 100) for **56 specific diagnostic groups** (accounting for 80% of all activity). The expected deaths are calculated from logistical regression models taking into account and adjusting for a case-mix of: age, sex, depravation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.

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

From November 2025 we moved from Telstra Health to HED as our Mortality / HES software provider . There is a change to the statistical method for calculating HSMR however there was no significant differences to our HSMR by both methods

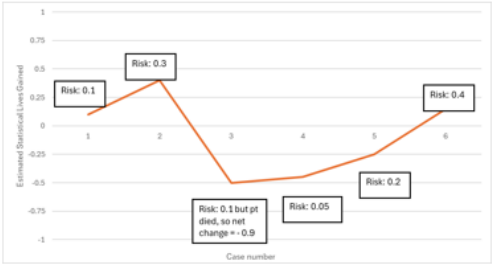
Summary Hospital-level Mortality Indicator (SHMI) v Hospital Standardisation Mortality Ration (HMSR)

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

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

From Spring 2026 we will be changing statistical reporting to Variable Life Adjusted Display (VLAD)

- VLADs are a type of statistical process control chart.
- Each 'event' (either a discharge or a death) is plotted on the chart.
  - A discharge goes up by the risk of death for that spell.
  - A death goes down by one minus the risk of death for that spell.
  - Effectively this results in plotting the cumulative risk minus the number of deaths.



- In addition to this line, there are upper and lower control limits that are statistically generated. When this line hits one of these control limits, the VLAD 'triggers' (or 'flags') and the control limit that has been hit is reset.
- VLADs have been adopted by NHSE as part of the publication of the SHMI using the SHMI risk values and are part of HED.

Learn more about VLADs at these links:
https://www.health.qld.gov.au/__data/assets/pdf_file/0029/426872/vlad-present.pdf
https://www.researchgate.net/publication/225093140_VLADs_for_Dummies (link to access PDF of VLADs for Dummies)
https://www.mja.com.au/journal/2007/187/10/identifying-variations-quality-care-queensland-hospitals

PUBLIC – Board of Directors
31st March 2026

Report	**Agenda Item 15.**	**Self-Assessment and Designated Body Controlled Drugs Accountable Officer (CDAO) Improvement Framework for 2026**						
Purpose of the Report	Decision	**X**	Ratification		Assurance		Information	
Accountable Executive	Dr Nigel Scawn			Medical Director				
Author(s)	Karen Adams			Director of Pharmacy and Medicines Optimisation/ Controlled Drugs Accountable Officer (CDAO)				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X** 	The impact on the BAF is assurance around the legislative requirements for Boards of Designated Bodies to meet their duties under the Controlled Drugs Regulations 2013 & 2020 (as amended)			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X**
Previous considerations	Previous annual self-Assessment and Designated Body Controlled Drugs Accountable Officer (CDAO) Improvement Framework 2025 received by the Board.							
Executive summary	The Trust (as a designated body) is required to complete and submit a self-assessment via their CDAO, of their systems and processes for handling controlled drugs (CDs). The self-assessments allow a regional assessment of current state and improvements. CDAOs are required to obtain board sign off prior to submission. During 2025 there have been significant actions undertaken that have contributed to **improvements** in the following areas of the self-assessment: • Staff vigilance and reporting concerns • Evidence of staff updates following policy review • Evidence of staff updates on learning from CD incidents							

	• Evidence of a systems improvement methodology for identifying the cause of CD-related incidents • Clear policy requirements around information sharing with external organisations eg NHSE No areas have seen a decline in the self-assessment. The answers proposed for submission show that systems and processes in place to safely manage CDs at the trust are sufficient to meet the Controlled Drugs regulations and highlight the positive improvements during 2025.
Recommendations	The Board of Directors is asked to **approve** the proposed answers for submission of the Self-Assessment and Designated Body Controlled Drugs Accountable Officer (CDAO) Improvement Framework for 2026.

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

Self-Assessment and Designated Body Controlled Drugs Accountable Officer (CDAO) Improvement Framework for 2026

1. Introduction

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

2. Background

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

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

3. Purpose

The purpose of this report is to share the proposed responses of the CDAO for the Designated Body CDAO Improvement Framework self assessment 2026 with Board members to seek approval for submission to NHS England. Answers proposed for submission are indicated in boxes highlighted.

4. Proposed submission

4.1 Systems and processes to handle concerns

How confident is the DB CDAO that all relevant areas know how to report CD-related concerns, including suspected diversion and misuse of CDs by colleagues? (1= not confident to 5 = fully confident)	
Answer: 5 (no change from 2025)	

How confident is the DB CDAO that all relevant areas of the organisation are reporting CD concerns including suspected diversion and misuse of medicines by colleagues? (1= not confident to 5 = fully confident)	
Answer:5 (no change from 2025)	

4.2 Workforce Knowledge and Skills

	Yes	Somewhat	No	Don't know	No recruitment in past 24 months
Can the DB provide evidence (in past 24 months) that relevant staff are trained on induction about vigilance and reporting concerns about unsafe behaviour and systems?	✓				
Improvement for 2026 (from 'somewhat') Rationale for answer: • Nurse induction attendance log (content updated) • Pharmacy staff CD SOPs log • Freedom to Speak Up (FTSU) (stronger links for 2026) • Safeguarding link (new) • Policy wording strengthened					
Can the DB provide evidence that relevant staff receive training on SOPs for handling CDs and reporting concerns?		✓			
No change from 2025 Rationale for answer: • Nurse induction attendance log • Pharmacy staff CD SOPs log					
Can the DB provide evidence that relevant staff are updated following SOP/policy reviews for reporting concerns and handling CDs?	✓				
Improvement from 2025 (from 'somewhat') Rationale for answer: • CD policy full review and update undertaken- approved by Drug & Therapeutics Committee, ratified by QGG. Updates clearly documented and cascaded to divisional governance meetings					
Can the DB provide evidence that relevant staff are updated on learning from incidents related to CDs?	✓				
Improvement from 2025 (from 'somewhat') Rationale for answer: • Weekly learning • Quarterly CD report (including improvement actions) and cascade • Divisional updates from Medication safety group • Trust wide communications of significant changes eg Gabapentin/ Pregabalin					

4.3 Systems in place to investigate CD related incidents

	Yes	Somewhat	No	Don't know	No incidents in past 24 months	Agree	Strongly agree
Can the DB provide evidence (from the past 24 months), that a systems improvement methodology is used to examine the cause of CD-related incidents?	✓						
Improvement from 2025 (from 'somewhat') Rationale for answer: • Multi-disciplinary, trust wide review of incidents undertaken quarterly • Triangulation of information from incidents, audit and practice • Significant process changes introduced Oct 2025 to safeguard schedule 3 CDs							
Can the DB provide evidence (from the past 24 months), that lessons from CD-related incidents are implemented?	✓						
No change form 2025 Rationale for answer: • Significant process changes introduced Oct 2025 to safeguard schedule 3 CDs • Local changes in key reconciliation in urology unit • Local changes in storage arrangements in ED							

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

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

Answer: Quarterly **(no change from 2025)**	

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

- Yes
- Somewhat
- No
- Don't know

Answer: Yes **(improvement from 2025 'somewhat')**	

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

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

Externally shared incidents (during 2025)

- Professional or Employee of concern-Illicit use-illicit drugs

4.4 Prescribing, clinical monitoring and taking action

	Yes	Somewhat	No	Don't known	Not applicable
The designated body has systems in place for identifying unusual prescribing of CDs (Schedules 2-5) in relevant areas	✓				
Evidence (from the past 24 months) can be provided that all unusual prescribing of Sch 2-5 CDs in relevant clinical areas has been/is being investigated.					✓ No unusual prescribing detected

No change from 2025
Rationale for answer:

- Ward based pharmacy review for inpatients
- Pharmacy clinical check for outpatients
- Quarterly usage review of Schedule 4 and 5 (improved reconciliation through new BI dashboard)
- Review of FP10 data in place

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

	Yes	No	Don't know how / no capacity
The designated body has support available for staff well-being including substance misuse support	✓		
Evidence (from the past 24 months) can be provided that all identified alleged diversion of drugs liable to misuse (including CDs), have been investigated.	✓		
No change from 2025 Rationale for answer: • Evidence of reports and investigations held on datix/ NHSE incident portal • Significant changes implemented during 2025 around management of schedule 3 CDs (pregabalin and gabapentin)			

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

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

Please select at most 2 options.

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

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

- Yes
- Somewhat
- No
- Don't know

Proposed answer: Somewhat **(no change from 2025)**

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

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

5. Conclusion

Systems and processes in place to safely manage controlled drugs at the trust are sufficient to meet the controlled drugs regulations with mechanisms to identify areas to improve these processes well embedded. Significant changes have been introduced during 2025 to further safeguard the use of controlled drugs which provide evidence to supported improvements in many of the self-assessment results for 2026.

6. Recommendations

The Board of Directors is asked to **approve** the proposed answers for submission of the Self-Assessment and Designated Body Controlled Drugs Accountable Officer (CDAO) Improvement Framework for 2026.

Countess of Chester Hospital NHS Foundation Trust

Committee Chair's Report
Thursday 22nd January 2026, 8.00am – 1.00pm
Education and Training Centre

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

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

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

- Ophthalmology waiting list and follow up backlog review underway and action plan required within 7 days for EDG to understand how risks are being mitigated.

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

- CEO update including system, provider collaborative, NHSE undertakings
- Quality and harms update including PSIIs, incidents and themes, complaints and concerns.
- Finance position month 9 adverse variance reported aligned to the DSF not being received. Pay underspend linked to vacancies, non pay pressures including drugs and orthotics, income and contract discussions close to be concluded with the ICB. Forecast is that we will deliver to plan with the exception of DSF. Non recurrent mitigations have been applied and managed risks taken in the balance sheet. Application for emergency cash made for February 2026. Planning for 2026/27 and 5 year integrated plan progressing in line with timetable. Budget setting commenced.
- PDO/ CIP update 85.4% fully transacted and fully developed. Focus remains on moving the schemes through to transacted. Options and proposed approach to CIP allocation supported with a move needed to more transformational schemes. Workshops being held to identify and share opportunities and the plan for 2026/27. Transformation Programme Board to be established. Expectation that schemes will be identified by 31st March 2026.
- Operational performance report focussing on RTT, UEC and Cancer. Includes improvements for performance including 4 hour but in the context we are still behind plan and the trajectory to 78% by end March. Demand (attendances) for UEC has been unprecedented in December and January. Work continuing with introduction of RAT and discharge improvements, with ECIST visiting again to support. 18 week RTT continues to improve. Gap in delivery of 52 week trajectory reduced in November as we start to recover the position. 65 week performance resulted in 2 breaches at December when the target of 0 patients was expected. Actions at speciality level include insourcing, outsourcing, WLI and locum. Improved cancer performance in November, and focussed on improving performance to return to meeting the standard. Focus is also on diagnostic performance to improve against a range of metrics.

- People performance update against a range of KPIs including sickness absence, and mandatory training. Request for timeliness of data recognising some challenges within the systems to do this. Also covered People Strategy update, culture and leadership framework progress, and sexual safety charter action plan progress including a discussion on chaperoning and the new training that has been launched.
- NOF review of position and forward look recognising that some areas have been improved but probably wont impact the rating this quarter due to the timing of data and comparative organisations will also be improving. Discussion took place regarding areas where we meet the target but comparative ranking takes us into a lower quartile. The implications of the NOF and provider improvement programme is still to be confirmed.
- Research strategy and research update including budget allocations, NIHR performance targets, funding and finance, and Good Clinical Practice update.
- Divisional Performance and Risk updates were provided by each clinical Division. These covered quality and safety, activity, finance, risk and people metrics. OMB requested further updates on e'discharge (specifically planned care); Paediatric audiology plans; Therapies contacts and options; feedback from ED admittance criteria audit; ophthalmology waiting list and follow up paper for EDG.

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

- N/A

Risks discussed and new risks identified

- High risk report presented recognising correlation with Divisional reports. Update on risk management guidance training plans to be reviewed at RMC for roll out in Q4. Divisions asked to review risk registers to ensure coverage of the areas raised in reports and consistency of scoring.

Committee Chair's Report

Thursday 26th February 2026, 8.00am – 1.00pm
Education and Training Centre

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

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

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

- There were no new alerts for the Board, recognising the Board is already sighted on the challenges of Urgent Emergency Centre (UEC) performance with a range of actions progressing.

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

- Received an update on Patient Flow Actions from the Programme Manager Lead including Divisional actions and impact, and the priorities for quarter 4.
- High risk and divisional risk report providing an overview of the risk registers and escalations, noting triangulation with OMB agenda and importance of continuing with the risk management improvement work.
- Divisional risk and performance updates, including quality and safety, workforce, finance, activity and productivity, risks, and specific updates on e'discharge.
- Papers and action plans reviewed for key areas escalated through OMB:
    - Paediatric audiology position discussed with actions to review clinic utilisation to increase capacity.
    - Ophthalmology waiting lists review and action plan including validation, risk stratification and digital. Plan requested on approach to data cleanse as part of the Electronic Patient Record (EPR) system developments.
    - Phlebotomy pressures due to capacity and sites for clinics being explored. Further update requested to integrate wider actions with assurance needed on progress in mitigating risks and resolving long standing challenges.
- Quality and Safety overview including a deep dive on open incidents, levels of harm and the need to improve timeliness of review, learning and closure.
- Finance month 10 position received and confirmed that with the exception of Deficit Support Funding (DSF) we are slightly ahead of plan and the forecast is in line to meet the plan. Cost Improvement Programme (CIP) under delivery mitigated by non-recurrent actions, with the focus on CIP critical to 2026/27 planning and performance. Income will also be key, ensuring utilisation of core capacity and where required appropriate additional capacity.
- Productivity growth estimate update demonstrated clear improvement in comparison to previous year and through regional and national benchmarks.
- Operational update with Referral to Treatment (RTT) (65 and 52 weeks) and cancer performance (FDS, 32 and 62 days) on track. UEC performance

continues to be significantly below target. Diagnostics performance improving, but challenge remains in the capacity for Echocardiographs.
- People update on compliance levels with metrics and the key areas for focus.
- Annual planning update including the 5 year integrated plan submitted for regional review and approval.
- Chief Executive Officer (CEO) report and partnerships updates sharing national, regional and local updates including the focus on collaboration. This included sharing aspects of the Cheshire & Merseyside blueprint.

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

- Not applicable.

Risks discussed and new risks identified

- Review of high risk and divisional report, alongside Divisional performance and risk updates with triangulation to OMB agenda.

Countess of Chester Hospital NHS Foundation Trust

Committee Chair's Report

21st January 2026 at 3.30pm via Microsoft Teams

Committee	Finance & Performance Committee (Interim 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)*

- **Loss of Deficit Support Funding (DSF):** No DSF assumed for 2025/26; any future support likely to be loans impacting income.
- **Emergency cash requirement:** Cash expected to decline from £16.1m, with Department of Health support required in February 2026.
- **Significant financial deficit:** £24.36m deficit at December, Forecast £33.8m year-end deficit in line with plan.
- **Cost Improvement Programme (CIP) underperformance:** £8m shortfall against plan.
- **Contract uncertainty:** Delay in financial planning due to late commissioner offer and ongoing risks (including headcount and system funding).
- **Board Assurance Statements:** Requirement for extraordinary Board review ahead of 12 February 2026 submission deadline.

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

- **External assurance (PwC):** Increased confidence in delivery of the current financial plan, despite some risks.
- **CIP oversight strengthened:** Appointment of Director of Delivery has improved tracking and governance.
- **Contract risk mitigation:** £3m Integrated Care Board (ICB) related risk mitigated through central funding arrangements (formal confirmation pending).
- **Workforce cost control:** Vacancy management contributing to underspend, with oversight to ensure patient safety and staff wellbeing.
- **Cash position (short-term):** Current balance of £16.1m provides temporary stability.

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

- **Financial planning status:** Delayed pending clarification of commissioner contract; further discussions planned with the ICB.
- **Five-year plan:** Draft under development, targeting Board approval by 27 January 2026.
- **Updated NHS England guidance:** New requirements for Board Assurance Statements received.

Financial drivers:

- Income underperformance (£8.3m behind plan)
- DSF withholding (£1.6m/month)
- Offset by overperformance and vacancy-related underspend

- **CIP strategy:** All schemes planned as recurrent to support long-term sustainability.
- **Committee focus:** Emphasis on transparency in reporting CIP delivery, contract risks, and transformation impacts.

Risks discussed and new risks identified

- **System funding risk:** availability of DSF and increasing reliance on loans.
- **Liquidity risk:** Declining cash balance and dependence on external financial support.
- **Delivery risk (CIP):** Slippage in CIP delivery and need for more realistic planning and ownership.
- **Contract risk:** Ongoing uncertainty in commissioner agreements and funding assumptions.
- **Income risk:** Continued underperformance against income plan.
- **Operational risk:** Managing vacancy-related savings without compromising patient safety or staff wellbeing.
- **Strategic risk:** Financial resilience dependent on successful risk management and alignment with system partners.

Committee Chair's Report

25th February 2026 at 1.30pm in Conference Room A, 1829 Building

Committee	Finance & Performance 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)*

- Urgent Emergency Centre (UEC) performance, with continued work with Getting it Right Frist Time (GIRFT) to maximise effectiveness of the triage processes; and work focussing on the acute take model. Non-compliant plan element within the submitted 5 Year Integrated Plan with a three year recovery plan.
- Cost Improvement Programme (CIP) slippage mitigated in year non recurrently, but focus remains on 2026/27 which includes the carry forward gap in addition to a significant in year CIP.

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

- Review of Integrated Performance Report (IPR) for performance against operational targets. UEC performance continues to be significantly below target. Referral to treatment (RTT) actions being taken to meet the 65 week target by year end; greater challenge to meet 52 week target which is impacting in part by the work on 18 week waits. Cancer performance is back above target for Faster Diagnosis Standard (FDS), 32 and 62 day standards. Diagnostics performance improving, but challenge remains in capacity for Echocardiography with recent action starting to demonstrate improvement and longer term bid for the development of a local Community Diagnostic Centre.
- Divisional Director update on Non-criteria to Reside (NCTR) numbers (19-21%), including context on delay days which significantly vary, and the gradual reduction in bed days. Actions being taken with partners, but challenge in Flintshire in particular for places for care. Exploring opportunity for the Trust to provide services in Flintshire to enable supported discharge and rehabilitation at home with rapid response similar to Cheshire model.
- Update on Strategic digital programme including Ambient Voice Technology; Artificial Intelligent (AI) solutions; eRS (referral service) and Electronic Patient Record (EPR); operational workflow; and Regional order comms (radiology and pathology).
- Senior Information Risk Officer (SIRO) update covering cyber security work including responses to cyber alerts and overall security posture. Data Security Protection Toolkit (DSPT) initial audit complete and awaiting feedback. Information governance, Freedom of Informaiton (FOI) compliance, mandatory training compliance and Information Commissioner's Office (ICO) reportable incidents.
- Finance (month 10) position adverse to plan due to the withholding of Deficit Support Funding and excluding this we are slightly ahead of plan, but context

is that the £3M stretch target is profiled into Month 12. Contract dispute with the Integrated Care Board (ICB) has been resolved and financial risk mitigated. Forecast is to deliver plan, and the known risks continue to be mitigated including non-recurrent mitigation for in year CIP slippage. Over £20m recurrent CIP achieved with an additional £7m carry forward built into 2026/27 plans.

- Planning update noting plan acceptance deadline in March 2026; financial deficit plans and recovery trajectory over 5 years; post Board amendments to plans as approved by the Board including £3m investment reserve per annum in 2027/28 and 2028/29 through increased CIP allocations. Plan submitted to NHS England (NHSE) (compliant plan with exception of UEC with recovery trajectory to compliance in 2028/29) and now awaiting feedback and confirmation of acceptance. Contract dispute remains for 2026/27 in respect of funding for growth which is now with NHSE for review. Risks to income, expenditure, performance and workforce summarised.
- National cost collection paper confirmed good position on cost comparisons nationally.
- Waivers report included overview of 14 waivers and the reasons in line with Standard Financial Instruction (SFIs). Progress discussed which demonstrates improved compliance with procurement processes.
- Summary of the Trusts assessment against the NHS Productivity Growth Estimate for 2025/26 showing strong positive improvement.
- Received paper on Thirlwall Inquiry spend against budget, noting externally funded through NHSE.
- Chair reports from Commercial Procurement Income Group; Capital Management Group; Information Governance and Cyber Security Committee; Operational Performance Executive Lead Group; Estates and Facilities Divisional Group; and Digital Clinical Systems Programme Board. Alert on Subject Access Requests (SARs) compliance and actions being taken to improve triage and apply appropriate extensions for complex SARs to ensure true compliance figure; clinical lead for sustainability needed; and Non DM01 diagnostic waiting times. Agreed that updates would be provided to the next Finance & Performance Committee.

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

- Theatre redevelopment continues to be on the action plan recognising programme is a longer term piece alongside other strategic priorities.

Risks discussed and new risks identified

- Reviewed Board Assurance Framework (BAF) extracts for BAF 3 operational effectiveness; BAF 5 Finance: BAF 6 Capital and BAF 7 Digital. Narrative view on trajectory of reducing residual risk score was included in the paper, with the drivers for the risk score and the review timeframes at which the scores could be considered once actions delivered and consistent outcomes achieved.
- Approach to assurance on clinical risk assessment for Digital programmes to be discussed with Quality & Safety Committee Chair.

Countess of Chester Hospital NHS Foundation Trust

Committee Chair's Report

3rd February 2026 – 9.30 – 12.30

Women & Children's Building Seminar Room

Committee	Audit Committee
Chair	Mr P Williams, 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)*

- None to raise.

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

- Committee received recent assurance committee agendas and Chair reports for triangulation. Will revisit Audit Committee approach to effectiveness of committees during 2026/27.
- Mersey Internal Audit Agence (MIAA) presented the anti-fraud workplan for 2026/27 covering the core and mandatory requirements aligned to Counter Fraud Authority strategy pillars.
- MIAA presented anti-fraud progress report on activity being undertaken as part of the 2025/26 plan, including updates on the small number of ongoing investigations.
- Draft annual governance statement reviewed and supported.
- Update received on out-of-date policies progress. Good progress made, but concerns remain relating to key clinical policies. To remain under review by the Audit Committee. Assurance sought that remaining policies to be updated are prioritised based on risk.
- Compliance with the Provider Licence approved, recognising the implications of the NHS England (NHSE) Enforcement Notice and importance of review at year end.
- Code of Governance Compliance: partial for external audit and the Committee requested that the succession planning provisions included in the code were assessed as partial, recognising the further work needed, with an action ongoing through the Remuneration Committee.
- Annual accounts and annual reporting timetable provided confirming alignment with guidance deadlines.
- Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SORD) updates approved including procurement legislation changes. Request made to consider adding reference to the preventing fraud act (e.g. in relation to waivers).
- Bad debt write off in 2025/26 of £91k, which included a debt of £57k relating to a deceased overseas patient and a number of smaller amounts relating to overseas visitors, salary overpayment, salary sacrifice, parking fines and R&D.
- Internal audit progress report, including substantial assurance on digital and data strategy; substantial assurance on key financial transaction processes;

and divisional governance mapping. Significant amount of work in progress to be completed for the head of internal audit opinion at year end. • Internal audit follow up report and Trust audit tracker providing assurance on completion of management actions arising from internal audit reports.
Advise *(items presented for the Board's information)*
• Reviewed the risk-based internal audit plan for 2026/27, recognising risks to be kept under review and those scheduled for future years. Committee deferred approval pending clarification on the rationale for the planned Consent audit. The plan to be approved after the meeting following confirmation on this point and a final review with Non-Executive Directors (NEDs). • Reviewed and approved KPMG indicative external audit risk briefing for year ending 31st March 2026. This included the materiality levels for the audit work; audit risks and approach; timeline; value for money risk assessment; and audit fees.
Risks discussed and new risks identified
• Reviewed relevant BAF 8 extract, noting the residual risk had reduced to 8 as per January 2026 Board of Directors. • Risk Management Improvement Plan progress recognising ongoing system and reporting developments, training material and planned roll out.