NHS
Countess of Chester Hospital
NHS Foundation Trust

Public meeting of the Board of Directors Agenda
(published items)
Tuesday 19th May 2026, 09.00 – 13.00
Women & Children's Building Seminar Room

Chair	Mr N Large, Trust Chair
Apologies	
In attendance	Ms K Jones, Practice Development Nurse and Ms M Kynaston, Deputy Director of Nursing & Quality (Item 3.), Ms N Macdonald, Director of Midwifery (Item 11.) and Dr P Bamford, Director of Clinical Research (Item 17.)

Time	Agenda No.	Agenda item	Lead	Page No.	Decision Required
09.00	1.	Welcome, apologies and Chair's opening remarks (verbal)	Trust Chair		For noting
09.03	2.	Declarations of Conflicts of Interest with agenda items (verbal)	Trust Chair		For noting
09.05	3.	Service Showcase – Nursing Excellence Programme (to be presented on the day)			
09.30	4.	Patient Story (to be presented on the day)			
09.40	5.	Minutes of the previous meeting held on 31st March 2026 (attached)	Trust Chair	5 - 29	For approval
09.45	6.	To consider any matters arising and action and decision log (attached)	Trust Chair	30 - 32	For noting
09.50	7.	a) Chief Executive Officer's Report (attached) b) NHS England Enforcement Notice Progress Update (attached)	Chief Executive Officer Chief Executive Officer	33 - 41 42 - 47	For noting For approval
10.00	8.	Chair's Update (verbal)	Trust Chair		For noting
10.10	9.	a) Board Assurance Framework and Strategic Objectives 2026/27 (attached) b) Significant Risks Report (April 2026) (attached)	Director of Governance and Risk Director of Governance and Risk	48 - 54 55 - 64	For approval For noting
Quality of Care					
10.20	10.	Quality & Safety Committee Chair's Report – 7th May 2026 (attached)	Chair Quality & Safety Committee	65 - 66	For assurance
10.25	11.	Perinatal Services Quarterly Update Quarter 4 2025/26 (attached)	Director of Midwifery	67 - 76	For assurance

Operational Performance					
10.45	12.	Integrated Performance Report (IPR) (to follow) Operational Performance Quality Safety People Finance	 Chief Operating Officer Director of Nursing & Quality Medical Director Chief People Officer Chief Finance Officer		For assurance
11.00	13.	Operational Management Board Chair's Report – 26th March 2026 and 23rd April 2026 (attached)	Chief Executive Officer	77 - 81	For assurance
Comfort Break (11.05 – 11.10)					
Finance, Use of Resource and Performance					
11.10	14.	2025-26 National Cost Collection (NCC) Pre submission Board Assurance Report (attached)	Chief Finance Officer	82 - 87	For assurance & noting
11.20	15.	Finance & Performance Committee Chair's Report – 29th April 2026 (verbal)	Finance & Performance Committee Chair		For assurance
11.25	16.	Audit Committee Chair's Report – 24th April 2026 (attached)	Audit Committee Chair	88 - 89	For assurance
Strategic Change					
11.30	17.	Research Update (to follow)	Director of Clinical Research		For noting
Leadership, Improvement Capability, Organisation Development and People					
11.40	18.	People Committee Chair's Report – 28th April 2026 (attached)	People Committee Chair	90 - 91	For assurance
11.45	19.	Fit and Proper Persons (FPPT) Report (attached)	Director of Governance and Risk	92 - 95	For ratification
11.55	20.	Review of Register of Interests (attached)	Director of Governance and Risk	96 - 106	For ratification

2

12.00	21.	Risk Management Policy (attached)	Director of Governance and Risk	107 - 128	For approval
Governance					
12.10	22.*	Council of Governors Report – April 2026 (attached)	Director of Governance and Risk	129 - 131	For noting
12.15	23.	Annual review of effectiveness of the committee(attached): a) Annual Committee Effectiveness Review 2025/26: Quality & Safety b) Annual Committee Effectiveness Review 2025/26: Audit Committee c) Annual Committee Effectiveness Review 2025/26: People Committee d) Annual Committee Effectiveness Review 2025/26: Finance and Performance Committee	Director of Governance and Risk	132 - 139 140 - 146 147 - 155 156 - 168	For assurance & approval
12.25	24.	Use of Trust Seal: St Johns Ambulance and Countess of Chester Hospital NHS Foundation Trust (attached)	Director of Governance and Risk	169 - 170	For approval
Items for noting					
12.35	25.*	Items for noting and receipt (attached): ***Sent under separate cover*:** **Minutes of Committee Meetings:** a) Approved minutes of the Quality & Safety Committee – 5th March 2026. b) Approved minutes of the People Committee – 10th February 2026. c) Approved minutes of the Finance & Performance Committee – 25th February 2026. d) Approved minutes from the Audit Committee – 3rd February 2026. e) Approved minutes from the Operational Management Board – 23rd October 2025, 22nd January 2026, 26th February 2026 and 26th March 2026. f) Chair's Report and minutes from the Research and Innovation Committee (tbc) **Other items:** g) Draft Board of Directors Workplan 2026/27. h) Neighbourhood Health	Trust Chair		For noting
Other items					
12.40	26.	Any Other Business (verbal)	Trust Chair		For noting

3

12.50	27.	Questions from Governors and members of the Public relating to items on the meeting agenda - ***Questions to be submitted in writing in advance of the meeting to:*** coch.membershipenquiriescoch@nhs.net ***by Thursday 14th May 2026*** **Future Dates:** 21st July 2026 29th September 2026 24th November 2026 26th January 2027 16th March 2027	Trust Chair		For noting
13.00	28.	Closing remarks (verbal)	Trust Chair		For noting

Next Meeting: Tuesday 21st July 2026 at 8.30am, Women & Children's Building Seminar Room

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

4

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

Members	20/05/25	29/07/25	30/09/25	25/11/25	27/01/26	31/03/26
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**	**27/01/26**	**31/03/26**
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	n/a
Healthcare Assistant, Ms M Facer	☑ (item 3)	n/a	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)	n/a
Director of Clinical Research, Mr P Bamford	☑ (item 23)	n/a	n/a	n/a	☑ (item 18)	n/a
Deputy Medical Director, Dr I Benton	n/a	☑	n/a	n/a	☑ (item 3)	n/a
Maternity and Neonatal Voices Partnership Lead, Ms R El Boukili	n/a	☑ (item 4)	n/a	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	☑ (item 15)
Intensive Care Consultant and Organ Donation Clinical Lead, Mr D Zeinali	n/a	n/a	☑ (item 4)	n/a	n/a	n/a
Safeguarding Lead, Ms J Cooper,	n/a	n/a	☑ (item 10)	n/a	n/a	n/a
Deputy Chief Operating Officer, Mr S Brown	n/a	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	n/a

Named Nurse for Safeguarding Children, Ms L Ates	n/a	n/a	n/a	☑ (item 3)	n/a	n/a
Head of Nursing - Infection Prevent & Control, Mr M Woodward	n/a	n/a	n/a	☑ (item 4)	n/a	☑ (item 3)
Associate Medical Director, Dr S Brigham	n/a	n/a	n/a	☑ (item 13)	n/a	n/a
Head of Midwifery, Ms C Davies	n/a	n/a	n/a	☑ (item 14a)	n/a	n/a
Deputy Chief People Officer, Mr P Marston	n/a	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)	n/a
Consultant, Mr S Sheppard	n/a	n/a	n/a	n/a	☑ (Item 3)	n/a
Medical Microbiology Consultant and Clinical Lead for Microbiology, Ildiko Kustos	n/a	n/a	n/a	n/a	n/a	☑ (item 3)

Observers in attendance:
Tony Fisher – Public Governor
Tom Vellender – The Guardian Service

Agenda No.	Agenda item	Action
1.	**Welcome, apologies and Chair's opening remarks** The Chair welcomed members and attendees to the meeting. Apologies were noted from Mrs H Gunawickrema (HG), Non-Executive Director and Mrs K Wheatcroft (KW), Director of Governance, Risk & Improvement. The Chair congratulated Mr D Nash on his substantive appointment as Director of Transformation and Productivity. The Chair highlighted recent engagement with Members of Parliament regarding visa sponsorship issues affecting Trust staff. The Chief Executive and Chair had met with MPs and would be submitting a letter of support. The Chief People Officer provided an update on the position relating to Certificates of Sponsorship, graduate visas and dependent visas. It was noted that six staff were currently affected, with a wider cohort of approximately forty staff on graduate visas potentially impacted.	

	Recent Government confirmation that Agenda for Change pay uplifts would not immediately raise the sponsorship threshold creates a limited window to support eligible staff. A paper is being developed for Executive consideration on graduate and dependent visa options, taking account of cost implications. The Chair reiterated the Trust's commitment to retaining affected staff wherever possible. Prof A Hassell (AH), Non-Executive Director asked what the cited £0.5m figure represented. The Chief People Officer clarified this reflected average skilled worker visa costs of approximately £3,000 per person per year. The Board **noted** the update.	
2.	**Declarations of Conflicts of Interest with agenda items** There were no declarations of interest to note.	
3.	**Service Showcase** I Kustos (IK), Medical Microbiology Consultant and Clinical Lead for Microbiology and M Woodward (MW) Head of Nursing - Infection Prevent & Control presented the antimicrobial resistance action plan, detailing the trust's progress against national targets, benchmarking data, key concerns, and ongoing actions, with board-level oversight and involvement IK explained that antimicrobial resistance is a major health threat, with the UK government implementing a five-year National Action Plan starting in 2024. The plan sets ambitious targets for the NHS, requiring coordinated actions across trusts, and NHS England has requested executive oversight and board-level involvement. MW described the process of establishing baselines for drug-resistant infections and gram-negative bloodstream infections, highlighting the complexity of data analysis and the trust's progress in matching 2019-20 infection numbers, which contrasts with a national increase post-COVID. The team developed an online training package for nursing staff, integrated into the competency framework, and are working on a similar package for prescribers, aiming to track staff completion rates by year-end, with IT support for implementation. The trust's total antibiotic usage is below regional and national averages, with a downward trend since 2022. However, achieving the target of 70% usage from the 'access' category remains a challenge, and actions such as formulary reviews, horizon scanning, and education are underway to improve performance.	

	Concerns include microbiology staffing, limited time for stewardship activities, and the need for broader engagement. Plans involve recruiting a specialty doctor, increasing board rounds, reviewing antibiotic formulary, and launching an app to facilitate guideline access and improve stewardship. The Board discussed the planned deployment of an antimicrobial prescribing app, noting its potential to significantly improve accessibility to up-to-date guidance and support prescribing decisions at the point of care. It was confirmed that development was nearing completion, subject to final microbiology review, with an anticipated launch in early May. Board members strongly endorsed this development, emphasising its importance in supporting stewardship objectives and frontline clinicians. Mrs W Williams (WW), Non-Executive Director raised a question regarding the benchmarking data and what differentiated the highest-performing Trusts regionally and nationally. In response, it was explained that high-performing organisations had undertaken significant formulary reviews to shift prescribing towards narrow-spectrum antibiotics, supported by local resistance data, updated prescribing guidance, and electronic decision-support. Education and sustained clinical engagement were also highlighted as critical enablers. The Chair thanked IK and MW for attending and they exited the meeting. The Board **noted** the service showcase.	
4.	**Patient Story** A patient story was shared via video, highlighting consistently high standards of care, compassion and professionalism across Ward 47 and Ward 44. Particular commendation was given to named staff and teams for exemplary nursing care and support provided to the patient and family. The Board **noted** the patient story.	
5.	**Minutes of the previous meeting held on 27th January 2026** The minutes of the previous meeting held on 27th January 2026 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** – Progress was noted. The Chair asked the Assurance Committees to contribute to forward trajectories where relevant.	

	Action 7 – An update was provided following a recent GIRFT visit. Strengths in rapid triage were acknowledged, with actions identified to reduce reliance on escalation and frailty spaces. A follow-up visit is planned in approximately six weeks. The Chair requested Quality & Safety Committee oversight of discharge process improvements. Action closed. The remaining actions were closed or not due yet. The Board **noted** the action log updates.	
7.	**Chief Executive Officer's Report** The Chief Executive Officer's report was taken as read. Ms J Tomkinson (JT), Chief Executive Officer, highlighted key issues. JT advised that the provider collaborative may assume aspects of system leadership currently undertaken by the ICB, supported by a developing blueprint. She referenced the Leadership Board on 18 February 2026 and a subsequent follow-up meeting. JT confirmed that work was progressing to de-escalate escalation and corridor care, noting this remained challenging. Ms S Pemberton (SP), Deputy CEO and Director of Nursing and Quality was leading work, with Mr Shaun Brown Deputy Chief Operating Officer, to assess implications and requirements. SP explained that a programme to de-escalate corridor care was underway, alongside strengthened flow governance. A new flow and discharge forum, chaired by SP, would commence in April, with SP, Ms C Chadwick (CC) Chief Operating Officer and Dr N Scawn (NS) Medical Director leading workstreams. The forum would address internal delays and strengthen engagement with external partners. It was noted that NC2R levels remained very high and that the recent Professor Tim Briggs visit and subsequent correspondence had made clear expectations to eradicate corridor care. Work on long length of stay was ongoing. In response to a question from Prof A Hassell (AH) Non-Executive Director, SP confirmed a loose weekend discharge plan was in place, including Friday identification of patients for discharge. She emphasised the need for clear medical documentation to support criteria-led, nurse-led weekend discharges, reporting improvement in the most recent weekend and confirming continued focus. Mr S Corcoran (SC), Non-Executive Director asked whether there was sufficient senior leadership capacity to deliver the programme. SP confirmed that Chris Owens, Alison Swanton and Shaun Brown were accountable for operational delivery, with executive oversight. She confirmed an exit strategy was in place.	

	NS noted that medical leadership capacity was limited but being strengthened. The Chair commented that sustained progress required whole-system working. JT highlighted a significant improvement in the Trust's position within the National Oversight Framework, recognising staff efforts. She also referenced the visits by Professor Tim Briggs and Ms Lesley Watters, noting the constructive challenge provided. Improvements in the Patient-Led Assessments of the Care Environment (PLACE)assessment and NHS England quality assessment were reported. JT advised that CEO planning sessions had been held with around 120–130 colleagues, focusing on delivery of the annual plan. Finally, she confirmed that resident doctor industrial action was anticipated the following week, with strike planning arrangements in place. The Board **noted** the CEO's report.	
8.	**Chair's Update** The Chair reflected that 2025/26 was always intended to be a tactical year, with the Trust's current position shaped by challenges and performance in previous years. He referred to the disappointing staff survey results, recognising the sustained pressures on staff and emphasising that delivery of improvement was not possible without staff being supported and engaged. Ms S Pemberton (SP), Deputy CEO/Director of Nursing and Quality updated the Board on recent engagement with the Royal College of Nursing, including emerging work on compassionate leadership. She advised that the College had offered to attend a future Board meeting to share insights from other NHS organisations in turnaround. SP noted that organisations can focus heavily on metrics, and that improvement in staff experience indicators can take time to follow operational improvements. The Chair confirmed that Mr P Jones (PJ), Non-Executive Director would take on the role of NED strategy lead, to support the Director of Strategy and Partnerships, with scope to involve Ms A Simpson, Non-Executive Director. The Chair also highlighted transformation as a key challenge, confirming that Mr D Nash has been appointed as Director of Transformation and Productivity, and to be supported by Mrs H Gunawickrema, Non- Executive Director as the NED Transformation lead. Ms J Tomkinson (JT), CEO emphasised the need for clarity that the Board would not move away from its focus on operational delivery, noting that strategy sets the future direction, but operational performance represents execution in practice. She confirmed there would never be a point at which the Board focused solely on strategy at the expense of operational oversight.	

	The Chair informed the Board that Ms Cathy Cowell had been appointed Chair of NHS England North West, and would provide valuable support in strengthening system-wide working. NL also welcomed Dr Eve Collins (University of Chester) to the Council of Governors and reported on a recent visit by the High Sheriff, who had toured the Women's and Children's Services and provided positive feedback on the care observed. Finally, it was noted that the Integrated Care Board (ICB) remained focused on organisational restructuring and the redevelopment of its strategic commissioning role, which would continue to evolve over the coming period. working. The Board **noted** the Chair's Update.	
9.	**a) Board Assurance Framework – 2025/26 Q4 Update** Mrs N Cleuvenot (NC), Head of Corporate Governance reported that the BAF had been fully reviewed by the Executive Team, with additional narrative included in the paper to reflect trajectory and areas of risk reduction. However, it was acknowledged that further work was required. A reset of the BAF was planned, to be undertaken through a dedicated session at the Board Development Day in May. The Chair noted that the BAF remained a work in progress and invited feedback from Assurance Committees on how they would like the BAF to be shaped going forward. He observed that risk scores appeared largely static and highlighted the need for greater clarity and focus on the Trust's most significant risks, to strengthen Board assurance and oversight. The Board: • **approved** the updates to the 2025/26 Board Assurance Framework • **noted** the update on progress in delivering strategic objectives **b) High Risks Report March 2026** NC reported that an internal audit review had been completed by Mersey Internal Audit Agency (MIAA), with management responses in the process of being finalised. The Trust received moderate assurance, reflecting improvements made to date, while recognising that further actions remained outstanding. Improvements were noted in training and reporting arrangements, which would strengthen the Trust's ability to hold services to account through more effective use of the risk register. Mrs S Corcoran (SC), Non-Executive Director commented that the quality and maturity of risk registers had significantly improved compared to previous years. However, she highlighted that some	

	staffing and cultural risks were not yet sufficiently reflected and would benefit from clearer articulation. Mr P Jones (PJ), Non-Executive Director referred to the Glaucoma risk, drawing attention to the target date position within the register. Mr J Bradley (JB), Chief Digital and Data Officer confirmed that the Microbiology reporting risk had a target date of March, with joint work underway with Wirral colleagues. He advised that this risk was in the process of being closed, subject to completion of the final actions. In relation to staffing levels, Ms V Wilson (VW), Chief People Officer was asked to provide an update. It was confirmed that the Trust continued to experience gaps, particularly within nursing, and that the risk could not yet be considered reduced. Further review of this risk was ongoing. On General Surgery on-call, Dr N Scawn (NS), Medical Director advised that a business case had been considered by the Executive Directors Group, but was not affordable in its current form. Alternative options were therefore being explored. The Board discussed the Vascular Hybrid Theatre risk, acknowledging this as a significant capital investment. Mr J Develing (JD), Director of Strategy and Partnerships confirmed that partnership options were being explored. In response to a question from Chair regarding the level of risk, JD clarified that the absence of a hybrid theatre remained a risk, currently mitigated by staff managing procedures using full lead protection throughout the day. It was reiterated that developing a hybrid theatre remained the strategic intention, with work underway to assess activity required to support the medium-term plan. The Chair queried whether the risk score remained appropriate; Ms J Tomkinson (JT), CEO confirmed the risk should remain at its current score (16) until a substantive solution was in place, noting this was linked to the Estates business case scheduled to come to the Board later in the year. Mr P Williams (PW), Non-Executive Director asked whether the Trust had considered the wider geopolitical risk landscape, including cyber security, energy costs, contractor resilience, supply chains, fuel poverty and community tensions. JT confirmed that Executive discussions had taken place, particularly in respect of energy, staff support and cyber security. While the issue was appropriate to monitor, it was not currently considered to meet the threshold for inclusion within the High Risk Report. JB added that the National Cyber Security Team had issued alerts, which were being monitored. NS also highlighted emerging concerns regarding drug shortages, advising that a dedicated pharmacy team was actively sourcing medicines, including from less common suppliers. The Board noted that this would be kept under review and escalated within the risk framework should the position deteriorate.	

	The Board considered and **noted** 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.	
10.	**Quality & Safety Committee Chair's Report – 5th March 2026** The Board received the report of the Quality & Safety Committee meeting held on 5 March 2026, presented by Professor A Hassell (AH), Non-Executive Director. AH highlighted key areas of discussion, noting ongoing performance challenges against UEC constitutional standards. He also drew attention to two areas of sustained good performance, specifically Safeguarding and Complex Care, which had provided assurance to the Committee. Under assurance, AH raised the issue of Emergency Department resuscitation capacity. While a risk assessment had been provided, the Committee had requested a further detailed paper to provide additional assurance around patient safety. Under advise, AH highlighted progress and challenges relating to Patient Safety Partners (PSPs). While there were a number of areas where the Trust aspired to include PSPs, progress was currently constrained by financial limitations. Mrs S Pemberton (SP), Deputy CEO/ Director of Nursing and Quality advised that following Committee discussions, consideration was being given to engaging the Council of Governors to explore whether there was interest in supporting or participating in a PSP role. The Chair queried the Committee's discussion on pressure ulcer prevention, seeking clarification on areas of concern. SP confirmed that there had been an overall reduction in pressure ulcers during the year, but acknowledged that performance was less consistent in certain areas, particularly the Emergency Department, where timely risk assessments remained challenging. SP also noted that a significant number of new mattresses had been installed in ED, which was expected to support further improvement. The Board **noted** the update	
11.	**Freedom to Speak Up Report (FTSU)** The Board received the Freedom to Speak Up report presented by Ms C Chadwick (CC), Chief Operating Officer. CC reported that 85 concerns had been raised during the period, representing an 11% reduction compared to the same period last year. The main themes related to patient and staff safety, which were noted to commonly correlate with winter pressures and staffing levels.	

	It was noted that the Trust was awaiting further guidance from the National Guardian's Office. The FTSU policy had been reviewed, approved by the Partnership Group, and was scheduled for ratification at the next People Committee. Feedback from the FTSU Champions Network indicated that, where colleagues raised concerns informally with Champions, they often chose not to escalate further. CC advised that Ms H Ellis (FTSU Guardian) was meeting with Divisional leadership teams to strengthen learning, feedback and communication. She further reported that, following discussion at the People Committee, a small task-and-finish group (including the FTSU Guardian) would triangulate FTSU concerns with other intelligence sources (such as complaints and other routes for raising issues), with this analysis to be incorporated into future reports. The Chair queried the reference in the report to the 'continuation of concerns', asking whether this indicated any emerging hotspot. CC confirmed that this related to multiple concerns within a single department, which had been appropriately escalated, investigated and concluded, with feedback provided to the department. Ms W Williams (WW), Non-Executive Director reminded the Board that the report had been discussed in depth at the People Committee, where recent focus had been on ensuring the Trust was benefiting from learning arising from FTSU cases, while maintaining confidentiality. She noted that while the process was now well embedded and understood, there was less clarity around actions taken and organisational learning and expressed concern that delays in HR processes appeared as a top theme. Ms V Wilson (VW), Chief People Officer confirmed that FTSU was discussed at every People Committee, and acknowledged the significant work undertaken by the FTSU Guardian to encourage speaking up. She echoed the view that the Board and Committee required greater visibility on actions taken, learning achieved and feedback provided, noting that the prominence of HR process delays did not clearly align with the primary themes of patient and staff safety. The Chair commented that, based on his attendance at a recent session, concerns raised via FTSU often reflected dissatisfaction with the outcome of HR processes, rather than the processes themselves. The Board **noted** the update.	
12.	**Guardian for Safer Working Report** The Board received the Guardian for Safer Working Report, presented by Mr Nigel Scawen (NS), Medical Director.	

	NS provided an overview of the annual reporting process, noting that medical staffing could sign off work schedule breaches of less than two hours. The report included a breakdown by specialty, highlighting areas of pressure. NS advised that the introduction of the e-rostering system and delivery of the 10-point plan were key enablers to improving the working lives of resident doctors. While progress was being made, NS acknowledged ongoing challenges, including significant staffing gaps driven by increased less-than-full-time working, and a high reliance on bank and locum doctors, with associated cost pressures. In response to a question from Prof A Hassell (AH), Non-Executive Director, NS advised that workforce pressures were expected to remain challenging in the short term, particularly among Foundation Year doctors, where locum usage was high. It was noted that some tasks currently undertaken by junior doctors could, in future, be supported through expanded Advanced Nurse Practitioner (ANP) roles. NS outlined the cost constraints and recruitment difficulties associated with developing ANP capacity. Mrs S Corcoran (SC), Non-Executive Director queried the position in Accident & Emergency (A&E). NS confirmed that A&E represented the largest cohort of resident doctors, describing it as a transient workforce with seasonal variation and higher levels of turnover. The Chair asked what the Board should focus on in providing oversight. NS advised that the Board should monitor trends over time, with a view to testing in 6–12 months whether intended improvements had been delivered. The Chair also asked about the relevant business case, to which NS confirmed it would be returned to the Executive Directors Group in Q2. Ms J Tomkinson (JT), CEO noted that there was no dedicated funding available next year, meaning solutions would need to be self-managed within existing resources. NS highlighted ongoing complexity around safe staffing, particularly in urgent care. He explained that while the minimum requirement for the organisation was one medical registrar overnight, the Trust had historically funded a second registrar due to workload intensity. As resident doctors had become accustomed to this higher level of cover, exception reports continued to be submitted even when minimum safe staffing levels were met. NS emphasised the distinction between minimum safe staffing and normal operating levels. The Board **noted** that quarterly monitoring of safer working arrangements would continue through the People Committee, with the annual report brought back to the Board for assurance.	
13.	**Safety Surveillance and Learning Report – Quarter 3 2025/26**	

	The Board received the Safety Surveillance and Learning Report for Quarter 3 2025/26, presented by Mrs S Pemberton (SP), Deputy Chief Executive and Director of Nursing and Quality. SP advised that the paper had previously been reviewed by the Quality & Safety Committee and provided an overview of incidents, complaints, concerns and learning from deaths. She noted that while overall governance arrangements were robust, learning from deaths required further strengthening. A more detailed paper was therefore being taken to the Quality Governance Group, with Mr Ian Benton leading this work. SP also highlighted progress in developing an Organisational Learning Policy to support systematic sharing and embedding of learning across the Trust. Professor A Hassell (AH) commented that learning and improvement themes were strongly reflected throughout the report. The Board **noted** the report**.**	
14.	**Quarter 3 2025-2026 Mortality Surveillance Report (Learning from Deaths)** The Board received the Quarter 3 2025/26 Mortality Surveillance Report, noting that overall trends remained satisfactory. Mrs S Corcoran (SC), Non-Executive Director queried the position of the stroke mortality outlier, asking whether improvement was expected. In response, Dr N Scawn (NS) explained that the data was based on a 12-month rolling average, with peaks occurring around Christmas last year and again in May. As a result, improvement would not be reflected until later in the year, once earlier peak periods fell out of the reporting window. NS reminded the Board that Dr Sam Shepherd had provided a detailed update on the stroke service at the previous Board meeting. The Board **noted** the report.	
15.	**Self-Assessment and Designated Body Controlled Drugs Accountable Officer (CDAO) Improvement Framework for 2026** The Board received the CDAO Self-Assessment and Improvement Framework presented by Ms K Adams (KA), Chief Pharmacist and Controlled Drugs Accountable Officer. KA reported that the Trust had turned the dial on several elements of the framework, highlighting significant improvements following a previous controlled drug diversion incident. As a result, the Trust had strengthened controls around lower-schedule controlled drugs, with revised arrangements now embedded in routine practice and reported to be well-received after ten months of implementation.	

	Further improvements included the development of a Business Intelligence (BI) function, enabling quarterly review of lower-schedule controlled drugs and improved visibility of usage patterns. KA acknowledged that while the dashboard was not comprehensive, it provided much clearer assurance on administration trends than previously available. Professor A Hassell (AH), Non-Executive Director commended the progress made and asked about gaps in staff training compliance. KA confirmed that controlled drugs training had now been incorporated into the nursing competency framework, noting that evidence of uptake would become visible in future reporting cycles. Ms J Tomkinson (JT), CEO referred to Section 4.5 of the framework and queried the remaining gaps. KA confirmed that the primary gap related to capacity, explaining that some trusts operated dedicated controlled drugs teams and specialist software solutions. While the Trust did not currently have these, the BI dashboard represented a pragmatic interim solution. She advised that when diversion concerns arose, her capacity was appropriately redirected to manage these issues. The Board **approved** the proposed answers for submission of the Self-Assessment and Designated Body Controlled Drugs Accountable Officer (CDAO) Improvement Framework for 2026. *KA exited the meeting.*	
16.	**Integrated Performance Report (IPR)** **Operational Performance** Ms C Chadwick (CC), Chief Operating Officer provided an overview of operational performance, noting that 4-hour A&E performance had improved, but remained at around 60%, below the constitutional standard. A&E attendances continued to increase, including a rise in attendances from Wales. Ambulance turnaround times were reported to be within 45 minutes. Corridor care had been used during February, although significantly less than in January. CC reported that Non-Criteria to Reside (NC2R) levels remained high, with approximately 22% of the bed base affected during January and February, compared to a national target of 15%. Bed occupancy remained high at an average of 98%, exceeding the national average. In relation to planned care, CC advised that the Trust had committed last year to achieving 60% RTT performance and was on track to exceed this, placing the Trust in the top 4–5 most improved nationally. There were five 65-week breaches at the end of February, with significantly fewer patients entering the month requiring treatment. On cancer performance, CC explained that a dip in January followed a significant increase in referrals compared to December, impacting	

	performance. However, there had been a reduction in patients waiting over 62 days. CC updated on diagnostics, noting the Trust had been placed into tiering for January, but performance improved in February to 86.4%, close to the 87% target. The Trust was now the highest-performing endoscopy service regionally. Mrs W Williams (WW), Non-Executive Director congratulated the team on the endoscopy improvement and asked what had enabled the turnaround. Mr D Nash (DN), Director of Delivery explained that this included benchmarking activity, engagement with clinicians, booking and scheduling teams, focused work with Advanced Nurse Practitioners (ANPs), a robust rostering system, and the embedding of 6-4-2 working within endoscopy. A business case approved in January 2025 for additional ANP and consultant capacity had also supported improvement. Wendy noted this represented sustained process change and asked about resistance. DN acknowledged initial resistance, but reported a clear cultural shift, with staff now proud of performance. Professor A Hassell (AH), Non-Executive Director congratulated the Trust on Referral to Treatment (RTT) performance and asked whether the opening of a new mental health assessment service had reduced A&E attendances for mental health presentations. CC confirmed the MCAS service was operational, but data was still required from CWP colleagues to assess impact. She noted that length of stay for mental health patients remained a challenge. The Chair asked whether length of stay had reduced overall; CC confirmed this continued to be an issue despite improvements elsewhere. **Quality** Ms S Pemberton (SP), Director of Nursing and Quality and Deputy CEO presented the Quality update. SP reported that the Trust continued to perform well in relation to risk assessments, with overall compliance at around 90%, noting that performance in the Emergency Department remained more challenging. There were no STEIS incidents reported in February, although one incident had been reported the previous day. Incident reporting had reduced in February. In relation to infection control, SP advised that there had been a spike in infections during February, however the Trust was expected to be back within trajectory for Clostridioides difficile by the end of the day. SP highlighted that Friends and Family Test (FFT) results indicated that further improvement was required, with a continued focus on patient experience across inpatient and outpatient settings. Risk assessment remained a key focus area. In response to a question from Mrs S Corcoran (SC), Non-Executive Director regarding safer staffing levels, SP confirmed that unregistered staff shortages remained a challenge, with a current gap of approximately 30–35 posts, partly reflecting the transition from Band 2 to Band 3 roles. SP confirmed that there were no concerns in relation to critical care staffing.	

	Safety Dr N Scawn (NS), Medical Director presented the Safety update. NS reported that electronic discharge (e-discharge) performance continued on a slow upward trajectory. He advised that the next anticipated step change would come from a multi-disciplinary working group, led by the Deputy Medical Director, with Pharmacy and Medical teams, to introduce a simplified discharge form within the Electronic Patient Record (EPR). Progress was described as incremental but continuously challenged, with system changes to EPR potentially achievable by Q3. In relation to sepsis, NS confirmed that screening compliance had improved, supported by a hard stop within Cerner, and that assessment within required timeframes was above benchmarking averages. A detailed deep dive had been undertaken at the Quality & Safety Committee with senior nursing leadership. NS acknowledged that antibiotic administration timeframes remained the key area requiring improvement. Mrs W Williams (WW), Non-Executive Director queried what was delaying timely antibiotic administration. NS explained this was primarily due to availability of a nurse in the Emergency Department to administer IV antibiotics, driven by very high patient volumes, rather than baseline establishment levels. WW noted that public-facing statistics did not appear to reflect the extent of improvement work undertaken and suggested that additional narrative may be required alongside performance data. NS confirmed that quarterly sepsis progress was monitored through the Quality & Safety Committee. SP highlighted that pressures within ED were compounded by sickness, annual leave and workload intensity, stressing that staff were striving to meet standards within a highly complex and prioritised environment. AH supported this view, noting it was evident that staff were working diligently to meet sepsis standards. The Chair commented that the underlying constraint remained system capacity, noting that demand levels significantly exceeded those of 18 months ago and that current performance was not sustainable within existing funding and structural arrangements. WW sought reassurance on patient outcomes. NS confirmed that the Trust had received positive assurance, with a low number of deaths attributable to sepsis. SC observed that reduced compliance during winter correlated with higher sickness absence, which was consistent with operational pressures. NS also confirmed that the Sepsis Group continued to meet weekly to oversee and drive improvement. **People** The Board received the People Update presented by Ms V Wilson (VW), Chief People Officer.	

	VW reported that sickness absence had increased marginally by 0.02%. She clarified that the sickness figure reported within the National Oversight Framework (NOF) was an annualised rate, which continued to show an overall downward trend. While sickness had increased during the winter period, this rise was less pronounced than in the previous winter. Staff turnover was reported to be reducing overall. VW noted that turnover within administrative and clerical staff remained higher than other groups, reflecting areas where the Trust had intentionally reduced headcount. VW confirmed that appraisal and mandatory training compliance remained above target, although a slight reduction since January had been observed. This was being actively addressed, with Estates and Facilities continuing to be an area of comparatively lower compliance. In relation to agency use, VW acknowledged ongoing staffing pressures, which had required some continued use of agency staffing. However, she reported that agency spend had improved, reflecting tighter controls and mitigation actions. At the Chair's request, Mr J Bradley (JB), Chief Digital & Data Officer provided an update on the Trust's position within the National Oversight Framework (NOF). JB advised that improving performance over time was now beginning to translate into the NOF, with the Trust currently assessed as overall green. However, the Trust remained in Segment 4, reflecting its position within the lower quartile when benchmarked against other trusts. JB noted that until improvement was seen in the lower-scoring domains, a shift in segment was unlikely. The Chair commented that the Board had already discussed the areas contributing negatively to the NOF position. In response to a question from Prof A Hassell, Non-Executive Director regarding whether the NOF was weighted, JB confirmed that it was not weighted. Scores across the four domains were aggregated and averaged, with trusts then ranked against peers. JB noted that this quartile-based approach did not always accurately reflect underlying performance improvement. VW added that sickness absence data within the NOF lagged significantly, with the current assessment reflecting Q2 data, rather than the Trust's more recent performance. **Finance** The Board received the Finance Update presented by Mrs K Edge (KE), Chief Finance Officer.	

	KE reported that at Month 11 the Trust was reporting a £14.9m year-to-date deficit, representing a favourable variance of approximately £1.5m against plan. She noted that Month 12 remained a challenging target, and that delivery would be dependent on maintaining progress achieved in Month 11. KE advised that financial trends were broadly stable, with no additional issues to highlight. However, delivery of the Cost Improvement Programme (CIP) remained the principal concern. At Month 11, CIP delivery was approximately £10m behind plan, with a £7m gap relating to recurrent schemes, which had been factored into financial planning. KE emphasised that, despite this, the Trust had still delivered a significant level of CIP during the year. KE confirmed that the Trust had received £14m of Deficit Support Funding (DSF) in Month 11, representing previously withheld funding. She noted that the Trust was one of a small number of organisations to receive this in full, reflecting confidence in delivery. As a result, the cash position had strengthened significantly, improving liquidity and supporting compliance with the Better Payment Practice Code, although some emergency cash funding would require repayment. The Chair commented that receipt of DSF represented more than a cash benefit, but a signal of confidence in delivery and progress. He highlighted that this position should support and reinforce the ongoing work on CIP delivery, led by Mr D Nash (DN) in the new role as Director of Transformation & Delivery with the NED Lead for Transformation, Mrs H Gunawickrema. The Board **noted** the Integrated Performance Report.	
17.	**Operational Management Board Chair's Report – 22nd January 2026 and 26th February 2026** The Board received the Operational Management Board Chair's report, which set out areas to alert, assure and advise the Board, including any new or emerging risks. Ms J Tomkinson (JT), Chief Executive Officer, highlighted the following: • Alerts: An ongoing ophthalmology risk was noted. • There were no new significant issues requiring escalation to the Board, with UEC-related matters already addressed. • JT referred to a previous OMB alert regarding the Stryker cyber-attack and the associated risk to orthopaedic implant availability, noting the need to consider how the Trust could strengthen resilience to future supply-chain disruption. The Board **noted** the update.	

18.	**Finance & Performance Committee Chair's Report – 21st January 2026 and 25th February 2026** The Board received the Finance and Performance Committee Chair's report which included areas to Alert to the Board, areas where Assurance had been received, areas to Advise the Board and any new risks discussed. There were no further comments or questions. The Board **noted** the update.	
19.	**Audit Committee Chair's Report – 3rd February 2026** The Board received the Audit Committee Chair's report from the meeting held on 3 February 2026, which covered areas to alert, assure and advise the Board, and any new risks discussed. Mr P Williams (PW), Non-Executive Director, reported the following: • There were no alerts for escalation to the Board. • The Committee received assurance on progress in addressing out-of-date policies. While good progress had been made overall, it was noted that a number of key clinical policies still required updating. • The Committee reviewed the self-assessment against the Code of Governance, noting partial compliance in two areas, external audit tenure and succession planning, where further development was required. • The Committee received a strong presentation on the Internal Audit Plan for 2026/27 and held a constructive discussion on the tracking of internal audit recommendations, expressing confidence in the robust arrangements in place. Mrs S Corcoran (SC), Non-Executive Director asked where oversight of clinical policy compliance was being reported. Professor A Hassell (AH), Non-Executive Director confirmed that this had been discussed at the Committee and agreed that Audit Committee would continue to monitor progress. The Board **noted** the update.	
20*.	**Cheshire and Merseyside 5 Year Strategic Commissioning Plan (2026-2031)** The Board received an update on the Cheshire & Merseyside 5-Year Strategic Commissioning Plan (2026–2031). Mr J Develing (JD), Director of Strategic Partnerships, presented this item alongside the associated paper for item 21, noting that both were ICB-led documents reflecting changing roles within the ICB as a strategic commissioner. JD advised that the papers had been subject	

	to system-wide consultation and were intended to help Boards understand new terminology and emerging system direction. In response to a question from Prof A Hassell (AH), Non-Executive Director, it was confirmed that there was no established digital centre of excellence at present. Mr J Bradley (JB), Chief Digital & Data Officer commented that Chief Accountable Officers within the provider collaborative were considering how these strategies would be collectively implemented, including whether a single digital plan and shared centre of excellence could be developed across Cheshire & Merseyside. The Chair reflected on what the range of system plans and strategies meant for the Trust, emphasising the need to link them coherently, so that the Board could retain control of its own strategy while influencing system partners. AH asked what outcomes-based commissioning might look like in practice. JD responded that this could mean different things in different contexts, but highlighted the importance of being data-driven, for example focusing on drivers of ill health and the needs of an older, frailer population in Cheshire West. Mrs W Williams commented positively on Pat Oakley, suggesting it might be helpful for her to engage directly with the Board. Further discussion took place on how the Trust could shape, interpret and align multiple system strategies. The Board **noted** the update.	
21*.	**Cheshire and Merseyside Population Health Improvement Plan (2026-2031)** Item 21 had been presented and discussed under item 20.	
22.	**Equality, Diversity & Inclusion Annual Report** The Board received and considered the Equality, Diversity & Inclusion (EDI) Annual Report, presented by Ms V Wilson (VW), Chief People Officer. VW advised that the Trust's approach to EDI focused on embedding equality and inclusion within day-to-day activity. The report set out the workforce profile, alongside key findings from the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and the Gender Pay Gap report. The report had also been considered by the People Committee, with the Board provided sight of the full detail via the appendix. VW acknowledged that representation across some protected characteristics, including disability and other groups, particularly at	

	senior levels, could be improved. Priority areas were clearly identified within the report, supported by an integrated EDI action plan. Mrs W Williams (WW), Non-Executive Director commended VW and her team for creating a strong platform to better understand EDI across the organisation, noting that while the Trust recognised it was behind as an employer, this was now clearly understood due to improved insight and compliance with external requirements. WW highlighted the importance of understanding barriers to progression, including for women and colleagues from ethnic minority backgrounds, and noted the role of an effective sub-committee in addressing these issues. Mrs S Corcoran (SC), Non-Executive Director described the report as excellent and insightful, commenting that while the NHS often had good intentions around EDI, this did not always translate into practice. She suggested the Trust had an opportunity to lead by example, including through more effective use of EDI information within Board papers, such as consistent use of EDI sections on cover sheets. The Board: • **received assurance** that the Trust continues to meet its statutory duties as an employer in relation to the Equality Act 2010, and the Public Sector Equality Duty. • **received and noted** the high level summaries of the statutory reporting completed in year • **received and approved** the Trusts Workforce EDI Annual Report 2025/26 for publication (Appendix 1) • **received and noted** the Trusts WRES and WDES metrics for 2025 (Appendix 2)	
23.	**People Committee Chair's Report – 10th February 2026** The Board received the People Committee Chair's report from the meeting held on 10 February 2026, covering areas to alert, assure and advise the Board, and any new risks discussed. Mrs W Williams (WW), Non-Executive Director, highlighted that this was a positive meeting, with significant progress underway on Equality, Diversity & Inclusion (EDI). WW advised that the Committee did not receive sufficient assurance on Freedom to Speak Up (FTSU) and had therefore requested that this return to the Committee for further consideration. Under advise, WW reported positively on the operation of the People Committee sub-committees, noting they were functioning effectively. She highlighted that their strength lay in being operationally led, enabling real-time insight and informed discussion, and providing useful assurance to the Committee. While still developing, good	

	progress was being made. Relevant risks were noted as set out in the paper. Ms V Wilson (VW), Chief People Officer credited Ms Liz Pritchard and Mr Paul Marston, Deputy Chief People Officers, who chair the sub-committees, noting that this leadership had enabled more effective and constructive discussion at People Committee. The Board **noted** the report.	
24.	**Standing Financial Instructions Review 2026** The Board considered the Standing Financial Instructions (SFIs) Review 2026, presented by Mrs K Edge (KE), Chief Finance Officer. KE advised that the SFIs are subject to annual review and had been reviewed by the Audit Committee, with the revised version now presented for ratification and approval by the Board. She confirmed that the changes were minor, reflecting updates to terms of reference, legislative requirements, terminology and job title amendments. The Board **approved** the Standing Financial Instructions.	
25.	**NHS Staff Survey 2025 – Results and High-Level Actions** The Board received an update on the NHS Staff Survey 2025 results and proposed high-level actions, presented by Ms V Wilson (VW), Chief People Officer. VW expressed disappointment with the results but emphasised the importance of viewing them in the context of sustained organisational pressure. She noted that the absence of further deterioration should be recognised as a positive outcome. VW highlighted that the breadth of survey questions allowed results to be interpreted in different ways, with some positive indicators evident, including line management relationships and flexible working, reflecting focused efforts over the past year. VW reiterated that perceptions of insufficient resources continued to strongly influence staff experience, alongside the concept of moral injury. Divisional patterns were reported to be consistent with previous years. VW outlined priority areas for the coming year, noting that staff discussion sessions had been held to explore the results in more depth. These sessions were well received, with staff expressing a strong desire for greater involvement, particularly around communication and how key messages are delivered. VW advised that improved communication and engagement would address a number of the issues identified.	

	Prof A Hassell emphasised the importance of the results being discussed at People Committee. He also reflected on the challenge of survey data not always capturing recent improvements. VW confirmed that the report had not yet been considered by People Committee but would be taken to the next meeting. The Board: • **Noted** the Trust's Staff Survey 2025 results • **Noted** the analysis undertaken and areas for action identified. • **Agreed** the Trust priorities identified in section 5 (subject to review and approval at the next People Committee) • **Took assurance** that the Trust continues to engage its staff in the completion of the staff survey, review and analysis of the survey results, and identification of appropriate actions, and will monitor progress via People Committee.	
26.	**Sexual Safety Charter Framework Implementation** The Board received an update on the Sexual Safety Charter Framework implementation, presented by Ms V Wilson (VW), Chief People Officer. VW advised that the framework had been considered by both the People Committee and the Operational Management Board, and remained a continued area of focus, having been established in 2023. She noted that, nationally, specialist training was required for those managing sexual safety incidents. While incidents were currently being managed locally, the Trust would implement the national training once access was available. In the interim, the Trust had engaged Weightmans to provide relevant training. In response to a question from The Chair regarding whether sexual safety formed part of staff induction, VW confirmed that key sexual safety messages were included within induction training. The Board **noted** the update.	
27*.	**Council of Governors Report – February 2026** The report summarised the key topics presented and discussed at the Council of Governors meetings in February 2026 and Governor activity since the last Board meeting. The Board **noted** the Council of Governors Summary Report.	
28.	**Provider Licence Compliance 2025/26**	

	The Board received an update on Provider Licence Compliance for 2025/26, presented by Mrs N Cleuvenot (NC), Head of Corporate Governance. NC reported that a full review of compliance against the Provider Licence had been completed, including mapping compliance to NHS England (NHSE) undertakings. This assessment was reviewed in full by the Audit Committee in February, with a summary provided to the Board. The Trust had received undertakings from NHSE in November 2025, aligned to key Provider Licence conditions. These undertakings were incorporated into the compliance assessment, with mitigating actions and outputs reviewed. NC advised that a final review would be undertaken at year-end, and that any exceptions to compliance would be reflected in the Annual Governance Statement (AGS). She also noted that a separate paper had been considered in Private Board providing a detailed update on progress against the NHSE undertakings, and that NHSE was expected to undertake a review in Q1. The Board **approved** the Trust's current compliance against the Provider Licence, with a final review to take place as at 31st March and any implications from this to be included in the Trust's Annual Governance Statement and Annual Report.	
29.	**Code of Governance Compliance 2025/26** The Board received the Code of Governance compliance assessment, presented by Mrs N Cleuvenot (NC), Head of Corporate Governance. NC advised that a full and detailed assessment, undertaken on a 'comply or explain' basis, had been considered by the Audit Committee. The Trust was compliant with the majority of the Code's provisions, with two areas of partial compliance, representing a significant improvement compared to the prior year. NC highlighted year-on-year progress, noting that in 2024/25 the Trust declared partial compliance in seven areas, and that actions agreed last year were now embedded and operating. The Board: • **Approved** the Trust's current compliance position • **Noted** that a final review as at 31 March 2026 will inform The Annual Governance Statement	
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. **Other items:** e) Board of Directors Workplan 2025/26 and Draft Workplan 2026/27.	
31.	**Any Other Business** There was no other business to raise. The Chair invited views on whether Board members were content with the papers presented and decisions taken. Mrs S Corcoran (SC), Non-Executive Director confirmed that the papers were of a high standard, noting however that some items and further detail could appropriately be considered by assurance committees for additional scrutiny.	
32.	**Questions from Governors and members of the Public relating to items on the meeting agenda** Prof T Fisher, Public Governor commented that the Service Showcase was informative, noting that greater clarity on the clinical drivers of antibiotic use would be helpful. He queried the risk of reducing antibiotic use in relation to clinical outcomes. It was confirmed that patients would not be placed at unnecessary risk, and that clinical judgement would remain central to decision-making. **Future Dates:** 19th May 2026 21st July 2026 29th September 2026 24th November 2026 26th January 2027 16th March 2027	
33.	**Closing remarks** The Chair thanked everyone for their contributions and closed the meeting.	

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

NHS
Countess of Chester Hospital
NHS Foundation Trust

Public Board of Directors
Action Log & Decision Log
Updated May 2026

Action Log:

Action No.	Meeting Date	Allocated to	Action Details	Action Update/ Outcome	Due Date	Status
1	29th July 2025	Chief Digital and Data Officer	Mr J Bradley, will develop IPR 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. **Update 31st March 2026** – Progress noted. The Chair requested that assurance committees contribute to forward trajectories where relevant.	Sept -25	**Open**
2.	27th January 2026	Medical Director/Chief People Officer	Ms V Wilson and Dr N Scawn to explore 0.8 trainee contracts through Medical Staffing.		Jul-26	**Open**
3.	27th January 2026	Medical Director	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	Jul-26	**Open**

Action No.	Meeting Date	Allocated to	Action Details	Action Update/ Outcome	Due Date	Status
				(GIRFT) Urgent Emergency Centre (UEC) visit on 25th March 2026. **Update 30th April 2026** – This action has been combined with action 4, with the GIRFT update to the July 2026 Board of Directors.		
4.	27th January 2026	Chief Operating Officer	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).	**Update 30th April 2026** – Action deferred to July 2026 Board of Directors pending GIRFT completion.	~~May 26~~ Jul-26	**Open**

Decision Log:

No.	Meeting Date	Decision
1.	31st March 2026	The Board **approved** the updates to the 2025/26 Board Assurance Framework
2.	31st March 2026	The Board **approved** the proposed answers for submission of the Self-Assessment and Designated Body Controlled Drugs Accountable Officer (CDAO) Improvement Framework for 2026.
3.	31st March 2026	The Board **approved** the Trusts Workforce EDI Annual Report 2025/26 for publication
4.	31st March 2026	The Board **approved** the Standing Financial Instructions.
5.	31st March 2026	The Board **agreed** the Trust priorities identified in section 5 NHS Staff Survey Results and Actions (subject to review and approval at the next People Committee)
6.	31st March 2026	The Board **approved** the Trust's current compliance against the Provider Licence, with a final review to take place as at 31st March and any implications from this to be included in the Trust's Annual Governance Statement and Annual Report.
7.	31st March 2026	The Board **approved** the Trust's current compliance position. (code of governance)

PUBLIC – Board of Directors
19th May 2026

Report	**Agenda Item 7a.**	**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 and Risk				
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 Updates

On the 1st April 2026 Sir James Mackey issued a letter to ICB and Trust CEOs setting out the priorities for 2026/27.

This includes working together to ensure

- Clarity of strategic commissioning and how this will be developed
- Ambitions for neighbourhood care, and how this links to key challenges
- Agreement of areas for review and changes to financial flows and/or payment systems
- Consideration of areas of support or change from NHSE to help accelerate the pace of change.

The letter sets out the following areas of focus

1. Outpatient transformation
2. A step-change in reducing hospital bed-days for highest-risk cohorts
3. Scheduling and access reform for urgent care
4. Technology-enabled productivity improvements
5. The NHS App
6. Payment reform
7. Quality
8. Capability building and a focus on our people

2. Regional Updates NHS England North West

NHS England have announced the appointment of Kathy Cowell as NHS England North West Regional Chair, who will be taking up post from 1st May 2026. This is a new role in the regional team. As set out in the Model Region Blueprint, the Regional Chair will provide visible, independent non-executive leadership across the region, working with the Regional Executive Team to develop a strategy to deliver against the 10-year health plan, ensuring improved life expectancy and quality of life, consistently high quality and efficient services and reduced inequalities in health outcomes. The Regional Chair will work with provider and ICB Chairs to deliver against that strategy and ensure high performing Boards and support improvement and intervention efforts across all organisations.

3. Regional Updates Cheshire and Merseyside ICB Senior Structure and operating model

On 28th April 2026 we received a letter from the Cheshire and Merseyside Integrated Care Board (ICB) confirming their senior structure and operating model. This provided an overview of the ICB leadership team, vision and values, strategic commissioning, and how they will work with partners.

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

20th March 2026

CEOs attended the Leadership Board on 20th March 2026. This meeting included:

- Discussion on CMPC and Cheshire and Merseyside Integrated Care Board priorities.
- Progress in respect of the CMPC programmes and professional groups including elective recovery and transformation, diagnose to refer, community services, finance, contracts and procurement.
- Feedback on C&M ICB Strategic Commissioning strategy.
- Feedback from Providers on the UEC Board.
- Discussion on locum rates.

17th April 2026

CEOs attended the Leadership Board on 17th April 2026. This meeting included:

- An update on Neighbourhood plans.
- The UEC Strategy and priorities as set out by the Cheshire and Merseyside ICB Performance Lead.
- A presentation on enabling technology and at scale collaboration.
- Finance and contracts update.
- Next steps and planning and priorities.

5. Mental Health Tripartite Agreement

NHS Cheshire and Merseyside (NHS C&M) has established a tripartite agreement with the Countess of Chester Hospital NHS Foundation Trust (COCH) and Cheshire and Wirral Partnership NHS Foundation Trust (CWP) to address long waits for people presenting with mental health needs to the COCH's emergency department (ED). The agreement includes shared principles and ways of working.

The assurance against this will be reviewed through the Mental Health Steering Group with Chair's reports to the new Executive Led Discharge, UEC and Admission Avoidance Group, subsequently reporting through to OMB.

6. NHS England Provider Capability Publication

NHS England wrote to organisations in early April confirming that whilst the intention had not been to publish the Q2 2025/26 Provider Capability Ratings, they had received a Freedom of Information (FOI) request and these would now be published. As previously reported the Trust had received a Red rating. This rating related to a review a number of months ago and therefore did not reflect the improvements made or the delivery of plans. The Q3 NHS Oversight Framework segmentation and rankings demonstrated a 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. In Q4 the Trust had already received communication from NHS England North West that the review of the Trust's Provider Capability would be carried out in Q1 2026/27 and we welcome this review.

7. Medium Term Plan Acceptance

On 16th April 2026 the Trust received confirmation of acceptance of the Trust's Medium Term Plan (MTP) and 5 Year Integrated Delivery Plan from NHS England. The acceptance was with conditions due to the non-compliant UEC plan.

The letter sets out a summary of the delivery targets and includes areas for further review and/or action in respect of finance, activity and performance, urgent care, and population health.

Refer Appended letter.

8. Single Point of Access

Outpatient transformation is a key National priority, to ensure systems have streamlined pathways for referrals onto elective pathways. There is an ambition that by Q3 each system has at least 10 referral pathways managed by a Single Point of Access (SPoA). Patients on the selected pathways will be referred into a SPoA and then triaged to determine the most appropriate next step for the patient. The options will include Advice and Guidance, referral to a community provider, return to referrer or onward referral to an acute provider if the patient requires consultant led care. It is anticipated this will reduce the number of patients that are referred onto provider waiting lists, incurring long waits when their condition can be managed in another way.

In Cheshire and Merseyside this work is being led by the provider collaborative. The project is in its infancy and currently providers are being asked to provide data and information so priority pathways can be selected. Specialties for consideration include ENT, Dermatology and Gynaecology. Further updates will be provided as this project progresses.

9. Celebrating our services: welcoming the Chief Nursing Officer for England

On the 10th April 2026, we were delighted to host Duncan Burton, Chief Nursing Officer for England, at our Trust. His visit was an opportunity to showcase the positive work happening across our teams. Duncan was given a tour of the Paediatric and Neonatal Units, where he spoke to a number of front-line colleagues about the new clinical environments and how they have positively impacted patient care and experiences. He also had the chance to see the improvements made to our Emergency Department including the new triage process, the improved paediatric areas and also the Millbrook Unit, our new dedicated space for patients with mental health care needs.

10. CQC Report

After a long wait, we have now received the Care Quality Commission's (CQC) draft report following their inspection of our services in October 2025. We have reviewed the report in detail and have provided evidence-based feedback to the CQC to ensure the report accurately

reflects our services. The Trust has also sent a letter summarising out concerns and findings to the Interim Chief Executive Officer and Head of Hospital Inspections. We await a response to both.

11. Transforming People Services

NHS England's Transforming People Services programme continues to progress following approval of the Outline Business Case in February 2026. The programme will establish a new target operating model for People Services, bringing together more standardised processes, digital-first access, greater use of automation and AI, and a clearer focus on strategic business partnering and workforce transformation. All regions and providers are expected to begin preparedness activity, including policy standardisation, data quality improvement, capability development and planning for future operating models. This work is aligned to the 10 Year Health Plan and the Future Workforce Solution, and the Trust will continue to engage through regional and national arrangements to ensure local plans remain aligned with the emerging model and opportunities for improvement, with ongoing progress monitored through People Committee.

12. UK threat level

On 1st May 2026 the Trust received notification from NHS England that the Joint Terrorism Analysis Centre (JTAC) has advised that the UK Threat Level should be changed from SUBSTANTIAL (an attack is likely) to SEVERE (an attack is highly likely). This change in alert level has been cascaded to staff.

The Trust has Emergency Preparedness, Resilience and Response (EPRR) frameworks in place and will continue to review the updates and advice provided.

Classification: Official-Sensitive

Ref 2026-04-16 CA COCH

NHS England

To: Jane Tomkinson, Chief Executive
Neil Large, Chair
Countess of Chester NHS
Foundation Trust

North West Region
4th Floor
3 Piccadilly Place
Manchester
M1 3BN

16 April 2026

Dear Jane and Neil

Medium-Term Plan (MTP) Acceptance Status: Accepted

I am writing in response of the submission **of your final medium-term plan for 2026/27–2028/29** and your **five-year Integrated Delivery Plan**, and to set out next steps. Thank you for the extensive work across the organisation that has contributed to the development of these plans. The annex to this letter summarises the key commitments your organisation has set out for delivery and any supporting actions to address key issues that have been agreed.

As we move into implementing the plans our shared focus moves firmly toward delivering the strategic shifts and long-term transformation required to reset NHS performance and build a sustainable, modern health and care service. The Medium-Term Planning Framework set a clear expectation that organisations will work over multiple years to restore constitutional standards, strengthen community-based care, and accelerate prevention and digital transformation. Planning over multiple years means that planning does not end with the agreement of the plan; the focus on delivery will also be accompanied by ongoing foundational work as you continue to work understand and assess any changes in the demand and capacity of your services and population health needs.

Transforming our services remains essential to achieving the required outcomes for patients as well as productivity and efficiency improvements to ensure sustainability. We will continue to work with you to ensure your organisation has access to the development and improvement support needed to strengthen capability and capacity.

Your submitted plan has been reviewed against the expectations set out in the national guidance and has been assessed as:

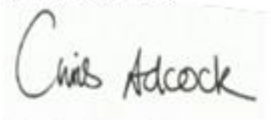
- **Non-Compliant for UEC but accepted with conditions**

It is imperative that the Board continually seeks to improve on any areas of non-compliance. Effective oversight of the delivery of these plans will be important to ensure that the ambitious trajectories are met. There is an expectation that the Board will remain focussed on demonstrating compliance with the undertakings agreed in 2025. We will review progress

against these plans with you through our regional governance arrangements to ensure that there is continuous oversight, alignment across organisations, and transparent governance.

Please let me know if you wish to discuss any of the above. I would be grateful if you could share this letter with your full Board.

Yours sincerely



Chris Adcock
Regional Director of Finance (North West)

Annex

Below is the outcome of your full submission and the compliance against the key ambitions within the three years until 2028/29:

Headline Targets - the targets/baselines specified in tables in the NTP Framework

Planning Metric	Metric ID	ICB or Provider Based	2026/27 Time point	2026/27 Baseline /Target	2026/27 Plan	2026/27 Variance	2027/28 Time point	2027/28 Baseline /Target	2027/28 Plan	2027/28 Variance	2028/29 Time point	2028/29 Baseline /Target	2028/29 Plan	2028/29 Variance
Percentage of RTT waiting list within 18 weeks (national target 70%)	E.B.40 / E.B.3a	Provider	Mar-27	67.0%	67.0%	0.00%	Mar-28	79.5%	79.5%	0.00%	Mar-29	92.0%	92.0%	0.00%
28-day cancer Faster Diagnosis Standard	E.B.27	Provider	Average across 2026/27	80.0%	80.0%	0.00%	Average across 2027/28	80.0%	80.0%	0.00%	Average across 2028/29	80.0%	80.0%	0.00%
Percentage of patients receiving a first definitive treatment for cancer within 62 days	E.B.35	Provider	Mar-27				Mar-28				Mar-29			
Percentage of people treated beginning first or subsequent treatment of cancer within 31 days	E.B.38	Provider	Mar-27	94.5%	94.5%	0.00%	Mar-28	96.0%	96.1%	0.12%	Average across 2028/29	96.0%	96.0%	0.00%
4-hour A&E performance	E.H.11	Provider	Mar-27				Average across 2027/28				Average across 2028/29			
12 hour breaches	E.H.11g	Provider	2026/27 Annual Total	14,998	11,487		2027/28 Annual Total	11,487	6,992		2028/29 Annual Total	6,992	7,000	

Supporting Metrics - these are wider targets/baselines maintained through the tool in the NTP Framework

Planning Metric	Activity and Performance	ICB or Provider Based	2026/27 Time point	2026/27 Baseline/Target	2026/27 Plan	2026/27 Variance	2027/28 Time point	2027/28 Baseline/Target	2027/28 Plan	2027/28 Variance	2028/29 Time point	2028/29 Baseline/Target	2028/29 Plan	2028/29 Variance
Total Waiting List	E.B.3a	Provider	Mar-27	26,110	25,899	-0.82%	Mar-28	25,899	22,079	-14.74%	Mar-29	22,079	18,674	-15.42%
Average handover time (Total Handover time (ED and non ED)/No of handovers (ED and non-ED))	E.E.42	Provider	Average across 2026/27	00:26:33	00:26:37		Average across 2027/28	00:26:37	00:17:04		Average across 2028/29	00:17:04	00:13:00	
Percentage of Handovers over 45 Minutes	E.E.47	Provider	Average across 2026/27											
Percentage of Handovers over 15 Minutes	E.E.48	Provider					Mar-28				Average across 2028/29			
Percentage of attendances at all type A&E departments where the patient spent less than 4 hours from time of arrival to admission / discharge / transfer (<5 Children	E.H.13f	Provider	Sep-26				Average across 2027/28				Average across 2028/29			

Specific issues that require ongoing review and/or further system action are:

Finance:

- The Trust has submitted a compliant finance plan for 2026/27, 2027/28 and 2028/29. The total deficit support funding (DSF) £21.9m is subject to national rules and to the conditions set out in this letter – our teams will agree monitoring arrangements and the process by which DSF will be allocated or withheld.
- We will work with you to build greater assurance on your financial sustainability plan and trajectories as represented in your medium-term plan submission.
- The Trust is expected to comply with all the requirements set out in undertakings.
- At the end of March 2026 your weekly Cost Improvement Programme (CIP) submission showed 3% of total CIP £25.4m is fully developed or implemented. As part of the planning process, we required that all 2026/27 CIP schemes were fully developed by 31 March. The Trust must prioritise work to rapidly develop CIP. Workforce reductions associated with the CIP programme must be implemented in a timely manner to ensure delivery of planned savings.

- As at 31 March the Trust did not have a signed contract with your main commissioner. NHS planning guidance required that all contracts be signed by 31 March. The Trust must now move urgently to reach signature on all contracts.
- The underdevelopment of CIP and unsigned contracts represent material financial risk Progress on mitigating these risks alongside process on the sustainability program will be carefully monitored and failure to make the required progress may result in the trust moving back to high risk and enhanced regional oversight arrangements being put in place supported by PwC and Stephen Hay as System Turnaround Director. Should this intervention be required, the trust would be responsible for the cost.

Activity & Performance:

- To meet the ambitions set out in the plans, it is assumed these are based on robust contingency plans which have been tested and are in place to mitigate any potential risk to delivery.

Urgent Care:

- It is recognised that Countess of Chester Hospital have submitted a plan for 4 hour A&E performance that is non-compliant for Years 1 and 2, but compliant by Year 3. The Trust will now need to enact plans to implement the Model ED framework consistently, continuing to mitigate risks and improve performance over the course of the 3 years. Delivery will be closely monitored and failure to deliver the improved performance could result in enhanced regional oversight arrangements being put in place.

Population Health:

- All NHS bodies must continue to demonstrate how they are meeting their statutory duties to have due regard to reducing inequalities in access, experience and outcomes, and how this is continually being translated into sustained and systematic action across all pathways. This includes maintaining a clear and explicit focus on improving population health, embedding prevention as core business, and delivering on sustainability commitments, including the implementation of organisational Green Plans. These priorities should be consistent with the NHS 10-Year Health Plan and its three shifts (from sickness to prevention, from hospital to community, and from analogue to digital). All activity should therefore reflect not only delivery against agreed plan commitments, but also how health inequalities, prevention and sustainability are embedded through governance arrangements, performance oversight and ongoing decision making for the populations you serve.

PUBLIC – Board of Directors
19th May 2026

Report	**Agenda Item 7b.**	**NHS England Enforcement Notice Progress Update**						
Purpose of the Report	Decision	**X**	Ratification		Assurance		Information	
Accountable Executive	Jane Tomkinson			Chief Executive Officer				
Author(s)	Karan Wheatcroft			Director of Governance and Risk				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X** **X** **X** **X** **X** **X** **X** **X**	Linked to all BAF areas.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X** **X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	A briefing on the draft NHSE Enforcement Notice and proposed Trust response was presented at the Board development day on the 21st October 2025. The response was subsequently circulated to Board members by email on 22nd October 2025 and the final draft undertakings considered by the Board at its private meeting on the 25th November 2025. The final NHSE undertakings letter was received by the Board at the Public meeting on the 27th January 2026. An update on progress was reported to the Private Board on 31st March 2026.							
Executive summary	NHS England (NHSE) has responsibility for the regulation of providers of NHS services (both ICBs and Providers), the exercise of provider enforcement powers, and producing and revising guidance on those powers. The summary below shows the current position against the NHSE undertakings placed on the Trust:							

	Undertakings	**Summary Position**
	Financial planning	The Trust achieved the delivery of its financial plan in 2025/26. The 5 Year Integrated Plan includes eradicating the underlying deficit over the course of the plan. The Trust is **meeting** this requirement.
	Funding conditions and spending approvals	The Trust has complied with the nationally processes for cash support. The Trust is **meeting** this requirement
	Performance	The Trust continues to focus on delivering improvements for UEC performance. There is more to do to sustain improvement for 4-hour and 12-hour performance to meet constitutional targets. The Trust continues to make progress but **did not meet** this requirement in 2025/26.
	Quality	Significant improvements can be evidenced, and effective oversight and assurance mechanisms are in place for UEC CQC action plans. The Trust is **meeting** this requirement.
	Reporting	The Trust has responded to all requests from NHSE. The Trust is **meeting** this requirement.
	The Board receives assurance of performance against these and there is clear correlation through the Board Assurance Framework. In March 2026, the Trust received a letter from NHSE confirming that they will undertake a review against the enforcement notice which will in turn inform a review of the provider capability assessment in Q1 2026/27 prior to publication. This paper provides an update on progress against the areas included in the NHSE enforcement undertakings at the end of 2025/26.	
Recommendations	The Board of Directors is asked to **approve** the reported position against the NHSE enforcement undertakings as at 31st March 2026.	

Corporate Impact Assessment	
Statutory/regulatory requirements	Trust compliance with the Provider Licence and Code of Governance.
Risk	Various risks included on Board Assurance Framework (BAF) and risk registers.
Equality & Diversity	Meets Equality Act 2010 duties & Public Sector Equality Duty 2 aims and does not directly discriminate against protected characteristics.
Communication	Published through Public Board papers.

NHSE Enforcement Notice Progress Update

1. INTRODUCTION

NHS England (NHSE) has responsibility for the regulation of providers of NHS services (both ICBs and Providers), the exercise of provider enforcement powers, and producing and revising guidance on those powers.

NHSE enforcement undertakings were signed by the Trust in November 2025 with the final letter received in January 2026.

In March 2026, the Trust received a letter from NHSE confirming that they will undertake a review against the enforcement notice which will in turn inform a review of the provider capability assessment in Q1 2026/27 prior to publication.

The purpose of this paper is to provide an update on progress against the requirements set out NHSE enforcement undertakings at year end 2025/26. Whilst the elements of this are received through other assurance mechanisms, it was felt that a consolidated report would be helpful in bringing this together.

2. CURRENT POSITION

The NHSE undertakings are set out below along with an update on the position as at 31st March 2026.

1. Financial Planning 1.1 The Licensee will deliver the 2025/26 Financial Plan, as agreed with NHS England. 1.2 The Licensee will deliver a quarter-on-quarter run rate improvement from Quarter 3 2025/26 and throughout 2025/26. 1.3 The Licensee will comply with all documented actions required by NHS England through the oversight meetings, led by NHS England or its representative.	
Current Position: The Trust achieved delivery of the financial plan for 2025/26. The Trust has delivered quarter on quarter run rate improvements from Q3. The Trust has complied with all requests and has continued to provide updates to and deliver actions from the FPRM. The Trust was stood down from FPRM in year due to demonstrable improvements in the financial position and confidence in the forecast delivery for 2025/26. The Trust's 5 Year Integrated Plan has been reviewed as credible and signed off by NHS England North West. The plan includes eradicating the significant underlying financial deficit over the next 5 years.	**Our Assessment:** The Trust is **meeting** this requirement.

2. Funding conditions and spending approvals

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

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

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

Current Position:	**Our Assessment:**
The Trust has complied with the national processes for cash support. Deficit Support Funding (DSF) was withheld in the earlier part of the year due to the system financial position, but the Trust applied for and received Distressed Cash Funding (DCF). Due to confidence in our forecast outturn for 2025/26 and our compliant financial plans for 2026/27, DFS was reinstated in March 2026 (with the expectation that DCF received during the year would be repaid).	The Trust is **meeting** this requirement.

3. Performance

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

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

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

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

Current Position:	**Our Assessment:**
In November 2025, the Trust was recognised as one of the top 10 most improved Trust's nationally c.f. 2024: for 4-hour compliance (5% improvement), 12-hour compliance (improved by 5%) and ambulance handovers average time (reduced by 37%). The Trust experienced an extensive period of operational pressures over the winter months which impacted A&E performance for both 4- and 12-hour metrics. The Trust has maintained excellent performance with average ambulance handover times, performing above plan and has significantly reduced use of the ED corridor.	The Trust continues to make progress but **did not meet** this requirement in 2025/26.

As at March 2026, there is a 1% improvement on 12-hour performance when compared to February, which is compliant with the plan (24%). 4-hour performance is improving month on month with a year-end position of 61.2%, however both measures were below targets in the operational planning guidance. The Trust has an extensive action plan including UEC and wider flow actions and has established a revised governance structure to oversee delivery. The Trust submitted a 5 Year Integrated Plan which has been accepted by NHS England, and this includes a recovery plan for compliance with the 4-hour and 12-hour UEC performance metrics by year 3 (as at end April 2026 the Trust is currently ahead of this plan).	

4. Quality 4.1 The Licensee will ensure that by a date to be agreed with NHS England: 4.1.1 there is an overarching improvement plan to address the performance and quality of care for mental health wait (s) in the ED, within a timeframe agreed by NHS England. 4.1.2 there is an overarching CQC action plan to address the section 29 A warning notice concerns and has effective oversight and assurance processes in place to monitor improvement.	
Current Position: The overarching UEC CQC improvement plan includes mental health improvements with progress updates and assurance reported through the Trust's Quality and Safety Committee. The proportion of mental health patients are within the department for a significant time whilst waiting on a mental health bed. The Trust has been working with CWP and there has been a steady decline in length of stay since July 2025. Significant improvements have been demonstrated in mental health risk assessments, safety plans, observations and mental health roundings. The CQC action plan to address the Section 29a warning notice and subsequent CQC report continues to be progressed to ensure sustainable improvements are delivered. The Quality and Safety Committee has effective oversight of the delivery and impact of these actions through the Urgent and Emergency Care (UEC) Assurance Report. Feedback from the Health Watch visit in January 2026 demonstrated the significant improvements made. *To note: the CQC report from the October 2025 inspection (including UEC) has not yet been finalised.*	**Our Assessment:** The Trust is **meeting** this requirement, with improvements evidenced and effective oversight and assurance in place.

5. Reporting 5.1 The Licensee will provide regular reports to NHS England through the oversight meetings led by NHS England or its representative, on its progress in complying with the undertakings set out above. 5.2 The Licensee will attend monthly oversight meetings, or, if NHS England stipulates, conference calls, as required, to discuss its progress in meeting those undertakings. Oversight meetings will be led by NHS England or its representative, with attendees specified by NHS England. 5.3 The Licensee will provide NHS England with the assurance relied on by its Board in relation to its progress in delivering these undertakings, upon request. 5.4 The Licensee will comply with any additional reporting or information requests made by NHS England.	
Current Position: The Trust has responded to all requests for reports and attendance at meetings, providing updates on financial and operational performance as required. The Trust has provided NHS England with the assurances relied on by the Board as requested, including through the Provider capability assessment and the 5 year integrated plan assurance statements.	**Our Assessment:** The Trust is **meeting** this requirement.

3. CONCLUSIONS

The Trust has made significant progress in delivering the requirements set out within the NHSE Enforcement Notice with all requirements met as at the 31st March 2026, with the exception of the UEC targets. The Trust's 5 Year Integrated Plan which was approved by the Board of Directors and accepted by NHS England sets out a trajectory to deliver constitutional UEC targets by the end of year 3. Our plan recognises that significant improvement is required and investment needed to achieve this.

4. RECOMMENDATIONS

The Board of Directors is asked to **approve** the reported position against the NHSE Enforcement Undertakings as at 31st March 2026.

PUBLIC – Board of Directors
31st March 2026

Report	**Agenda Item 9a.**	**Board Assurance Framework and Strategic Objectives 2026/27**						
Purpose of the Report	Decision	**X**	Ratification		Assurance		Information	
Accountable Executive	Karan Wheatcroft			Director of Governance and Risk				
Author(s)	Karan Wheatcroft			Director of Governance and Risk				
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) risk were reviewed at the Board development day in May 2026. The purpose of this paper is to provide an update to the Board of Directors on the BAF risks for 2026/27 along with the Strategic objectives. The BAF risks and residual risk scores largely remain the same as at the previous quarterly update, with an additional risk agreed for transformation. The Trust's strategic risks are: • 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) • BAF11 – transformation (16) The Executive Directors are currently populating the BAF with the controls, assurances, gaps and actions. The full BAF along with the revised Risk Appetite Statement will be reported to the Board in July 2026. The paper also sets out the strategic objectives against each of the Trust goals, including alignment to the 10 Year Health Plan, the Cheshire and Merseyside Provider Collaborative priorities, and the Trust's Medium Term Plan.
Recommendations	The Board of Directors is asked to: (i) **approve** the Board Assurance Framework risks for 2026/27 (ii) **approve** the Strategic Objectives for 2026/27 (iii) **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 Public Board papers.

Board Assurance Framework (BAF) and Strategic Objectives 2026/27

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 BAF risks were reviewed at the Board development session in May 2026 along with proposed strategic objectives for 2026/27.

The Board of Directors receives the BAF each month with a full update completed on a quarterly basis. The Executive Directors are currently populating the BAF with the controls, assurances, gaps and actions. The full BAF along with the revised Risk Appetite Statement will be reported to the Board in July 2026.

2. BAF RISKS 2026/27

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	Key Controls	Residual Risk Score	Current Assessment/ Driver to reduce risk
BAF1. Failure to maintain **quality of care** would result in poorer patient & family experience	• Quality and Safety Strategy quality priorities • Quality and wider governance structures • Regulatory compliance • Patient and family experience	16	Improvement evidence but not fully embedded; reduction when patient and staff feedback, and regulatory assurance demonstrates this.
BAF2. Failure to **maintain safety and prevent harm** would result in poorer patient care and outcomes	• Quality and Safety Strategy safety priorities • Organisational learning including review of deaths • Delivery of Clinical Strategy	16	Improvements progressing and not yet fully embedded, reduction when improved metrics on sepsis, UEC waits, patient and staff feedback, harms levels, reduction of risks on risk register and regulatory assurance demonstrates this.

Principal Risk	Key Controls	Residual Risk Score	Current Assessment/ Driver to reduce risk
BAF3. Inability to deliver **operational planning standards**, as set out in the medium term plan could result in poorer patient outcomes, and result in financial and regulatory consequences to the Trust.	• Annual activity plan and performance against trajectories • UEC performance and patient flow • Performance management framework and governance structure	16	Drive by UEC performance; reduction when consistent improvements in 12-hour waits and on delivering planned position for 4-hour targets.
BAF4. Challenges in ensuring a high quality, engaged, diverse and inclusive **workforce and culture** would affect our ability to deliver patient care	• Workforce plan delivery as part of the Medium Term Plan • People strategy • Education and development including leadership and management capabilities	15	Reduction when staff feedback supports positive culture shift.
BAF5. Failure to deliver **financial plan** and underlying financial position could impact long term financial sustainability for the Trust and system partners	• Medium Term plan and underlying sustainability • Annual budget and systems of budgetary control • CIP including QIA • Cash management	16	Reduction when confident in CIP delivery and track record of delivering annual financial plan including deficit recovery.
BAF6. Inability to achieve the **capital programme** within a challenging and uncertain operating environment and deliver an Estates Strategy could impact the provision of safe services	• Capital management governance • Capital planning and prioritisation • Estates Strategy	15	Number and severity of infrastructure risks on the risk register would need to continue to reduce to a manageable level to enable reduction of the overall risk 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	• Delivery of Digital and Data Strategic Programme • Delivery of annual plans for cyber security, information governance, and digital infrastructure • Investment, upgrade and optimisation of applications and new solutions • Development of digital and data capacity, culture, and capabilities	15	Inherent cyber risk makes it difficult to reduce this risk score.

Principal Risk	Key Controls	Residual Risk Score	Current Assessment/ Driver to reduce risk
	across the Trust workforce.		
BAF8. Failure to ensure effective **corporate governance** could impact our ability to comply with legislation and regulation.	• Effective Board and governance structures • Compliance with governance, regulation and legislation • Partnership governance • Public Inquiry	8	Risk has reduced and is now within risk appetite. Further embedding of risk management and assurance on effectiveness of sub governance structures and Divisional accountability framework needed.
BAF9. Failure to ensure that the Trust is engaged with **systems partners** so to place the organisation in the best possible strategic position	• Leading and influencing in external committees • Stakeholder mapping and engagement • Executive representation at respective CMPC professional groups • Health Inequalities framework and reporting	12	Risk is within risk appetite. Further work progressing on stakeholder engagement and collaboration.
BAF10. Failure to deliver the **Research and Education** agenda will limit our ability to exploit future opportunities	• Research Strategy delivery • Regional research network • Academic partnerships and appointments with Chester University	12	Risk is within risk appetite. Further work progressing on partnerships to support delivery of Research Strategy.
BAF11. Inability to deliver **transformation and productivity** programme would impact our ability to deliver our Medium Term Plan	• Transformation plan delivery as part of the Medium Term Plan • CIP delivery • Transformation programme approach and governance • Benchmarking framework	16	New strategic risk recognising the shift to transformation needed to delivery our strategy, with processes, culture, governance and assurance developing; reduction will be based on embedded frameworks and measurable delivery against programmes.

3. STRATEGIC OBJECTIVES 2026/27

Strategic objectives have been reviewed and reset for 2026/27. This includes alignment to the 10 Year Health Plan (10YP references), the Cheshire and Merseyside Provider Collaborative priorities (BP references), and the Trust's Medium Term Plan (5TMTP references) as set out below.

Goals	SG1 Patients and Family	SG2 People and Culture	SG3 Leadership	SG4 Adding Value	SG5 Partnership	SG6 Populations
Objectives	Ensure consistent application of quality and safety standards SP	Deliver the people strategy VW 10YP	Delivery of the clinical strategy through divisional accountability linked into divisional reviews. NS	Deliver the financial plan and deficit recovery KE 5YMTP 10YP	Deliver the research strategy. NS	Develop a Health Inequalities reporting framework . JD
	Delivery of operational constitutional targets CC 5YMTP 10YP	Deliver the workfroce plan VW 5YMTP 10YP	Develop our leadership capability VW 10YP	Deliver the data and digital strategy JB BP5 10YP	Take a leadership role within CMPC on the assessment and development of provider collaborations at all levels JD BP1&2	Working with partners to align community services and neighbourhood health development KW BP4 10YP
	Develop a programme of patient and family engagement. SP		Ensuring effective regulatory compliance including governance and risk. KW	To deliver the transformation and productivity programmes, including CMPC priorities of corporate and clinical service consolidation DN BP5	Identify and assess the options and implications from the CMPC fragile services review NS BP3	Continued implementation of being an Anchor Institute (prevention, green and social value). JD

4. RECOMMENDATIONS:

The Board of Directors is asked to:

(i) **approve** the Board Assurance Framework risks for 2026/27

(ii) **approve** the Strategic Objectives for 2026/27

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

PUBLIC – Board of Directors
19th May 2026

Report	**Agenda Item 9b.**	**Significant Risks Report (April 2026)**						
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Karan Wheatcroft			Director of Governance and Risk				
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	As at April 2026, the Trust has twelve risks with a residual risk score of 15 or above. Three risks have been closed or reduced since the last report and two new risks have increased in score or been added to the report. The risks primarily relate to patient access and flow, infrastructure and equipment safety, workforce capacity, digital resilience and financial sustainability. Several risks are long-standing and reflect structural or system-wide challenges rather than short-term control failures. Work is ongoing to further embed consistent and effective risk management across the Trust. The Risk Management Committee provides oversight and scrutiny of risks scored 10 and above across Divisions and Corporate areas. Targeted training and planned reporting developments are underway to support clear ownership and accountability. Risks with a residual score of 15 and above are reported to the relevant assurance committees to provide focused scrutiny and assurance.							

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.

Significant Risks Report (April 2026)

1. Background

The Significant 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. Current Risk Profile

The significant risk register profile is detailed below. It is recognised that not all risks on the register have been significant risks since the date they were added.

Category	Count
Total Risks 15>	**12**
15	4
16	7
20	1
No. Risks removed/reduced	3
No. Risks open >12 months	7

The risk themes primarily relate to patient access and flow, infrastructure and equipment safety, workforce capacity, digital resilience and financial sustainability. Several risks are long-standing and reflect structural or system-wide challenges rather than short-term control failures. A number of risks are capital-dependent, with mitigation linked to capital planning decisions

The details of the risks along with mitigations and actions are provided in Appendix A. The narrative against the risks has been manually updated whilst work is ongoing to improve our risk management processes and Datix reporting.

Work continues to strengthen and embed risk management across the Trust. The Risk Management Committee provides oversight and scrutiny of risks scored 10 and above across Divisions and Corporate services. Training materials and reporting enhancements are being progressed to support clear ownership and accountability.

Risks with a residual score of 15 and above are reported to the relevant assurance committees to support focused oversight and assurance. It is recognised that some risks cut across multiple committee remits; in such cases, these risks are shared with all relevant committees to support joined-up governance and oversight.

3. Recommendations

The Board of Directors is asked to consider and **note** the current significant 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 – Significant Risks (as at 20th April 2026)

★ Added to the significant risk register since last Board Report
⇔No change in risk score since last Board Report
⇩ Decrease in risk score since last Board Report
⇧ Increase in risk score since last Board Report

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Change Score
Lead Committee: Finance & Performance									
31/12/2025	3584	Overdue Glaucoma Follow Up Patients in Ophthalmology	Planned Care	4x5	20	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. • Increase in diagnostic capacity • Development of validation scripts	Sept 2026	Cathy Chadwick	⇔

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Change Score
						• Patient communication Discussion and challenge took place at the Risk Management Committee as to why there are two separate risks related to overdue follow-up. Further follow up to take place with Divisions to understand rationale and risk scoring.			
01/09/2022	2857	Backlog of overdue follow up appointments in: • Ophthalmology	Planned Care	4x4	16	Waiting lists being validated and monitored through the Divisions and through OPELG. AI validation software has been agreed and we have started the procurement process. The patient engagement portal will be used to contact patients as of May 2025. Investment in Ophthalmology diagnostics will facilitate more frequent measurement and virtual approach to follow ups. In addition failsafe officer in place. An action plan has been developed to mitigate the risk and address the backlog with improvements to be embedded to ensure this does not reoccur.	Sept 2026	Cathy Chadwick	⇔

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Change Score
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	⇔
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.	Q1 2026/27	Karen Edge	⇔
09/02/2023	2964	High numbers of Non-criteria to reside (NCTR)	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	Sept 2026	Cathy Chadwick	⇔

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Change Score
		patients across both Trust sites				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. 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 from national			

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Change Score
						discharge team assessment in September 2025.			
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	⇔

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Change Score
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	⇔
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	⇔
23/09/2021	2524	Lack of electronic traceability due to delay in the implementation of Bridge _ Transfusion	Diagnostics and Clinical Support	4x4	16	Awaiting detailed update.	TBC	Jason Bradley/ Nigel Scawn	★
Lead Committee: Quality & Safety									
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	⇔

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Change Score
		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.			
22/12/2025	3581	Lack of Vascular Hybrid Theatre impacting on both staff and patient safety	Planned Care	4x4	16	Review of lead gowns in progress. Theatre development work continues to ensure all funding streams explored. Obtaining quotes for lead gowns and to be presented at the next Capital Management Group.	Q2 2026/27	Nigel Scawn/ Jon Develing	⇔
16/03/2026	3616	Under performance against NICE standards for administration of VTE prophylaxis	Planned Care	3x5	15	Divisionally led action plan in place, monitored through newly established VTE committee and reported to Quality Governance Committee.	Q2 2026/27	Nigel Scawn	★
Lead Committee: People Committee – currently no significant risks relating to People Committee									

Committee Chair's Report
7th May 2026

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)*

- Urgent and Emergency Care update report providing assurance on progress. This confirmed that the immediate Care Quality Commission (CQC) concerns have been addressed and actions embedded; quality and safety performance metrics continue to be monitored, and improvement driven; residual risk and mitigations continue to be delivered. This recognised there are still some challenges in consistency and sustainability of improvements in some areas, including Venous Thromboembolism (VTE), hand hygiene and risk assessment compliance. The Trust was recognised as one of the most improved for 4 hour performance, recognising there is more to do to meet the national targets.
- Committee were alerted to the current lack of compliance with the Medical Device Outcome Registry. This was introduced in March 2025, and the Trust is working closely with NHS England and progressing an action plan to improve this. There remains a lot of work to do across the management of medical devices, and the Committee also received assurance on progress as set out in the section below.
- Received the Sepsis Annual Report which summarised the improvements being made but recognised the continued challenges in meeting the standards, noting outcome data is good.

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

- Assurance report from Quality Governance Group (QGG), alerting a range of areas along with the actions progressing and assurance sought (e.g. medical devices, sepsis, VTE, transfusion, mortality reviews and rapid tranquillisation).
- Integrated Performance Report (IPR) Quality and Safety indicators reviewed, with a narrative cover paper providing a summary of the areas of good performance, areas of concern, forward look and improvements. This aligned to the Quality and Safety Committee agenda.
- Quarter 4 Perinatal update confirming achievement of all 10 Maternity Incentive Scheme year 7 standards, high compliance with Saving Babies Lives Care bundle, and that the Maternity outcomes signal system is now live. External assurance from the Regional Maternity Team and Local Maternity and Newborn System annual visit confirmed a strong safety culture, effective governance, high quality clinical environments and visible leadership. Small number of development areas are being progressed through agreed improvement plans.
- Quality Impact Assessment (QIA) report confirming completion of 117 QIAs (totalling £10.4m) in 2025/26. QIAs are required for schemes over £25K, with all approved by the Medical Director and Director of Nursing and Quality. Post implementation reviews are also being implemented and further developed with a recommendation that these will be reviewed through the new Transformation

Programme Board. The report is being developed to include assurance on Equality Impact Assessments (EIAs).

- Cancer harms reviews update showing progress against the outstanding reviews and improving processes to ensure timely review. Also received the chair's report from the Cancer Service Group with alerts around cancer harms reviews, and reduced target performance in January 2026.
- Medical devices review and action plan progress reported, noting some key actions taken to improve medical safety compliance, but still significant work to do to progress actions and improve compliance. Main areas relate to systems development, establishment of the medical devices oversight group (delayed due to the establishment and understanding of the new Clinical Audit & Effectiveness Group), and clear identification of the Trust decontamination lead.
- Infection Prevent & Control (IPC) Committee Chair's report including alerts in hand hygiene compliance with actions being taken Trust wide, Mandatory training compliance which has fallen just below the 90% threshold, environment and infrastructure risks, identification of a Trust decontamination lead (now resolved with the Deputy Director of Nursing and Quality Governance taking this role), and gaps in information systems to support data quality and surveillance with Electronic Patient Record (EPR) work ongoing to address this.

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

- Committee requested VTE paper to ensure sighted on the position and work in progress.
- The Committee received a patient story from the parent of a cancer patient who had received excellent care across a range of organisations. The support, in particular, from the Trust's cancer nurse was described as outstanding.
- Approved the Quality Accounts noting that these had been circulated in advance to the Non-Executive Directors and have been presented to the Audit Committee. These include the delivery against the 2025/26 priorities and the 2026/27 priorities.
- Verbal update on palliative and end of life care with actions being taken and a business case being developed to strengthen arrangements including 7/7 nursing. It was noted that the Care Quality Commission (CQC) report outcomes would be incorporated into action plans once a final report was received.

Risks discussed and new risks identified

- Risk assessment received on Emergency Department (ED) resuscitation spaces against the Health Building Note and Royal College of Emergency Medicine (RCEM) guidelines. Whilst there is recognition that the space is not fully compliant with the new building guidelines and isn't an optimal clinical space there are mitigations in place and the risk on the risk register is recorded as low. Strategic decision would be required to develop the estate further and there would be a negative impact reducing other clinical space within the department.
- Reviewed the high-risk report and Board Assurance Framework (BAF) extract in relation to the Committee responsibilities. Agreed the need for regular updates to the risks and whilst some of the CQC risks may be scored below 15 it was agreed to review the Divisional risk register for inclusion.

PUBLIC – Board of Directors
19th May 2026

Report	**Agenda Item 11.**	**Perinatal Services Quarterly Update Quarter 4 2025/26**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Sue Pemberton			Director of Nursing and Quality / Deputy Chief Executive				
Author(s)	Natasha Macdonald Sara Brigham Liz Kewin			Director of Midwifery Associate Medical director Divisional Director				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X**	BAF 1 – Failure to maintain quality may negatively impact patient and family experience BAF2 - Gaps in safety and harm prevention can compromise patient outcomes. BAF 3 – Failure to meet operational planning standards or address patient backlogs may lead to poorer outcomes and financial risk for the Trust.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Not applicable							
Executive summary	This report provides assurance to the Board of Directors on the safety, quality and performance of maternity and neonatal services at the Countess of Chester Hospital NHS Foundation Trust for Quarter 4, January to March 2026. Maternity and neonatal services continue to demonstrate a stable and reassuring safety position. The Trust has achieved full compliance with all ten Maternity Incentive Scheme Year 7 safety actions, confirmed through external verification. This reflects strong leadership, effective multidisciplinary working and robust Board oversight of maternity and neonatal safety. Preparations for							

	Maternity Incentive Scheme Year 8 are underway, with a clear focus on outcomes, workforce assurance, service user voice and strengthened Board accountability. Compliance with the Saving Babies Lives Care Bundle Version 3 has reached 96 percent, providing strong assurance that nationally mandated interventions to reduce perinatal harm are implemented and embedded in practice. The Maternity Outcomes Signal System is now live, providing near real time oversight of maternity outcomes and additional assurance of early identification and management of emerging risk. No concerns requiring escalation were identified during the period. External assurance from the Regional Maternity Team and Local Maternity and Newborn System annual visit confirmed a strong safety culture, effective governance, high quality clinical environments and visible leadership. Identified development areas are limited in number and are being progressed through agreed improvement plans. The Board is asked to note the assurance that maternity and neonatal services remain safe, effective, responsive and well led, with learning and improvement actions actively monitored through established governance arrangements
Recommendations	The Board of Directors is asked to note the assurance provided regarding the ongoing safety, quality and governance of maternity and neonatal services.

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

Perinatal Services Quarterly Update Quarter 4 2025/26

1. Introduction

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

2. Background

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

Purpose

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

MIS Progress Update.

Following confirmation through the external verification process and discussion with the Collaborative Advisory Group (CAG), it has been confirmed that the Trust has achieved all 10 safety actions for MIS Year 7. The Trust is therefore eligible for the full return of its contribution to the incentive fund, along with a proportionate share of any unallocated funds.

MIS Year 8 introduces a significant shift from a compliance-based model to a more streamlined, outcomes-focused approach, reducing the scheme from ten safety actions to six core areas centred on workforce, training, learning, service-user voice, care bundles and Board oversight. The changes respond to national evaluation findings and aim to reduce administrative burden while strengthening the focus on demonstrable impact for women and families. There is increased emphasis on local flexibility and, critically, enhanced Board accountability, with assurance now reliant on robust internal governance, triangulated evidence and CEO sign-off rather than routine external evidence submission. The scheme continues to be a key driver of Board-level focus on maternity and neonatal safety, and successful delivery will depend on the Trust's ability to evidence meaningful improvement, strong leadership and a positive safety culture

Dashboard

Maternity performance in remained stable. There were no maternal deaths, one stillbirth, and no neonatal deaths, and no immediate risks requiring escalation. Strategic priorities remain focused on:

- Reducing avoidable neonatal term admission
- Sustaining reductions in third-degree perineal tears
- Managing postpartum haemorrhage (PPH) rates, particularly in line with new guidance implementation

Perinatal Mortality Rate

The national average for stillbirth rate is 3.22 per 1,000 births and 1.63 per 1,000 births for neonatal death (2023). These rates are presented and adjusted by MBRRACE-UK according to the number of births per maternity service and whether the service has a Neonatal Intensive Care Unit (NICU). The rolling 12-month stillbirth rate at COCH is 2.2 per 1,000 births, The Neonatal Death rate for births ≥24 weeks gestation is 1.1 per 1000.

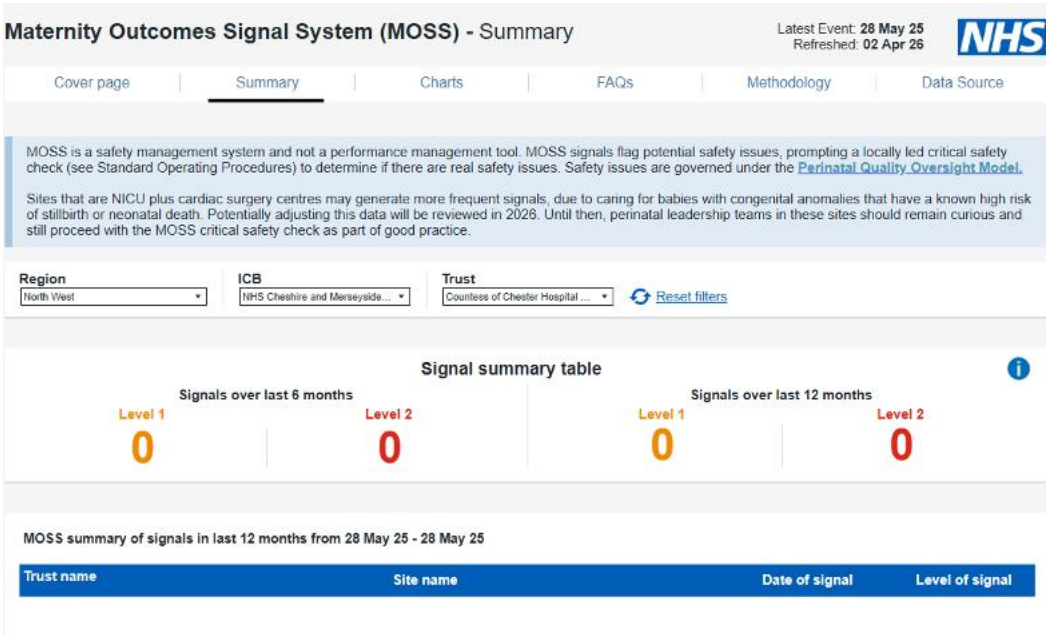
Maternity oversight signal system now live

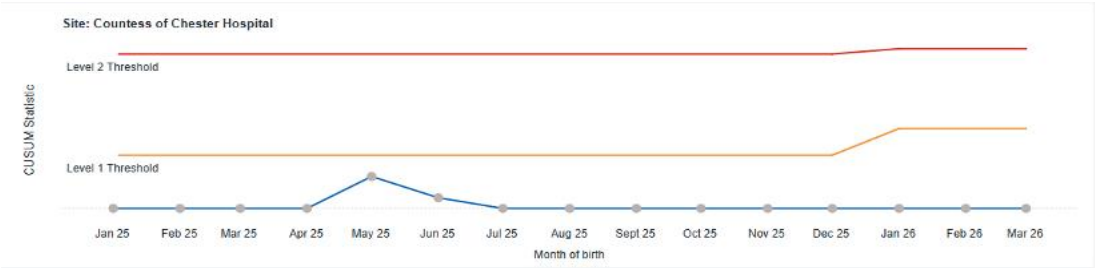
Maternity Outcomes Signal System (MOSS) is the national maternity safety surveillance system developed by NHS England to provide near-real-time oversight of maternity outcomes and identify emerging risk signals. MOSS supports early identification of potential deterioration, prompting timely local review, senior clinical oversight and assurance through established maternity governance arrangements.

MOSS provides the Board with early assurance that maternity safety risks are being identified and responded to proactively, rather than retrospectively. Board oversight is required to ensure signals are reviewed promptly, actions are agreed and monitored, and learning is embedded through the Trust's maternity governance and quality improvement framework.

Currently, MOSS looks at:

- Perinatal mortality - Stillbirths and neonatal deaths, monitored for statistical variation over time.
- Severe maternal outcomes - Including maternal deaths and selected indicators of severe maternal morbidity (using routinely coded data).
- Activity and context data - Such as birth numbers and service pressures, to provide context and avoid misinterpretation of outcome variation.





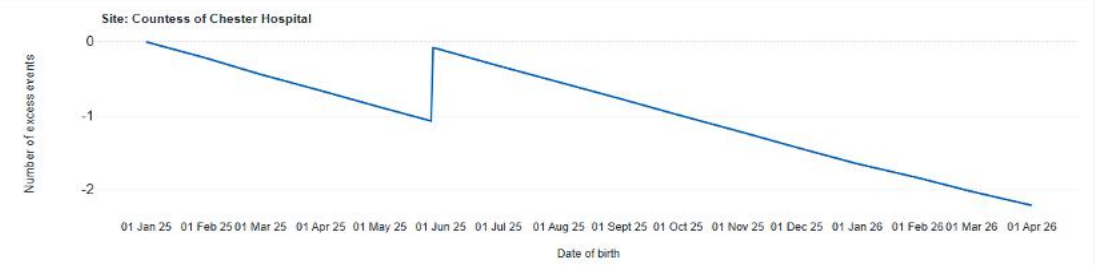


Table of Events - Trust: Countess of Chester Hospital NHS Foundation Trust

Date of term birth	Events (term only)	Site name
28 May 25	1 Term Stillbirth(s)	Countess of Chester Hospital

Cases Meeting Inclusion Criteria for Reporting to MBRRACE-UK (Q4 2025/26)

All cases where baby died in year 2026
Report rows are per baby; report date 17/04/26 12:13

Case ID	Live birth	Terminat	Gestatio	Birthweig	Surveillance case status	Surveillance assignm	Review status	Parents perspectiv	Factual questions currently completed (%)
101912	Yes	No	Not knov	615	Surveillance complete		Writing report	Parents views sou	100%

Saving Babies' Lives Care Bundle (SBLv3)

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Fully implemented	100%	Fully implemented	100%
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Fully implemented	100%	Partially implemented	92%
Element 6	Diabetes	Fully implemented	100%	Partially implemented	83%
All Elements	TOTAL	Fully implemented	100%	Partially implemented	96%

As of April 2026, the Trust is at 96 percent compliance with the Saving Babies' Lives Care Bundle, demonstrating sustained improvement and overall strong assurance across all six elements.

Two elements did not fully meet the audit standards at the point of validation:

Element 5 Preterm birth optimisation

Audit compliance identified the following gaps:

- Delayed cord clamping compliance was 64 percent against a standard of 70 percent.
- Full course of antenatal steroids compliance was 18 percent against a standard of 53 percent. This reflected a very small denominator of eight cases and no missed clinical opportunities were identified.

Element 6 Diabetes in pregnancy

- Audit compliance for HbA1c obtained before 30 weeks was 60 percent against a standard of 85 percent. Two women did not have HbA1c taken at the 28 week appointment. A smart action is being agreed through the diabetes multidisciplinary team meeting in May to address this.

Despite these audit variances, key areas of improvement and assurance remain evident, including strengthened smoking cessation pathways, consistently high performance in fetal growth restriction detection, improved audit compliance for reduced fetal movements and fetal monitoring in labour, embedded preterm optimisation processes, and enhanced diabetes pathways with improved multidisciplinary oversight. Overall performance has continued to improve through 2025, with focused actions in place to address the identified audit gaps and achieve full compliance.

Chester MNVP

The Chester Maternity and Neonatal Voices Partnership continues to provide assurance that family feedback is actively shaping maternity and neonatal services.

During March 2026, clear improvements were delivered across cultural inclusion, environment and communication. Actions included enhanced support for families observing Ramadan, environmental improvements across maternity and neonatal areas, strengthened bereavement spaces, improved neonatal communication tools and increased access to postnatal birth debriefs.

MNVP also strengthened its contribution to quality and safety governance through engagement with 15 Steps assessments, Picker feedback and the Perinatal Mortality Review Tool. Safety related feedback highlighted opportunities to improve communication around discharge, clinical interventions and postnatal ward experience.

Overall, this work demonstrates effective co production and provides assurance that patient experience intelligence is driving service improvement, quality and equity across the pathway.

Maternity and neonatal safety champion's feedback

A routine Safety Champions walkaround was completed across maternity and neonatal services with no immediate safety concerns identified and good staff engagement reported. The Labour Ward demonstrated a calm, well led environment, with staff reporting significant benefits from the new facilities. Two key quality themes were identified for committee oversight. Firstly, the separation of twins and parents within the Neonatal Unit due to unit designation, recognised as a poor family experience despite no identified safety risk. Secondly, increasing maternity triage attendances for primary care type concerns, impacting flow and capacity. A repeat audit has been proposed to support data driven service improvement. The walkaround provides assurance of safe care delivery while highlighting targeted areas for quality improvement and further monitoring.

The Regional Maternity Team and Local Maternity and Newborn System annual visit

The Regional Maternity Team and LMNS undertook their annual visit on 28 January 2026 to review progress, safety, quality, leadership and culture across maternity services. This included walkthroughs of clinical areas, staff engagement, governance review and focused discussions on current improvement priorities.

The regional visit identified a number of significant strengths across the service, providing strong assurance to the Board regarding quality, safety and culture. Safety culture and governance were highlighted as a particular area of excellence, with Safety Champion ward walkarounds described as exemplary, demonstrating visible leadership and effective engagement from the Board, MNVP and Non-Executive colleagues. The inpatient on-call escalation process was also commended and recognised as best practice for regional sharing.

The new maternity unit was described as exceptional, offering a high-quality, family-centred environment that promotes privacy, dignity and supports future service development. This was complemented by clear evidence of innovation and continuous service improvement, including

enhancements to antenatal pathways, digital referral processes, perinatal mental health provision and homebirth infrastructure. The Trust's Milk Bank service received notable regional praise and national recognition through RCM awards.

A strong learning culture was also evident, with effective implementation of the Patient Safety Incident Response Framework (PSIRF) and positive staff engagement. Student midwives in particular described a psychologically safe and supportive learning environment, with strong supervision and confidence in escalation processes. Overall, these findings reflect a mature safety culture, effective leadership and a clear commitment to continuous improvement.

The regional visit identified a small number of areas for development, all of which are recognised locally and are being progressed through established improvement plans. These include considering advancing a locally adapted maternity triage model aligned to BSOTS, alongside continued monitoring and optimisation of the co-located triage and Maternity Assessment Unit pathway to ensure efficiency and patient flow.

Work is also underway to address workforce and training considerations, including reviewing student midwifery placement capacity in the context of reduced birth numbers, and strengthening trainee doctor rota planning to ensure appropriate notice periods and balance between clinical and clinic commitments.

Further development is focused on enhancing clinical confidence and service capability, including building staff confidence in supporting out-of-guidance homebirths, and strengthening maternal medicine provision. This is aligned to the national maternity workstream, ensuring local improvements reflect wider system priorities and best practice.

Learning from Concerns and Complaints – Q4 2025/26

The maternity service received 12 concerns and 5 formal complaints, spanning antenatal, intrapartum, and postnatal care. Themes remain broadly consistent with previous quarters, with communication, clinical care, and delays continuing to be the most prominent issues.

<u>Key Themes</u>

Communication:

Communication remains the most frequently reported theme. Issues included lack of updates, unclear explanations regarding induction and care planning, delays in sharing test results (including GBS status), incorrect contact details, and inappropriate information sharing. Several patients also reported poor communication around debrief services and follow-up care.

Clinical Treatment & Delays:

Concerns were raised regarding delays in recognising and responding to labour and fetal risk, missed or delayed treatment (including antibiotics for GBS), and lack of appropriate monitoring for identified risk factors. There were also reports of perceived failures in clinical decision-making and escalation.

Staff Attitude & Compassion:
A small number of patients reported feeling dismissed, unsupported, or “gaslit,” with concerns about staff attitude contributing to dissatisfaction and, in some cases, escalation to formal complaints.

Postnatal Care & Follow-Up:
Delays in accessing postnatal debriefs and ongoing care were highlighted, alongside concerns about follow-up communication and support after discharge.

Continuity of Care:
Fragmented care and lack of consistent oversight contributed to patients feeling uncertain or unsupported, particularly where clinical findings were not clearly communicated or followed up.

Environment, Processes & Administration:
Administrative issues included appointment changes, policy queries (e.g. visiting and birthing partner policies), and errors in patient contact details. These contributed to delays, confusion, and in one case, inappropriate disclosure of sensitive information.

Formal Complaints (5**)**
The formal complaints related to:

- Delayed or inadequate clinical care, including failure to recognise labour and fetal distress, delayed escalation, and missed or delayed treatment (including GBS management).
- Poor communication and service delays, particularly in relation to maternity debrief processes, cancelled appointments, and lack of timely updates.
- Concerns regarding staff attitude and patient experience, including patients feeling dismissed and unsupported during care.
- Complex traumatic birth experiences, including allegations of avoidable harm, delayed labour management, and insufficient postnatal support.

One complaint was upheld due to delays and poor communication in accessing a maternity debrief. Other cases identified learning around earlier provision of support resources and improvements in communication pathways.

These complaints are being investigated or have been reviewed to ensure that all concerns are addressed, with learning identified to improve communication, clinical escalation, and overall patient experience.

3. Recommendations

The Board of Directors is asked to note the assurance provided regarding the ongoing safety, quality and governance of maternity and neonatal services.

Appendix: Glossary of Terms and Acronyms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Committee Chair's Report
Thursday 26th March 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)***
• Stryker supply issues nationally due to cyber incident but the risks are being managed well locally with daily risk assessments and consideration of alternatives to ensure there isn't a single point of reliance.
Assure ***(matters in relation to which the Committee received assurance)***

• **Divisional updates**
  • **Planned care**. overview of quality, workforce, operational and financial performance. Continuing to improve closure of concerns and complaints. Improved financial performance across the second 6 months of the year including increased activity, although overall financial position is a significant overspend and focus is on budgetary control and CIP for 2026/27. Improved RTT and productivity, expecting to achieve 65 week targets. E'discharge backlog reducing and continued improvement in 24 hour compliance. High risk for VTE and complicate with NICE standards for administration of prophylaxis which is a Trust wide risk. Challenges in Ophthalmology were discussed.
  • **Therapies and Integrated Community Care**. overview of quality, workforce, operational and financial performance. Recruitment progressing to support a reduction in unmet need. Community indicators added with good occupancy levels on virtual wards benchmarked to other providers; 2 hour community response action plan in place with a focus to increase performance noting this is a NOF indicator; no over 52 week community services waiters. Workforce indicator performance is good with the exception of sickness absence and continuing to look at actions to improve.
  • **Women & Children's**. overview of quality, workforce, operational and financial performance. Improvements noted on reducing open incidents and complaints. Two posters submitted for learning and best practice from NNU. Workforce indicator performance is good, with the exception of sickness absence. Some challenges in gynaecology RTT; cancer targets across specialities; and typing backlogs. Good financial performance and an update on achievements in specific services including breast and milk bank. The interim findings from the Amos Review had been reviewed by the Division.

- **Diagnostics and Clinical Support Services**. overview of quality, workforce, operational and financial performance. improvement in progressing complaints and concerns response and closure. Microbiology high risk will be closed as mitigated next week. IR business case to be reviewed through EDG. DM01 performance has increased and further actions being taken. Radiology dashboards being split for elective and non executive performance. Pathology performance is good. Pharmacy performance impacted in February as we implement changes in processes; challenges remain with procurement shortages. Overall good financial performance, with opportunities to work more closely with procurement on contracts. Gap in Assoc. Medical Director added to the risk register as a moderate risk.
- **Urgent Care**. overview of quality, workforce, operational and financial performance. Significant number of concerns and queries responded to; incident reviews (including after action reviews) and corners inquests; falls and pressure ulcers. Improved RTT position and DM01, with remaining challenge now just in echo diagnostic performance and non DM01 performance. Ambulatory monitoring devices longer term solution developed and approved through EDG. Performance in UEC 4 and 12 hour waits continues to be a significant challenge, including impact from sustained pressure from increased attendances. Significant challenge in financial performance including CIP which needs significant focus for 2026/27. Continued compliance in mandatory training and improvements in other workforce metrics.

- PLACE assessment results received demonstrating an improvement with the Trust now scoring above national average in 7 of the 8 domains. With the Countess site performing well and EPH demonstrating improvements, the Tarporley site is now the main area for focus along with some Trust actions to be taken in respect of food provision and specific points on ensuring disability standards are met.
- Quality and Safety update including incident reporting; planned changes which will provide live information to the ICB and CQC; oversight and decision making. Complaints and concerns. Infection prevention targets and performance.
- Month 11 finance report demonstrates an improved options following receipt of deficit support funding which was provided on the basis of delivery of the plan in year. Forecast on track to deliver planned deficit of £33.8m. Activity and income performance was shared including any outliers at specialty level; variable pay; CIP; and cash.
- Transformation programme 2026/27 overview presented including transformation schemes (clinical pathway redesign and standardisation; data driven decision making and benchmarking; theatre and diagnostic efficiency; reducing unwarranted variation) and rapid improvement events. CIP progress across BAU, productivity and transformation remains a focus from identification of opportunities through to fully developed maturity. The first Transformation Board meeting is planned for early April.
- Operational report update included ongoing UEC performance challenges and drivers including increased attendances and NCTR; RTT performance on

track; decreased cancer performance for January but improved in February; challenges in diagnostic performance for January but improved in February.
- Phlebotomy update with staff listening event held to understand the challenges and action plan being developed.
- Update on medical photography backlog providing assurance on reduction which is ahead of planned trajectory for completion by end June 2026.
- Reception cover update on actions to improve arrangements across reception areas.
- Staff survey results presented a largely static picture with some elements decreasing and these are reflective of the national results. Four key areas identified as the focus for improvement in 2026/27.

Advise
(items presented for the Board's information)

- Tim Briggs attended the Trust this week with a walkarounds and discussions with UEC and a session with the clinical leads. Clear focus on eradicating corridor care and improving UEC performance through a whole hospital approach.
- High level update provided on corridor care and the response to the national letter. There is a national update on criteria where corridor care will not include patients within the 45 minute ambulance hand over window. The Trust is currently de-escalating the winter escalation beds and this will remove the use of the SDEC top and bottom corridors, along with overnight bedding on the frailty unit which is impacting on operational functioning of this area to support ED.
- UEC assurance and admission avoidance group TOR approved by OMB. This includes admission avoidance, UEC, and ward process and discharge. Workplan being developed and reporting will be to OMB and the Board.
- Received an update on Devolution with agreement on combined authority and first mayor to be appointed May 2027, with an interim CEO now announced.

Risks discussed and new risks identified

- Received high risk report recognising triangulation with Divisional performance and risk reports. Work continues to progress to embed risk management and focus needed on actions and mitigations with a view to when residual scores will reduce based on this. Recent internal audit review of risk management has provided moderate assurance which reflects the improvements as well as the work still to do.

Committee Chair's Report
Thursday 23rd April 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 alerts to bring to the attention of the Board.

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

- **Divisional updates**
  - **Planned care**. Overview of quality, workforce, operational and financial performance. The update included a serious incident that had been reported on STEIS. Challenges noted in some areas of mandatory training compliance. There was a strong commitment to CIP, positive progress on activity and exceptional outcomes on RTT performance. Risks were discussed and would be further scrutinised through the Risk Management Committee.
  - **Therapies and Integrated Community Care**. Overview of quality, workforce, operational and financial performance. Updates included security at Ellesmere Port Hospital, and challenges with sickness absence.
  - **Women & Children's**. Overview of quality, workforce, operational and financial performance. The update included a deep dive into staff survey results and actions. Work is ongoing to around FP10s and the pressures this is creating.
  - **Diagnostic and Clinical Support Services**. Overview of quality, workforce, operational and financial performance. Updates included interventional radiology business case, and relocation of the DEXA scanner and move to a 7-day model.
  - **Urgent Care**. Overview of quality, workforce, operational and financial performance.Updates included performance metrics, e-discharge, typing backlogs, and escalation areas.

- Quality and Safety update including complaints and concerns update from the Head of Complaints setting out the themes of concerns received via PALs. Continued strong incident reporting culture with 94% of all incidents categorised as no or low harm; reduction in falls; improved compliance with risk assessments in in-patient settings; reduction in healthcare associated infections.
- Month 12 finance report demonstrates achievement of the plan in year. Timing and pace of CIP delivery needs to remain a focus.

• Transformation update presented including the approach to transformation, delivery and governance. CIP delivery group to continue chaired by the CEO. Transformation Board now commenced to provide programme level governance and assurance. Project management software being procured. Overview of the rapid improvement event for respiratory was provided as an example of progress being made. Focus remains on identifying schemes and developing their maturity level. • People update covering workforce metrics.
Advise ***(items presented for the Board's information)***
• OMB received a briefing on national and regional updates with particular emphasis on national and regulatory scrutiny.
Risks discussed and new risks identified
• Received risk updates through the Divisional reports.

PUBLIC – Board of Directors
19th May 2026

Report	**Agenda Item 14.**	**2025-26 National Cost Collection (NCC) Pre submission Board Assurance Report**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	**X**
Accountable Executive	Karen Edge / Helen Wells			Chief Finance Officer / Deputy Chief Finance Officer				
Author(s)	Paula Jones Calkin			Costing & Performance Accountant				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X**	BAF 5 – Failure to deliver financial plan and underlying financial position could impact long term financial sustainability for the Trust and system partners.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X**
CQC Domains	Safe Effective Caring Responsive Well led							**X**
Previous considerations	This paper is provided annually to Board or subcommittee ahead of the annual National Cost Collection.							
Executive summary	This report provides the Board with pre-submission assurance on the Trust's readiness to deliver the 2025–26 National Cost Collection (NCC). The NCC is a mandated requirement under the NHS Provider Licence and a key source of national cost information used by NHS England. The purpose of this report is to confirm that appropriate plans, governance arrangements and controls are in place to ensure the NCC submission can be completed in line with the Approved Costing Guidance and within the required national timetable. This includes assurance over resourcing, validation processes, senior review arrangements, and the management of known data gaps and limitations. This is the first of two assurance reports required by the Approved Costing Guidance. A further report will be presented to the Board (or delegated committee) at or around the point of final submission to confirm completion of the return, highlight any material issues, and seek formal approval over the submission.							

Recommendations	The Board of Directors is asked to : • **Note** the proposed approach, governance arrangements and timetable for delivery of the 2025–26 National Cost Collection submission. • **Be assured** that appropriate plans, validation processes and resources are in place to deliver the submission in line with the Approved Costing Guidance. • **Note** that known data gaps, limitations and areas requiring agreed adjustments or exclusions will continue to be identified and managed transparently as the NCC process progresses, with a further assurance report to be presented at final submission stage.

Corporate Impact Assessment	
Statutory/regulatory requirements	Per condition 3 of the NHS Provider Licence - it is the responsibility of the trust to ensure that costing data, including the counting, classification and reporting of costed activity, is correct. Trusts must treat costing as a fundamental financial and activity process subject to an audit.
Risk	BAF 5 – Failure to deliver financial plan and underlying financial position could impact long term financial sustainability for the Trust and system partners.
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.

2025-26 National Cost Collection (NCC) Pre submission Board Assurance Report

1. Introduction

The National Cost Collection (NCC) is a mandated annual submission of costs and activity for all NHS providers. The 2025–26 NCC will be prepared in accordance with NHS England's Approved Costing Guidance and within the required national timetable.

This report provides the Board with pre-submission assurance on the Trust's arrangements, readiness and governance to support delivery of the NCC submission.

2. Purpose

The purpose of this report is to provide assurance that:

- A plan is in place to produce the 2025–26 NCC submission by the required deadline (Appendix 1).
- The NCC return will be prepared in accordance with the Approved Costing Guidance.
- Appropriate processes exist to validate activity and cost data with clinical and operational services, where data and system availability allow.
- Known data gaps, limitations and areas of non-compliance with the guidance have been and will continue to be identified as the NCC process progresses and are being managed transparently (Appendix 2).
- The Costing Team and supporting functions are appropriately resourced to deliver the submission.

3. NCC Submission Approach and Key Issues

3.1 Scope and Approach to the 2025–26 NCC Submission

The Trust will submit patient-level cost data covering mandated service areas in line with national requirements. Costs will be reconciled to the Trust's financial statements and activity will be reconciled to relevant national datasets where applicable.

The costing process is supported by governance arrangements, including senior finance review and engagement with relevant clinical and operational services to validate both activity and costing assumptions, where data and system availability allow.

Any actions arising from previous NHS England reviews of costing, including feedback from the 2024–25 Costing Assurance Programme, have been or are being formally followed up and addressed as part of the 2025–26 National Cost Collection process.

3.2 Data Quality, Information Gaps and Use of Agreed Adjustments

As part of the NCC preparation process, an initial review has been undertaken to identify known data gaps, limitations and areas where full compliance with the Approved Costing Guidance may not be achievable. These primarily relate to service areas where patient-level activity data is not available in the prescribed National Cost Collection dataset format.

Further areas requiring agreed adjustments or exclusions may be identified as the NCC process progresses through model build, validation and assurance activity. Where it is not currently possible to produce reliable and compliant patient-level costs, the Trust will apply agreed adjustments or exclusions in line with National Cost Collection guidance. This approach is intended to protect the integrity and quality of the NCC submission and avoid distortion of national cost information.

Known issues and exclusions identified to date are summarised in Appendix 2.

NCC-relevant data quality anomalies identified to date have been formally reviewed and visibility raised through the Trust's Data Governance Group, with agreed default costing treatments applied where issues remain unresolved ahead of the NCC submission cut-off.

3.3 Resourcing, Governance and Timetable

The Costing Team, supported by Finance, Informatics and clinical services, is appropriately resourced to deliver the 2025–26 NCC submission to the required national timetable. A detailed plan and timetable for completion of the submission, including key milestones for validation, review and sign-off, is provided in Appendix 1.

4. Conclusion

The Board is provided with assurance that appropriate plans, governance arrangements and resources are in place to deliver a compliant and robust 2025–26 National Cost Collection submission. Known data gaps, limitations and areas of non-compliance have been identified to date, with a planned approach in place to manage these in line with the Approved Costing Guidance as the submission process progresses.

A further assurance report will be presented to the Board (or delegated committee) at or around the point of final submission to confirm completion of the return, highlight any material issues or adjustments identified during the process, and seek formal approval for submission.

5. Recommendations

The Board of Directors is asked to:

- **Note** the proposed approach, governance arrangements and timetable for delivery of the 2025–26 National Cost Collection submission.
- **Be assured** that appropriate plans, validation processes and resources are in place to deliver the submission in line with the Approved Costing Guidance.
- **Note** that known data gaps, limitations and areas requiring agreed adjustments or exclusions will continue to be identified and managed transparently as the NCC process progresses, with a further assurance report to be presented at final submission stage for formal approval.

Appendix 1 – 2025/26 NCC Plan

Appendix 1: 2025/26 NCC costing plan

TASKS	w/c
NHSE GUIDANCE	
Data Specification Published by NHSE	complete
Guidance Published by NHSE	complete

NHSE WINDOW	**15 Jun - 3 Jul**
Submission Window - Open Submission	*15 Jun*
Submission Window - *Full signed off submission*	*3 Jul*
Submission Window - NHSE/Trust DQ Checks	*6 Jul*
Submission Window - Resubmission Window	*13 Jul*
Submission Window - Contingency Window	*20 Jul*

PATIENT DATA	
Create NCC 25/26 Workflow	20 Apr
Request 25/26 data from Informatics (FLEX/FREEZE)	complete
Process through 25/26 Reference Cost Grouper (FLEX/FREEZE)	2 May
Collect other PLICS data (non PL) e.g. CMDT, Phlebotomy	20 Apr
Process 25/26 Patient Data	4 May
Review Validations	11 May
Clear Validations - FixData or at Source	11 May
Patient Data validate and reconciled in Costing	11 May
Information Gap Analysis - report to NHSE if applicable	22 May *latest*

COST MODELLING	**13 Apr - 22 Jun**
Create NCC 25/26 Scenario	5 May
Upload GL Data - Draft	5 May
Upload HR Data	5 May
Identify and Cost Exclusions	5 May
Identify and Cost Aggregate Data	5 May
Review Rules (2.2 and 3.1)	5 May
Upload GL if final Accounts are different to Draft	26 May
Populate INTREC	26 May
Initial Balanced Model	1 Jun
Review NCC Analytics - make any further changes	1 Jun

NCC VALIDATIONS	**18 May - 29 Jun**
Review High/Low Cost Patients	1 Jun
Review Invalid Combinations	1 Jun
Review any additional DVE Validations	1 Jun

SIGN OFF	**1 Jun - 1 Jul**
DoF Sign Off	1st July

Appendix 2 – 2025/26 NCC Known data gaps, limitations and areas of non-compliance (identified to date)

This appendix summarises known data gaps, limitations and areas where full compliance with the Approved Costing Guidance is not currently achievable at this stage of the 2025–26 NCC process. As the NCC submission progresses through model build, validation and assurance activity, further areas requiring agreed adjustments or exclusions may be identified.

Any additional issues identified will be assessed in line with National Cost Collection guidance and managed transparently to protect the integrity and quality of the submission. This appendix will be updated accordingly and reflected in the final submission assurance report.

Agreed adjustments and exclusions – identified to date

Cost exclusions:

Cost area	Reason for exclusion
Public Inquiry	Non-patient related expenditure

Service exclusions:

A number of services delivered collaboratively with other providers, or operating under community-type models, do not currently have the required patient-level activity data available within Trust systems to meet NCC reporting requirements. In these cases, inclusion within the NCC would risk misclassification or inaccurate attribution of costs.

Service	Approx Cost	Reason
Community Neurotherapy	£755k	Patient-level activity data is not available in the prescribed National Cost Collection community extract format
Rapid Response Team	£3.4m	
Hospital at Home Team	£3.2m	
Cardiac Rehab Service	£222k	
Pelvic Obstetric Physio	TBC	
Community Midwifery	TBC	
Potential other areas TBC		

Ongoing work continues with Informatics and system suppliers to improve data availability for these services. Until the required datasets are available, agreed exclusions will be applied in line with NCC guidance.

Ongoing identification and management

The Costing Team will continue to review activity, costing outputs and validation results throughout the NCC process. Any further data gaps identified during this process will be:

- assessed against Approved Costing Guidance requirements;
- documented and, where required, discussed with NHS England; and
- reported through the final NCC submission assurance report presented to the Board (or delegated committee).

Committee Chair's Report

Audit Committee – 24th April 2026

Committee	Audit Committee
Chair	Non-Executive Director, Mr P Williams

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

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

- Head of Internal Audit Opinion 2025/26 providing an overall level of assurance as Substantial Assurance with a good system of internal control to meet the organisation's objectives and that controls are generally being applied consistently. Especially notable given the Countess of Chester's risk based approach to internal audit, whereby scrutiny is invited of areas known to be high and emerging risk.
- Mersey Internal Audit Agency (MIAA) has received notification of a 'generally conforms' outcome from its recent External Quality Assessment (EQA) against Global Internal Audit Standards. This is the highest rating achievable, thus giving the Board ongoing confidence in MIAA as its internal audit and counter fraud assurance partner.

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

- Quality Account received and approved for recommendation to Board of Directors. This includes a review of 2025/26 performance and the priorities set for 2026/27.
- Received Committee effectiveness annual reports from each of the Board Assurance Committees, as presented by the respective Non-Executive Director (NED) Committee Chairs. These confirmed operation in line with terms of reference (TOR) for Finance & Performance Committee, People Committee and Quality & Safety Committee. Actions noted including terms of reference and work plan updates, and key areas for focus for 2026/27.
- Approved the Audit Committee effectiveness annual report confirming compliance with TOR, Healthcare Financial Management Association (HfMA) checklist best practice, and noting the valuable work of both internal and external auditors.
- Received the Anti-Fraud Annual Report which included assurance on delivery of the anti-fraud plan and completion of the self-assessment against government functional standards for counter fraud with an overall rating outcome of Green.
- Assurance on compliance with declaration of interests with a year-end position of 95%.
- Received substantial assurance on Mersey and West Lancashire NHS Trust payroll provider through the sharing of an MIAA internal audit report for 2025/26.
- Risk management improvement plan progress was reflected in the MIAA internal audit risk management report, which provided moderate assurance.
- Annual accounts and annual report timetable update confirmed progress in line with timeframes, with accounts already submitted ahead of deadline and annual report significantly progressed to meet the submission timetable (5th May 2026).

- Internal audit progress report provided an update on delivery of the internal audit plan and outcomes from the assignments completed since the last meeting, including risk management processes (moderate assurance); data centre (moderate assurance); e-roster and bank (substantial assurance); theatre utilisation (substantial assurance); and Board Assurance Framework (BAF) processes meeting the required standards. Assurance also provided on the follow up of agreed action plans through the Countess-led internal audit recommendation tracker, and independent assurance on these from MIAA.

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

- Audit Committee TOR approved with changes to quality account responsibilities, committee names and global internal audit standards, for recommendation to the Board of Directors.
- Audit Committee reviewed the significant issues arising in finalising the financial statements for year ended 31st March 2026.
- Out of date policy recovery plan continues. Audit Committee will retain oversight of this plan until substantially complete.
- Received and approved the review of the accounting policies used in preparation of the financial statements for 2025/26.
- Approved the External Audit Plan and Strategy for year ended 31st March 2026. Committee asked for a written context to the increase in fees and rationale for clarity.

Risks discussed and new risks identified

- Received BAF and high-risk report relevant to the Committee.
- Committee enquired about the remaining audit action regarding the Estates Strategy in context of risk.

Countess of Chester Hospital NHS Foundation Trust

Committee Chair's Report

28th April 2026

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

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

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

Plastics - The Committee wishes to draw the Board's attention to the ongoing position in relation to plastics, recognising the operational implications of the current arrangements and the need for continued oversight of service sustainability, workforce resilience and the impact on medical training.

Medical rate card - The Committee also wishes to highlight the continued challenge associated with the medical rate card, noting the implications for safe staffing, affordability and timely escalation decisions. Members recognised that inconsistency in application and continued reliance on escalation arrangements present an ongoing operational and financial risk.

Workforce Plan WTE reduction - The Committee reviewed progress against the workforce plan and wishes to highlight the scale of the required whole time equivalent (WTE) reduction, together with the continued dependence on transformation delivery and workforce controls to achieve the Trust's financial plan. Members noted that this remains a significant delivery challenge, with potential implications for service resilience, staff experience and the pace at which recurrent savings can be achieved.

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

Sub-committee updates:

- **Partnership Forum** - The Committee received assurance from Partnership Forum discussions, with themes including nurse staffing pressures, immigration rule changes and the ongoing Trust-wide job evaluation and re-banding programme. Staff-side representatives noted the actions underway to mitigate risk, whilst recognising that staffing pressures remain a material concern.
- **People & Culture (P&C) Sub-Committee -** The Committee was assured on work overseen through the P&C Sub-Committee, including the need to rationalise and prioritise Equality, Diversity & Inclusion (EDI) actions to maximise impact, the developing approach to reward and recognition, and the strengthening of Trust-wide communication and engagement. Progress against the Sexual Safety Charter was noted, with continued delivery and oversight through established governance.
- **Education, Learning and OD Sub-Committee (ELOD)** - An update from the ELOD Committee provided assurance on mandatory training compliance, appraisal quality improvement work and oversight of apprenticeship levy risks. The Committee noted that under-utilisation of student placement capacity can result in lost income and missed opportunities to support future workforce supply, and that this remains an area of focus.
- **Workforce Sub-Committee** - The update confirmed continued scrutiny of workforce Key Performance Indicators (KPIs) and improved visibility of performance, alongside ongoing challenges associated with medical and nursing

staffing gaps. The Committee noted that a new risk relating to nursing workforce sustainability has been added to the risk register, reflecting the sustained operational fragility in this area.

- **Joint Local Negotiating Committee (JLNC) -** The Committee received assurance from the JLNC discussions, including continued monitoring of junior doctor rate cards, industrial relations risks and the broader implications for staffing and service resilience.

Medical Job Planning - The Committee noted that the Trust has transitioned to a new electronic system and achieved near-universal engagement, with over 65% of job plans fully signed off. Initial modelling identified a potential cost pressure exceeding £1m; however, strengthened scrutiny and challenge has reduced this to an estimated £250k–£300k, with further work underway to complete sign-off and assure consistency.

Violence, Aggression and Staff Safety - The Committee also received assurance on work in relation to addressing violence and aggression, noting a reduction in reported incidents and progress in security staffing arrangements and incident review processes, alongside continued focus on staff support and feedback loops.

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

Staff Survey 2025 - The Committee noted the early engagement undertaken with colleagues following release of the 2025 staff survey headline findings, with feedback indicating that staff valued timely communication, opportunities to contribute and visible listening. The Committee also noted that Trust-wide priorities have now been agreed in response to the survey findings, with detailed action planning and delivery oversight continuing through the People Committee and the People & Culture Sub-Committee to support ongoing monitoring of progress and impact.

Employment Law Updates - The Committee noted a number of developments for the Board's information. This included emerging changes in employment legislation, particularly reforms relating to workplace harassment and third-party conduct, and the increasing legal expectation for employers to demonstrate that all reasonable steps have been taken to prevent harassment, including from patients and members of the public. The Committee noted that national guidance is still evolving and that preparatory work is underway locally to ensure compliance and reduce organisational risk.

Voluntary Redundancy - The Committee also noted progress in delivering workforce reductions through voluntary and mutually agreed exit schemes, with implementation approached carefully to minimise service impact.

Education & Training Centre Development - The Committee noted that outline plans for the education and training centre are progressing, recognising the importance of education infrastructure and placement capacity as enablers of workforce sustainability.

Risks discussed and new risks identified

The Committee noted the addition of a new nursing workforce sustainability risk to the risk register, reflecting continued workforce pressure and operational fragility. Wider risks relating to workforce sustainability, medical staffing and delivery of the workforce plan continue to be monitored through established governance arrangements.

PUBLIC – Board of Directors
19th May 2026

Report	**Agenda Item 19.**	**Fit and Proper Persons (FPPT) Report**						
Purpose of the Report	Decision		Ratification	**X**	Assurance		Information	
Accountable Executive	Karan Wheatcroft			Director of Governance and Risk				
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**	BAF 8 - Failure to ensure effective corporate governance could impact our ability to comply with legislation and regulation.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X**
CQC Domains	Safe Effective Caring Responsive Well led							**X**
Previous considerations	Not applicable							
Executive summary	The purpose of this report is to provide assurance that an annual Fit and Proper Person Test (FPPT) compliance check has been undertaken for all Board members. The NHS England FPPT framework (published in 2023/24) has been adopted fully in the Trust's FPPT Policy. The annual FPPT compliance check included: • Self-attestations completed by each Board Member • Social media checks undertaken for each Board Member • Confirmation of CRB checks within the last 3 years This paper confirms that the Board remains compliant with the Fit and Proper Persons' requirement, with no areas of concern identified. Appendix A sets out the self-attestation checklist and Appendix B provides the summary of FPPT compliance for Board members.							

Recommendations	The Board of Directors is asked to confirm and **ratify** the ongoing compliance with the FPPT Framework and FPPT Policy.

Corporate Impact Assessment	
Statutory/regulatory requirements	Meets the Trust compliance with Foundation Trust provider license
Risk	BAF 8 - Failure to ensure effective corporate governance could impact our ability to comply with legislation and regulation.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Public Board

Appendix A – Self-attestation checklist

Fit and Proper Person Test annual self-attestation

Countess of Chester Hospital

I declare that I am a fit and proper person to carry out my role. I:

- am of good character.
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties.
- (where applicable) have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals.
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (e.g. directors disqualification order).
- have not been convicted of a criminal offence.
- am not an un-discharged bankrupt nor have I been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors that have not been discharged.
- do not appear on any 'barred' list.
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.
- hold any registration with a relevant professional body necessary to carry out my role, I have the entitlement to use any professional titles associated with this registration. If I no longer meet the requirement to hold the registration, I will inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

Appendix B – FPPT Compliance

Board Member	Date FPP Self-Declaration Signed	Social Media Check	CRB within 3 years	Full compliance
Jane Tomkinson OBE, Chief Executive Officer	17/02/2026	Yes	Yes	Yes
Sue Pemberton, Director of Nursing and Quality/ Deputy CEO	26/01/2026	Yes	Yes	Yes
Nigel Scawn, Medical Director	17/02/2026	Yes	Yes	Yes
Karen Edge, Chief Finance Officer	29/01/2026	Yes	Yes	Yes
Cathy Chadwick, Chief Operating Officer	29/01/2026	Yes	Yes	Yes
Jason Bradley, Director of Digital and Data	09/03/2026	Yes	Yes	Yes
Karan Wheatcroft, Director of Governance and Risk	13/02/2026	Yes	Yes	Yes
Jonathan Develing, Director of Strategy and Partnerships	16/02/2026	Yes	Yes	Yes
Vicki Wilson, Chief People Officer	12/03/2026	Yes	Yes	Yes
Neil Large MBE, Trust Chair	26/01/2026	Yes	Yes	Yes
Paul Jones, Non-Executive Director	16/02/2026	Yes	Yes	Yes
Peter Williams, Non-Executive Director	06/10/2025*	Yes	Yes	Yes
Hasintha Gunawickrema, Non-Executive Director	10/10/2025*	Yes	Yes	Yes
Angela Simpson, Non-Executive Director	12/12/2025*	Yes	Yes	Yes
Andrew Hassell, Non-Executive Director	29/01/2026	Yes	Yes	Yes
Wendy Williams, Non-Executive Director	26/01/2026	Yes	Yes	Yes
Sarah Corcoran, Non-Executive Director	26/01/2026	Yes	Yes	Yes

*The mid-year dates reflect new members of the Board with the FPPT completed on appointment.

The following members of the Board of Directors left the Trust during 2025/26 and Board Member References were completed:

- Mick Guymer, Non-Executive Director
- Pam Williams, Non-Executive Director
- David Williamson, Non-Executive Director

PUBLIC – Board of Directors
19th May 2026

Report	**Agenda Item 20.**	**Review of Register of Interests**						
Purpose of the Report	Decision		Ratification	**X**	Assurance		Information	
Accountable Executive	Karan Wheatcroft			Director of Governance and Risk				
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**	BAF 8 – Failure to ensure effective corporate governance could impact our ability to comply with legislation and regulation, and our reputation.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X**
CQC Domains	Safe Effective Caring Responsive Well led							**X**
Previous considerations	Audit Committee – 24th April 2026							
Executive summary	The purpose of this report is to confirm the Trust's compliance with the Conflict of Interest Policy. In accordance with the Policy, all staff meeting the definition of a *Decision Maker* are required to submit a declaration upon appointment and update this annually by 31st March each year, including a nil return, or sooner where circumstances change. Declarations are completed via the Electronic Staff Record (ESR). Governors, who do not have access to ESR, continue to submit declarations using a Conflict of Interest Declaration Form. Board member interests are published on the Trust's website. The current Register of Interests for Executive Directors, Non-Executive Directors and Governors is appended to this report.							

	As at 31st March 2026, the Trust has achieved an overall compliance rate of 95.37%, demonstrating a marked and sustained improvement from 71.43% in 2024 and 92.29% in 2025. All Board members have completed their annual declarations, and no breaches or risks have been identified in relation to these. Follow up activity continues in respect of a small number of outstanding Governor declarations.
Recommendations	The Board is asked to **ratify** the Trust's compliance with the Conflicts of Interest Policy and review the Register of Interests for the Board of Directors and Governors.

Corporate Impact Assessment	
Statutory/regulatory requirements	Conflicts of Interest Policy reflects the NHS England model policy. Directors have a duty to declare interests held.
Risk	BAF 8 – Failure to ensure effective corporate governance could impact our ability to comply with legislation and regulation, and our reputation.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published as part of the meeting pack. Board of Directors Register of Interests are published on the Trust website.

APPENDIX A - REGISTER OF INTERESTS BOARD OF DIRECTORS

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST – April 2026

Please Note: After expiry, an interest will remain on this register for a minimum of 6 months and a private record of historic interests/registers will be retained for a minimum of 6 years, as per the Countess of Chester Hospital Conflicts of Interest Policy.

*Date Received/ updated	Name	Role	Description of Interest	Estimated Value	Relevant Dates From	Relevant Dates To	Actions agreed to mitigate risks & any approvals to adopt a certain course of action	Consent to declare
February 2026	Large, Mr Philip Neil	Chairman	Son is Andrew Large – Head of Finance, NHS England North West Regional Office	N/A		Ongoing	N/A	Yes
February 2026	Jones, Mr. Paul	Non-Executive Director	Nil	N/A	N/A	N/A	N/A	Yes
January 2026	Hassell, Professor. Andrew	Non-Executive Director	Financial Interest - Non-Executive Director at the University Hospital of North Midlands (until January 2026)	N/A	03/08/2020	31/01/2026	N/A	Yes
August 2025	Corcoran, Mrs. Sarah	Non-Executive Director	Non-Executive Director – The Christies Hospital NHS FT Interim post as Director of Clinical Quality at Northern Care Alliance (3 days a week)	N/A N/A	N/A 13/08/2025	N/A February 2026	N/A N/A	Yes
September 2025	Williams, Mrs. Wendy	Non-Executive Director	Financial Interest – Executive Coaching in various organisation (Including some NHS Trusts) Non-financial Personal Interest – Skill Donor for Cheshire Connect Non-financial Personal Interest – Board member Wrexham University	N/A	07/03/2024	Ongoing Ongoing Ongoing	N/A	Yes

January 2026	Williams, Mr Peter	Non-Executive Director	Nil	N/A	N/A	N/A	N/A	Yes
Dec-25	Gunawickrema, Mrs Hasintha	Non-Executive Director	Nil	N/A	N/A	N/A	N/A	Yes
April 2026	Simpson, Ms Angela	Non-Executive Director	Nil	N/A	N/A	N/A	N/A	Yes
March 2026	Tomkinson, Ms. Jane	Chief Executive Officer	Care Quality Commission (CQC) Executive Reviewer Pilkington's Charity Trustee Della Fish Foundation Trustee Joint Chair of Regional Research network Governor at University of Chester		June 2018 Feb 2019 Jan 2024 May 2024 Oct 2025	Ongoing Ongoing Ongoing Ongoing Ongoing	N/A	Yes
January 2026	Pemberton, Ms. Sue	Director of Nursing & Quality Deputy Chief Executive	Nil	N/A	N/A	N/A	N/A	Yes
February 2026	Edge, Mrs. Karen	Director of Finance	Trustee at Tarporley War Memorial Hospital	N/A	October 2024	Ongoing	CoCH hold lease with TWMH. Conflicts of interest at both Boards are declared and would not be involved in decisions where conflict is deemed.	Yes
January 2026	Chadwick, Miss Catherine	Chief Operating Officer	Nil	N/A	N/A	N/A	N/A	Yes

March 2026	Develing, Mr Jon	Director of Strategy and Partnerships	Voluntary Board Member of United Kingdom International Healthcare Management Association	N/A	May 2022	Ongoing	N/A	Yes
February 2026	Wheatcroft, Mrs Karan	Director of Governance, Risk and Improvement	Nil	N/A	N/A	N/A	N/A	Yes
February 2026	Scawn, Dr Nigel	Executive Medical Director	Financial Interest - Undertakes small volume of anaesthesia for private patients at both Spire Cheshire Hospital and Spire Liverpool Hospital. Non-Financial Personal Interest - Spouse is Associate Medical Director for Women and Children.	N/A N/A	01/09/2022	2023	Declared in line with the Conflicts of Interest Trust Policy.	Yes
March 2026	Bradley, Mr Jason	Chief Digital and Data Officer	Informatics consultant for Hunter Healthcare Consulting Informatics Consultant for Ethical Consulting Owner and Director of a limited company – JAB Health Chair of Digital Skills Development Network conference committee. Vice Chair of Digital Skills Development Network North West Steering Group	£4,500 £225 £21,000 N/A N/A	14/06/24 14/06/24 14/06/24 01/05/24 01/04/25	Ongoing 30/06/2025 Ongoing Ongoing Ongoing	Would not be involved in procurement or decision making in respect of these companies.	Yes
March 2026	Wilson, Ms Vicki	Chief People Officer	Nil	N/A	N/A	N/A	N/A	Yes

APPENDIX B - REGISTER OF INTERESTS, INCLUDING GIFTS & HOSPITALITY

COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST – April 2025 – March 2026

Please Note: After expiry, an interest will remain on this register for a minimum of 6 months and a private record of historic interests/registers will be retained for a minimum of 6 years, as per the Countess of Chester Hospital Conflicts of Interest Policy.

Date Received/ updated	No.	Name	Role	Description of Interest	Estimated Value	Relevant Dates From	Relevant Dates To	Actions agreed to mitigate risks & approvals to adopt a certain course of action	Consent to declare
COUNCIL OF GOVERNORS									
N/A	1.	Daryl Cassidy	Public Governor- The Rest of England & Wales (formerly Wider Area)	**Awaiting Form**	N/A	N/A	N/A	N/A	Yes
N/A	2.	Karen Chambers – **Stood down November 2025**	Partnership Governor – Flintshire County Council	N/A	N/A	N/A	N/A	N/A	Yes
N/A	3.	Dr Kausik Chatterjee	Public Governor - Ellesmere Port and Neston	**Awaiting Form**	N/A	N/A	N/A	N/A	Yes
10th March 2026	4.	Jan Chillery	Public Governor – Chester and Rural Cheshire	Nil	Nil	N/A	N/A	N/A	Yes
13th February 2026	5.	Dr Eve Collins	Partnership Governor – University of Chester	Nil	Nil	N/A	N/A	N/A	Yes
18th February 2026	6.	Sharon Cook	Public Governor – Chester and Rural Cheshire	Nil	Nil	N/A	N/A	N/A	Yes

Date Received/ updated	No.	Name	Role	Description of Interest	Estimated Value	Relevant Dates From	Relevant Dates To	Actions agreed to mitigate risks & approvals to adopt a certain course of action	Consent to declare
12th March 2026	7.	Naomi Cottrell	Staff Governor – All other staff	Nil	Nil	N/A	N/A	N/A	Yes
10th March 2026	8.	Sheila Dunbar	Public Governor – Chester and Rural Cheshire	Member – Royal College of Nursing Patient	Nil Nil	1979 2021	Present Present	Awareness, declarations should conflict arise with appropriate action. Awareness, declarations should conflict arise with appropriate action.	Yes
12th February 2026	9.	Paula Edwards	Staff Governor – Nurses/Midwives Qualified	Nil	Nil	N/A	N/A	N/A	Yes
6th February 2026	10.	Cheryl Finney	Staff Governor – Nurses/Midwives Qualified	Nil	Nil	N/A	N/A	N/A	Yes
4th March 2026	11.	Prof Tony Fisher	Public Governor – Chester and Rural Cheshire	(NHS) Academy for Health Care Science Guilden Sutton Green Space (Charity)	Nil Nill	2011 2016	Present Present	N/A N/A	Yes
19th February 2026	12.	David Foulds	Partnership Organisations Governor – Council for Voluntary Services	Employed by charity MHA (Methodist Homes) as the Locality Manager for Cheshire West. Member of the Cheshire West Voluntary Action. I represent the Cheshire West third sector on the board.	Nil Nil	Feb 2017 Feb 2017	Present Present	N/A	Yes

Date Received/ updated	No.	Name	Role	Description of Interest	Estimated Value	Relevant Dates From	Relevant Dates To	Actions agreed to mitigate risks & approvals to adopt a certain course action	Consent to declare
19th May 2025 **Awaiting Updated Form**	13.	Garol Gahan	Partnership Organisations Governor – Cheshire West and Chester Council	Nil	N/A	N/A	N/A	N/A	Yes
N/A	14.	Ian Gibbons – **Stood down November 2025**	Public Governor - Flintshire	N/A	N/A	N/A	N/A	N/A	Yes
N/A	15.	Robert Gorman	Staff Governor – Allied Health Professionals	**Awaiting Form**	N/A	N/A	N/A	N/A	Yes
20th February 2025	16.	Stephen Higgitt - **Completed term October 2025**	Staff Governor – All other staff	Nil	N/A	N/A	N/A	N/A	Yes
6th February 2026	17.	Christine Holloway	Public Governor - Flintshire	Nil	N/A	N/A	N/A	N/A	Yes
21st February 2026	18.	Robert Howe	Public Governor – Chester and Rural Cheshire	Nil	N/A	N/A	N/A	N/A	Yes
8th April 2025	19.	Ashley Jayne Caple – **Completed term October 2025**	Staff Governor – Allied Health Professionals	Nil	N/A	N/A	N/A	N/A	Yes

Date Received/ updated	No.	Name	Role	Description of Interest	Estimated Value	Relevant Dates		Actions agreed to mitigate risks & approvals to adopt a certain course action	Consent to declare
						From	To		
19th February 2026	20.	Louise Jha	Public Governor – Chester and Rural Cheshire	Nil	N/A	N/A	N/A	N/A	Yes
N/A	21.	Brian Jones – **Term of office completed September 2025**	Public Governor – Ellesmere Port & Neston	N/A	N/A	N/A	N/A	N/A	Yes
6th February 2026	22.	John Jones	Public Governor – Chester & Rural Cheshire	Nil	N/A	N/A	N/A	N/A	Yes
N/A	23.	Dadirai Kambasha – **Completed October 2025**	Staff Governor – Nurses/Midwives Qualified	N/A	N/A	N/A	N/A	N/A	Yes
26th February 2025	24.	Dr Kate Knight – **Stood down February 2026**	Partnership Organisations Governor – University of Chester	Partnership Governor	N/A	N/A	Ongoing	N/A	Yes
23rd February 2025	25.	Lucy Liang – **Term of Office Completed October 2025**	Public Governor – Chester & Rural Cheshire	Chair/Trustee of voluntary sector board – CMV action	N/A	Feb 2025	Feb 2028	N/A	Yes

Date Received/ updated	No.	Name	Role	Description of Interest	Estimated Value	Relevant Dates		Actions agreed to mitigate risks & approvals to adopt a certain course of action	Consent to declare
						From	To		
N/A	26.	Angel Lewis-Aaron – **Stood down July 2025**	Staff Governor – Nurses/Midwives Qualified	N/A	N/A	N/A	N/A	N/A	Yes
27th February 2025	27.	Ruth Overington – **Term of Office completed September 2025**	Public Governor – Flintshire	Nil	N/A	N/A	N/A	N/A	Yes
5th March 2025	28.	Chris Price – **left the Trust May 2025**	Staff Governor – All other Staff	Nil	N/A	N/A	N/A	N/A	Yes
17th March 2026	29.	Myrddin Roberts	Public Governor - Flintshire	Nil	N/A	N/A	N/A	N/A	Yes
23rd January 2026	30.	Paolo Tardivel	Partnership Governor - Betsi Cadwaladr University Health Board	Nil	N/A	N/A	N/A	N/A	Yes
10th March 2026	31.	Richard Taylor	Public Governor – Chester and Rural Cheshire	Nil	N/A	N/A	N/A	N/A	Yes
3rd March 2026	32.	Dr Salah Tueger	Staff Governor – Doctors	Haematology Conference – Vienna Austria	N/A – costs covered	29th January 2026	30th January 2026	N/A	Yes

Date Received/ updated	No.	Name	Role	Description of Interest	Estimated Value	Relevant Dates From	Relevant Dates To	Actions agreed to mitigate risks & approvals to adopt a certain course of action	Consent to declare
8th April 2025	33.	Tim Wheeler – **Resigned June 2025**	Public Governor – Chester& Rural Cheshire	Deputy Lieutenant for Cheshire Parish of St Peter with St John the Baptist, Chester – Member Cheshire Pitt Club – Member Chartered Institute of Management – Companion Freeman of the City of Chester Freeman of the City of London Lay Canon Emeritus Chester Cathedral Chair of the Board of Governors of Coleg Cambria, member of Board Committees and a Link Governor Member of Bangor University's Council Director- Novus Cambria (as Chair of Coleg Cambria)	N/A	N/A	N/A	N/A	Yes
N/A	34.	Maria Woodward – **Completed October 2025**	Staff Governor – Nurses/Midwives Qualified	N/A	N/A	N/A	N/A	N/A	Yes

PUBLIC – Board of Directors
19th May 2026

Report	**Agenda Item 21.**	**Risk Management Policy Update**						
Purpose of the Report	Decision	**X**	Ratification		Assurance		Information	
Accountable Executive	Karan Wheatcroft			Director of Governance and Risk				
Author(s)	Karan Wheatcroft			Director of Governance and Risk				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X**	BAF impact – Linked to all areas of the BAF but specifically the actions within BAF 8.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X**
Previous considerations	Risk Management Committee – 27th April 2026							
Executive summary	The Risk Management Policy has been reviewed and updated to reflect feedback following implementation in 2024 and the development and embedding of the risk management processes and assurances during 2025/26. The updates include: • Terminology for the Risk Manager and Risk Handler to ensure consistency with Datix. • Reference to equipment and medical devices including the Medical Devices Policy. • Reference to the risk assessment template used by some Divisions to support the assessment and analysis of risks. • Recognition that there may be disagreement on risk scores, with clarity on the need for discussion, resolution and escalation as required. • Board Assurance Framework considerations (in response to the MIAA recommendations).							

	• Updates to the monitoring, implementation, review and reporting to include training, Committee Chair's reporting to Quality Governance Group and Annual Report to the Audit Committee. • Addition of following sentence at 7.2: Future risks can be captured when horizon scanning and whilst these may present a low risk at the time of identification, these will continue to be reviewed an assessed. The full policy is appended to the report for review. As per the Schemes of Delegation, 'Approval and monitoring of the Foundation Trust's policies and procedures for the management of risk' is within the duties of the Board of Directors.
Recommendations	The Board is asked to **approve** the Risk Management Policy following recommendation for approval from the Risk Management Committee.

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

Countess of Chester Hospital NHS
NHS Foundation Trust

RISK MANAGEMENT POLICY

Document Properties	
Version:	3
Name of ratifying committee:	Board of Directors
Date ratified:	
Name of originator/author:	
Name of approval committee:	Risk Management Committee
Date approved:	27/04/26
Executive Sponsor:	Director of Governance &Risk
Date issued:	
Review date:	27/04/29

1. Version Control

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
1	August 2022	Deputy Director of Nursing and Quality Governance	Draft	New Document
2	October 2024	Director of Governance, Risk and Improvement	Draft	Streamline of sections and update
3	April 2026	Director of Governance and Risk	Approved – awaiting Ratification	Updates to terminology, references to other policies and Board Assurance Framework in response to internal audit recommendations.

2. Contents

Section Page

3. Quick Reference Guide

COCH – Risk Management Policy V1 Sept. 2022

3. Quick Reference Guide – Risk Management at a Glance

1. WHAT IS RISK MANAGEMENT

Risk management is the process by which risks are identified, assessed, recorded, mitigated, monitored & reviewed, and communicated. A risk is the threat that an event or action that will adversely affect the ability to achieve our objectives

2. WHY IS IT SO IMPORTANT?

Failure to effectively identify and address issues at an early stage can lead to unnecessary adverse events, affecting patient safety, staff welfare, or the Trust's performance. Good risk management is a preventative measure to stop bad things from happening.

3. WHO IS RESPONSIBLE FOR IT?

It is essential that you remain alert to issues that could lead to risk, which may have a negative impact on patients, staff and/or the Trust. You must also take personal responsibility for reporting such issues and acting upon them.

4. HOW DO I IDENTIFY & MANAGE RISKS?

IDENTIFY

How should I identify risks?
Risk assessments can be done through a specific ***planned*** process at corporate, division or ward/department level. It is, however, essential for us all to be alerted to risks on an ***ongoing*** basis, to ensure that we respond promptly to any emerging issues.

What types of risk should I identify?

- Risks to providing ***patients*** with safe, effective, and personal care.
- Risks to providing ***staff*** with a safe and rewarding work environment.
- Risks to **the Trust** achieving its broader Strategic, operational, and financial objectives.

What specific issues should I consider, that could lead to risk?

- Have you ***observed*** ay practice or behaviour which creates a risk for patients, staff and/or the Trust?
- Do you have ***information*** which indicates that there may be a risk for patients, staff, or the trust?
- Are you aware of any ***incidents*** where appropriate action has not been taken to prevent a recurrence?
- Have you received any ***feedback*** or **complaints** from patients or staff which have not been adequately addressed?

ASSESS/RECORD

All risks that cannot be addressed immediately should be recorded on Datix Risk Register module. Having identified a risk, the impact and the likelihood of the potential event happening needs to be assessed having regard to the descriptors set out in the table below.

LIKELIHOOD	IMPACT: Insignificant	Minor	Moderate	Severe	Catastrophic/death
	Patients Minimal impact on patients. **Staff** Minimal impact on staff. **Trust** Day to day operational challenges.	**Patients** Minor injury or harm to patients requiring minimal intervention. **Staff** Temporary staffing issues resulting in increasing pressures on staff and challenges in maintaining service quality. **Trust** Temporary restrictions to service delivery with limited impact on stakeholder confidence.	**Patients** Moderate injury or harm to patient(s) requiring clinical intervention. **Staff** Short term staffing issues resulting in how staff morale or restrictions to service quality. **Trust** Short term failure to deliver key objectives with temporary harm adverse local publicity.	**Patients** Serious or permanent harm to patient(s). **Staff** Medium term staffing issues resulting in very low morale or significant restrictions in service quality. **Trust** Medium term failure to delivery key objectives with ongoing adverse publicity or negative impact on stakeholder confidence.	**Patients** Avoidable death of patient(s). **Staff** Long term staffing issues resulting in poor morale, staff welfare issues or fundamental reduction in service. **Trust** Continued failure to deliver key objectives with long term adverse publicity or fundamental loss of stakeholder confidence.
Almost Never This potentially will never happen	1	2	3	4	5
Unlikely Do not expect it to happen occur, but it may do so	2	4	6	8	10
Likely Might happen/ occur occasionally	3	6	9	12	15
Highly Likely Will probably happen occur	4	8	12	16	20
Almost Certain Very likely to happen/ occur possibly frequently	5	10	15	20	25

MITIGATE/ESCALATE/COMMUNICATE

When is action required?
An action plan is required to mitigate all risks that cannot be resolved immediately. The actions must be recorded on Datix and must be S.M.A.R.T. (i.e.- Specific, Measurable, Achievable, Relevant, Time-bound.)

How do I escalate high risks?
Escalation will be based on the grade of the risk as illustrated in the diagram below.

It is important to note that the escalation of a risk does not negate the responsibility of the identified risk manager from the day-to-day management for specific risks assigned to them or governance group to pursue and follow-up identified risks.

How are risks reviewed and followed up?
Divisions, corporate functions, wards/departments are responsible for reviewing their risks on a regular basis (at least monthly or more frequently if change in risk status). Risks will also be reviewed via the Trust governance systems, including board sub-committees. The Trust executive team will review serious risks as part of its regular performance review.

4. Introduction & Purpose

This risk management policy aims to minimise risk to all stakeholders through a comprehensive system of internal control and risk management. The policy provides practical guidance on process and procedure for risk management within the Trust.

The Countess of Chester Hospital NHS Foundation Trust is committed to creating a culture of effective risk management, through simple processes that will identify, analyse, evaluate, control, escalate, communicate and monitor risks, with the overall aim of delivering safe, high quality effective care and create a safe environment for patient's staff, the organisation and the public.

5. Scope

This Policy applies to all Trust employees and staff working on behalf of the Trust. This included permanent, temporary, locums, voluntary, work experience and bank/agency staff, contractors and partners involved in Trust's business

6. Duties and Responsibilities

Chief Executive Officer: has overall accountability for Risk Management and as such has responsibility for maintaining a sound system of internal control that supports the achievement of the Trust objectives.

Director of Governance and Risk: is the executive lead for Risk Management and is accountable to the Board and the Chief Executive for the Trust's Risk Management activities.

Executive Directors: have responsibility for compliance with the risk management policy in their area of responsibility, including recording, escalation and mitigation of risk.

Divisional and Department Leadership Teams: are responsible for ensuring that Risk Management systems within the Divisions are effective and meet the objectives outlined within the Risk Management Policy. Divisional boards and governance assurance groups have a key role in assuring the effectiveness of Risk Management in all their services, including regular scrutiny and validation of divisional, departmental, and team risk registers.

All Staff: have an individual responsibility for the management of risk within the Trust. Managers (clinical and non-clinical) at all levels will understand the Trust's Risk Management policy and be aware that they have the authority and duty to manage risk effectively within their area of responsibility.

Risk Manager: Risks will be assigned to a named individual, who is accountable for ensuring the risk is managed, including ensuring controls and actions are in place to mitigate the risks. High/extreme risks will be escalated to executive directors and

appropriate questions determined. Any changes of risk ownership for any risks will be discussed and agreed with the new proposed risk manager.

Risk Handler: The risk handler is assigned to manage a risk by the risk manager, following discussion and agreement. The risk handler is responsible for completing the risk assessment, with relevant expert support. They report to the risk manager and are responsible for ensuring the risk is clearly identified on the register, reviewed and updated in a timely way, ensuring actions are progressing and inform the risk manager of any change in status of the risk. Changes to risk handler during the lifetime of the risk will be discussed and agreed with the new proposed risk handler.

Risk Action Owner: Risk action owners are chosen for their expertise in the subject matter and are responsible for delivery actions to manage or mitigate. All risks have action owners with whom the risk manager has agreed the action specifics (SMART), including target completion dates. The action owner thus has delegated responsibility for ensuring the delivery of a task or activity that will help to mitigate the risk, including documenting this clearly on the risk register and attaching relevant reports, meeting minutes etc.

Assurance Committees: the Board assurance committees have responsibility to monitor and provide assurance to the Board regarding specific risks identified within the Board Assurance Framework, and high risks within their areas of authority.

Risk Management Committee: has responsibility to ensure that operational systems and processes for risk management are in place to support compliance with the Risk Management Policy and inform the Annual Governance Statement; it will ensure that a culture of proactive and effective risk management is embedded across the Trust in order to improve quality and safety, ensure compliance with statutory requirements and support good governance.

7. The Risk Management Process

7.1. Establishing the Context

We need to have a clear understanding of the Trusts strategic and operational objectives, the external environment, the internal environment and the organisations approach to risk management. The external context will include, but is not limited to social and cultural, political, economic, the competitive environment, whether local, regional, national and/or international. Also consider key drivers and trends impacting on the strategic objectives and relationships, perceptions and values of external stakeholders.

7.2. Risk Identification

Risk assessments can be taken through a specific planned process at corporate, division, ward/department level. However, it is essential for us all to be alerted to risks on an ongoing basis, to ensure that we respond promptly to any emerging issues. Future risks can be captured when horizon scanning and whilst these may present a low risk at the time of identification, these will continue to be reviewed an assessed.

The risk identification wheel at Appendix 1 will support the identification of different sources through which risk can arise in the organisation.

The types of risks that should be identified are:

- Risks to providing patients with a safe environment (including equipment)
- Risks to providing staff with a safe working environment
- Risks to the Trust achieving its broader strategic, operational and financial objectives and managing the Trust reputation.

Should there be a situation/issue where immediate action to mitigate a risk is required and the action has been taken, this does not need to be recorded on the risk register unless residual risk remains. All risks that cannot be addressed immediately will be recorded on the risk register on the Trusts electronic risk management system (Datix) by risk owner.

7.3. Risk Assessment

It is essential all risks are assessed in an objective and consistent manner, if they are to be managed effectively. This will also support operational, project and programme planning and resource allocation. Risk assessments are required for all medical devices before first use (refer Trust Medical Devices policy).

Risks are first assessed on what would happen (impact/ consequence) should the risk occur and the probability (likelihood of the risk happening) when assessing what the impact/consequences of the risk could be if it happened, consider what the impact would be in most circumstances within your environment and what is reasonably foreseeable.

When assessing how likely a risk is to occur, take into account the current environment. Consider the adequacy of the controls already in place within the environment, which could address the causes of the risk and therefore the likelihood of the risk being realised, for example systems, processes, policies, current practice, training etc.

Not all risks can be dealt with in the same way. The 5 ‘T’’s’ provide the options available when considering how to manage risk:

- **Tolerate:** the consequences and likelihood of the risk is accepted
- **Treat:** actions are carried out to reduce the consequences or likelihood of the risk (this is the most common action)
- **Transfer:** shifting the responsibility or burden for loss to another party e.g., the risk is insured against or subcontracted to another party.
- **Terminate:** an informed decision not to become involved in a risk situation e.g., terminate the activity.
- **Take the opportunity:** actively taking the advantage, regarding the uncertainty as an opportunity to add benefit.

The assessment is completed by scoring the impact multiplied by the likelihood. In addition, to the matrix in the quick reference guide at the beginning of this document,

an additional more detailed 5x 5 matrix is available at Appendix 2. The risk score will inform the risk owner to whom the risk needs to be escalated.

Refer to the Trust Risk Assessment Policy for further guidance on the risk assessment process including the 5 steps to follow in the risk assessment process.

7.4. Risk Registers

Wards, departments, divisions and corporate service risk registers (repository of risks) are 'live' records. They contain all risks identified to services (both clinical and non-clinical) As a minimum when reporting a risk onto Datix the risk will contain:

- Date risk first identified
- Date of last review
- CQC domain
- Risk cause
- Risk description
- Risk impact/consequences
- Current controls in place
- Current gaps in controls
- Actions to address gaps
- Initial risk rating
- Current risk rating
- Target risk rating
- Review date (monthly)
- Risk manager
- Risk owner
- Assurance
- Link to BAF/Strategic goal

The risk needs to be described clearly. The recommended format for risk descriptions is to identify the cause, the event and the effect. When wording the risk, it is helpful to think about it in three parts. There is a risk (uncertain event) that …… this is caused by (issue) ……. and would lead to an impact/consequence on …….

7.5. Risk Analysis (Scoring)

Having identified a risk, the impact of the potential event and the likelihood of the event occurring will be assessed having regard to the impact descriptors in the risk matrix, Appendix 2.

The risk assessment template provides a line by line score of eventualities and can be a useful tool for the analysis of risk and determination of impact and likelihood scoring.

The impact score will be dependent on what the impact (what could happen should the risk occur) would be in most circumstances within the current environment and what is reasonably foreseeable, rather than defaulting to the 'worst case scenario'.

The likelihood scoring is dependent on firstly the inherent risk without any controls in place. The current likelihood scoring is dependent on adequacy of existing controls, for example systems, policies, training, and current practice.

Having assessed the impact and likelihood Datix will calculate the risk grading. All risks reported to Datix will have three scores as set out below

Inherent risk score	Is the level of risk score when the risk is first identified and reported before the effect of the mitigation
Current risk score	Is the score at the time of the last review taking into consideration the controls in place? The minimum review timescale for risks on the register is monthly or more frequently if there is any change in the risk status, for example if mitigating actions completed and identified as controls that will mitigate the risk, or the environment has changed resulting in an increase in the risk score requiring further action to mitigate.
Target (mitigated) risk score i.e., tolerable	Is the estimated exposure arising from a specific risk after implementing the proposed controls and actions contained in the action plan

Whilst the Trust scoring matrix provides a comprehensive reference for determining risk scores there will be occasions where the risk owner, risk handler and divisional leadership may disagree. It is envisaged that discussions will take place locally in the first instance to understand the risk and reach agreement on scoring, wording, mitigations and escalation.

Where dispute on risk scores cannot be resolved this will be reported at the appropriate escalation level as set out in 7.6 below and any agreed amendment to the risk will be recorded within the minutes of the meeting.

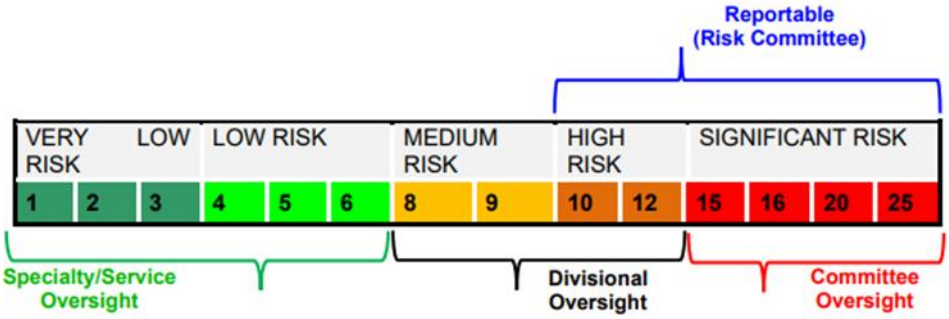
7.6. Escalation Process

Risk escalation is through the residual risk score, although risk managers may also determine that lower level risks require notification or oversight at a higher level in the organisation. The risk manager remains responsible for the management of risk, and the escalation of a risk does not negate this responsibility.

In terms of escalation:

- Low and very low risks will remain within the specialty/ service area for review and reporting.
- Medium and high risks will be reported and reviewed at a Divisional level. For corporate services this will be with the respective Executive Director lead.
- Significant risks will be reported to and reviewed through the Board level Assurance Committee alongside extracts of the Board Assurance Framework. These risks will form the corporate risk register reported alongside the Board Assurance Framework to the Board.
- The Risk Management Committee will review all high and significant risks across all Divisions ensuring consistency of scoring, management and delivery

of mitigating actions, as well as consistency and compliance with the risk management policy.



A key part of the risk escalation process will be automated notifications from Datix for new or amended risks triggering Divisional, Executive Director or Committee oversight.

Significant risks will be considered by Executive Directors in the context of the Board Assurance Framework (BAF). Assurance Committees will also receive combined BAF risk reports for those risks relevant to the duties within their Terms of Reference enabling consideration of the alignment and escalation, as appropriate, to the BAF.

7.7. Action Planning

Following completion of the risk assessment, consideration will be given to whether the risk requires further management action that will minimise the impact and likelihood of the threat. A risk should be scored on Datix for each risk that cannot be resolved immediately, to either eliminate, minimise or accept the risk.

The focus of the actions is to address the gaps in controls and/or assurance identified during the assessment process. The actions will be recorded on Datix together with the risk grading following completion of the action plan. It is expected that actions will be Specific, Measurable, Realistic Achievable Time bound, (S.M.A.R.T). When the actions are completed, they then often become controls that mitigate the risk, and the risk score reached appropriately.

The risk manager with the agreement of the risk owner will assign risk action owner(s). The risk manager and risk action owner(s) will agree the detail of the mitigating action and the expected completion date(s). The risk action owner will update on progress via Datix. The risk manager will:

- Review the progress of all mitigating actions
- Ensure completed actions are recorded as an existing control
- Record the review by entering the review date and amend current risk grading appropriately.
- Review the score based on the action taken.
- Identify new action and challenge with tolerance

It is not always possible to identify and then fully implement actions that eliminate or minimise risk. Where this is the case, it is essential the significance of the remaining

risk is understood, and the Trust confirms it is prepared to accept that level of residual risk. Acceptance of risk level is determined by the Trust risk appetite and tolerance.

7.8. Monitoring and Closure

Risks registers should be a standing item at ward/department, division, corporate function and Trust committee's agenda monthly. This ensures that risks are consistently identified, monitored and re-evaluated throughout the year.

As a minimum risks should be reviewed on Datix every 3 months, with the expectation that risks with a residual score of 15 or over would be reviewed monthly.

Once risks have reached their target they can be either closed or continue to be monitored if the risk is still a 'live' risk.

8. Monitoring, Implementation,Review and Reporting

The Director of Governance and Risk will oversee the implementation and monitoring of this policy through the Risk Management Committee.

The Risk Management Committee will report to the Quality Governance Group (QGG) through a Chairs AAA report following each meeting.

The Associate Director, Digital Transformation will establish and regularly review the training needs analysis, training plan, training material, training provision and compliance in-conjunction with the Datix Team.

Monitoring and implementation will be reported to the Risk Management Committee with an annual report to the Audit Committee.

This policy will be reviewed every three years or in response to any significant organisational changes.

9. Communication

This Policy will be communicated to staff via the following means

- Dissemination and sharing via representatives at approving group.
- Divisional notification via relevant divisions and corporate function governance processes.
- Email via communications to all staff.
- Available on the Trust document management system (SharePoint).
- Via Training sessions regarding risk management and Datix support.
- Risk Assessment Policy.

10. Appendices

10.1. Appendix 1 – Risk Identification Wheel

Risk Identification Wheel

Countess of Chester Hospital NHS Foundation Trust Risk Wheel

Different sources through which risk could arise in the organisation.

Use the risk wheel as a checklist to ensure that risk identification is comprehensive.

Countess of Chester Hospital NHS Foundation Trust

Risk Management Policy/Procedure

Appendix 1

10.2. Appendix 2 - Risk Matrix

The risk matrix used by Countess of Chester Hospital NHS Foundation Trust is based on the Australian / New Zealand standard (AS/4360:1999 – Risk Management), which is the system recommended for the NHS to use by the Department of Health.

Consequence Score

The consequence (impact) scores are derived by choosing the most appropriate domain for the identified risk from the left-hand side of the table by working along the columns in same row to assess the severity of the risk on the scale of 1 to 5, to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors (this is not exhaustive)				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on many patients
Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/ organizational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)

What is the likelihood of the risk being realised?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency. Alternatively, the probability chance of occurrence is also a useful method for identifying likelihood of risk being realised.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Probability chance of occurrence	Less than 20%	20-40%	40%- 60%	60%- 80%	Greater than 80%

10.3. Appendix 3 Definitions

Board Assurance Framework (BAF)	The BAF is the tool by which the Board corporately assured itself about the successful delivery of the Trusts strategic objectives. The BAF is designed to focus the Board on controlling principal risks threatening the delivery of those objectives. The BAF aligns principal risks, key controls and assurances on the operation of the controls.
Risk appetite	The level of risk the Trust is prepared to accept or be exposed to at any point in time
Hazard	Potential source of harm or adverse health effect
Issue	Essentially a risk that has happened
Risk	The chance of something happening that will have an adverse impact. It is measured in terms of consequences and likelihood.
Risk Management Process	Systematic application of management policies, procedures and practice to the tasks of establishing the contest of risk, then identifying, analysing, evaluating, treating, monitoring and communicating risk.
Risk assessment	Overall process of risk identification, risk analysis, risk action and risk evaluation. *Refer to Trust Risk Assessment Policy available on SharePoint.*
Inherent risk	This is the score assigned to a risk if the controls in place are found to be ineffective or absent. *It involves the use of the 5x5 matrix at appendix 2*.
Residual risk	This is also known as the current risk score. It is the score assigned to any risk after the control measures in place are taken into account. It involves the use of the 5x5 matrix with impact and likelihood being adjusted following the inherent risk score. *The scoring 5x5 matrix is provided at appendix 2*
Target risk	This is the future risk score assigned to a risk after gaps in control measures have been addressed and outstanding actions implemented. This should reflect the risk tolerance.
Impact	The potential consequences if the adverse effect occurs as a result of the hazard.
Likelihood	A qualitative measure/description or probability of frequency
Probability	The likelihood of a specific event or outcome occurring. This is measured by the ratio of specific events or outcomes occurring to the total number of possible events or outcomes. Probability is expressed along a scale ranging from rare to almost certain. Refer to 5x5 risk matrix at appendix 2.
Risk Rating	The total score worked out by identifying the consequences and likelihood score and cross referencing with the risk matrix. *Refer 5x5 matrix at appendix 2*
Risk Control	That part of risk management which involves the development and implementation of policies, standards, procedures and/or physical changes to eliminate or minimise adverse events of risk.
Gaps in controls	Processes or activities not yet in place in order to effectively manage the risk
Risk actions	A specific, measurable, achievable, relevant and time-specific piece of work that is to be completed, that will address an identified gap in control or assurance.
Secondary risks	Risks caused by actions/treatment
Risk assurance	Evidence that supports the measurement of controls in place, to ensure they are operating effectively, and the desired outcome is being achieved.

Gaps in assurance	Gaps in evidence to support the measurement/application of controls
Internal assurance	Assurance provided by reviewers, auditors and inspectors who are part of the organisation such as clinical audit or management peer review
External Assurance	Independent assurance provided by reviewers, auditors and inspectors from outside the organisation for example the CQC, Commissioners, NHS Improvement.

10.4. Appendix 4 – Equality Analysis

Officer responsible for Assessment:		
Name of Policy/Strategy/Change to be assessed:	**Date of Assessment:**	**Is this a New Policy/Strategy/Change? Substantially rewritten**
Risk Management Policy	October 2024	Policy Update
1. Briefly describe the aims, objectives, and purpose of the Policy.	This risk management policy aims to minimise risk to all stakeholders through a comprehensive system of internal control. The policy provides practical guidance on process and procedure for risk management within the Trust. The Countess of Chester Hospital NHS Foundation Trust is committed to creating a culture of good risk management, through simple processes that will identify, analyse, evaluate, control, escalate, communicate and monitor risks, with the overall aim of delivering safe, high quality effective care and create a safe environment for patient's staff, the organisation and the public.	
2. Are there any associated objectives of this policy? Please explain.	As above	
3. Who is intended to benefit from this Policy and why?	The Policy applies to all members of staff working in Countess of Chester Hospital NHS Foundation Trust including permanent, temporary, locums, voluntary, work experience and bank staff, including contractors and partners involved in Trust's business.	
4. What outcomes are wanted from this Policy?	To ensure there are sound systems of internal control and these are adhered to through the effective application of risk management systems and processes	

5. What factors/forces could contribute/detract from the outcomes?	None identified
6. Who are the main stakeholders in relation to this Policy?	Refer to section 3 of this equality analysis.
7. Who implements the Policy and who is responsible for the Policy?	All staff are responsible for the identification and implementation of risk management. Accountabilities detailed in the Risk. This policy document the responsibilities of the risk owners and managers is outlined. The Director of Governance and Risk is responsible for this policy and compliance is tracked through the Risk Management Commmittee.

8. Are there concerns that the Policy would have a detrimental impact on RACIAL Groups?	Y/N	No
What existing evidence (either presumed or otherwise) do you have for this?		Equally applicable to all staff
9. Are there concerns that the Policy could have a detrimental impact due to GENDER (including Transgender)?	Y/N	No
What existing evidence (either presumed or otherwise) do you have for this?		
10. Are there any concerns that the Policy could have a detrimental impact due to DISABILITY?	Y/N	No
What existing evidence (either presumed or otherwise) do you have for this?		Refer to Risk Management Strategy and associated policy and procedure document strategy
11. Are there any concerns that the Policy could have a detrimental impact due to SEXUAL ORIENATION?	Y/N	No

What existing evidence (either presumed or otherwise) do you have for this?	

12. Are there concerns that the Policy could have a differential impact due to AGE?	Y/N	No
What existing evidence (either presumed or otherwise) do you have for this?		
13. Are there concerns that the Policy could have a differential impact due to RELIGIOUS BELIEF?	Y/N	No
What existing evidence (either presumed or otherwise) do you have for this?		
14. Are there concerns that the Policy could have a differential impact due to MARRIAGE OR CIVIL PARTNERSHIP STATUS? (This must be considered for employment policies)	Y/N	No
What existing evidence (either presumed or otherwise) do you have for this?		
15. Are there concerns that the Policy could have a differential impact due to GENDER REASSIGNMENT?	Y/N	No
What existing evidence (either presumed or otherwise) do you have for this?		

16. Are there concerns that the Policy could have a differential impact due to PREGNANCY OR MATERNITY?	Y/N	No
What existing evidence (either presumed or otherwise) do you have for this?		Also: separate risk consent process in place.

17. Could the differential impact have identified in 8-16 amount to there being the potential for adverse impact in this policy	Y/N	No
18. Can this adverse impact be justified on the grounds of promoting equality of opportunity for one group? Or any other reason?	Y/N	Not applicable
19. If yes, what actions are to be taken to mitigate risk?	Y/N	Not applicable
20. If yes, who will be responsible for the ongoing management of risk?	Y/N	Not applicable
21. If No, are there any minor further amends that should take place?	Y/N	No
22. If a need for minor amendments is identified, what date were these completed and what actions were undertaken?	Y/N	Not applicable
Completed and signed by: (Policy/Strategy Lead)		Director of Governance and Risk Date:

PUBLIC – Board of Directors
19th May 2026

Report	**Agenda Item 22.***	**Council of Governors Report – April 2026**						
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Karan Wheatcroft			Director of Governance and Risk				
Author(s)	Nusaiba Cleuvenot			Head of Corporate Governance				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X** **X** **X** **X** **X** **X** **X** **X** **X** **X**	Relevant across all BAF areas.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X**
CQC Domains	Safe Effective Caring Responsive Well led							**X**
Previous considerations	Not applicable.							
Executive summary	The purpose of this report is to provide a summary of items discussed at the Council of Governors meetings.							
Recommendations	The Board of Directors is asked to **note** the report and the activity during this period.							

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

Council of Governors Report

1. PURPOSE

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

2. BACKGROUND

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

3. CURRENT POSITION

3.1 Council of Governors Meeting

A full Council of Governors meeting was held on 15th April 2026, and key items included the following:

- A patient story was presented.
- An update was provided from the Chair and the Chief Executive Officer on key matters.
- Chair's reports were received from the Quality and Safety Committee, People Committee, Audit Committee and Finance & Performance Committee.
- Lead Governor update.
- Staff Survey results and priorities.
- Cheshire and Merseyside Provider Collaborative Priorities.
- Quality Priorities Update.
- Urgent Care Update.
- The Trust's Integrated Performance Report (IPR) was provided setting out the Trust's performance in key areas from the NHS Oversight Framework Report including Operational Performance, Quality, Safety, Finance and People.
- Membership & Engagement Committee Chair's report including an update on the membership strategy and membership database cleanse.
- Feedback from Non-Executive Director/ Governor walkabouts.

Following the Council of Governors meeting held in public, a private meeting was held. The Council of Governors received papers detailing summary reports from the last Private Board meetings; a report on the outcome of the Chair's Appraisal 2025/26, an NHS England Enforcement notice update and a Thirlwall Inquiry and investigations update.

3.2 Council of Governors Workshops and Informal Meetings

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

One further informal Chair and Governor meetings took place on 7th May 2026.

4. RECOMMENDATIONS

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

PUBLIC – Board of Directors
19TH May 2026

Report	**Agenda Item 23a.**	**Annual Committee Effectiveness Review 2025/26: Quality & Safety**						
Purpose of the Report	Decision	**X**	Ratification		Assurance	**X**	Information	
Accountable Executive	Karan Wheatcroft			Director of Governance and Risk				
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**	BAF impact – Linked to all areas of the BAF but specifically the actions within BAF 8.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X** **X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Workshop took place on 9th March 2026. Reviewed by Committee members via email on 25th March 2026. Audit Committee – 24th April 2026							
Executive summary	The Audit Committee has an overarching responsibility to review the adequacy and effectiveness of governance systems in the organisation; this includes reviewing and receiving assurance on the effectiveness of the Board Assurance Committees on at least an annual basis. It is recognised good practice for committees to assess their effectiveness annually. The approach to assessing effectiveness included a desktop review of the committee agenda items against its Terms of Reference (ToR), attendance and observation, discussion with the committee Chair and a workshop with Committee members. The actions from the effectiveness review include:							

	• Update wording in the Terms of Reference regarding duties related to regular CQC reporting, Ombudsman reports, Complaints policy and safeguarding reports. • Update workplan to align with changes to Terms of Reference and to include standing item (verbal) on each agenda for Director of Nursing/ Medical Director to share a horizon scanning update as required. • Review work delegated to Quality Governance Group and sub groups and agree those reporting to Quality and Safety Committee • Invite wider attendance including AMD/ Divisional Director representation to support discussion on relevant papers. • Continue to improve quality of reporting, including Executive Summaries and committee to provide clarity on purpose of reports. The committee effectiveness review has confirmed the ongoing effectiveness of the Quality and Safety committee. The actions identified above will be implemented and monitored.
Recommendations	The Board of Directors is asked to **approve** the report and confirm that the committee has operated effectively during 2025/26.

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	The annual report is to be circulated as part of Audit Committee papers.

Committee Effectiveness Review 2025/26: Quality and Safety Committee

1. Executive Summary

The Quality and Safety Committee has met seven times during the financial year 2025/26 with good attendance demonstrated by all members. The purpose of the committee is to support the Board of Directors in ensuring the Trust's management of clinical and non-clinical processes, managing comments, compliments, concerns and complaints, improving quality of services and embedding organisational learning and improvements across the Trust.

The committee's work has continued to focus on strengthening assurance and sub-committee reporting through the Quality Governance Group. Focus has included improving Sepsis compliance, delivery of quality improvement outcomes, embedding Organisational Learning and progressing actions against the CQC warning notice. Risks and issues have been escalated to the Board of Directors through the Chair's Alert, Assure, Advise (AAA) Reports.

2. Committee Effectiveness

The effectiveness of the Committee has been reviewed through:

- Review of Terms of Reference (TOR) and workplan
- Desktop exercise to confirm alignment of agendas/ papers to TOR
- Wider considerations (insight, assurance, foresight and hindsight)
- Workshop to discuss findings

2.1 Delivery of Objectives

During the year, the Quality and Safety Committee undertook the full range of its responsibilities including:

- Oversight of clinical quality performance through routine review of the Integrated Performance Report (IPR) covering safety, quality, and patient experience indicators.
- Monitoring implementation of CQC Urgent and Emergency Care (UEC) action plans to ensure sustained improvement.
- Consideration of external regulatory reports and compliance updates, including CQC, NHS England, and NICE compliance reporting.
- Reviewing and challenging Safety Surveillance and Learning Reports, identifying themes, trends, and learning from incidents.
- Oversight of mortality governance via routine Learning from Deaths and Mortality Surveillance Reports (quarterly and annual).
- Monitoring of serious incidents, harm reviews, and cancer pathways, receiving specific Cancer Harm Review updates and assurance reports.

- Receiving regular patient experience intelligence, including patient stories, complaints/ concerns annual reporting, Friends and Family Test (FFT) improvement work, Health Watch feedback and national Patient Experience Survey results (including Children's and Young People).
- Receiving assurance in respect of complaints management, and review of complaints themes, and Trust response times.
- Receiving and reviewing assurance on the processes for Quality Impact Assessments (QIAs) linked to Cost improvement/ transformation programmes, ensuring no unintended negative impact on patient care.
- Receiving updates on maternity and perinatal services, including Maternity Incentive Scheme compliance, survey results, and quarterly maternity and perinatal updates.
- Oversight of safeguarding arrangements, reviewing quarterly Safeguarding and Complex Care reports covering adult and child safeguarding requirements.
- Receiving assurance on key clinical statutory areas, including Resuscitation Annual Reports, IR(ME)R compliance, medical devices safety, cleaning/estates standards, and discharge letter timeliness.
- Gaining assurance from Quality Governance Group (QGG) via quarterly Chair's Reports and minutes, supporting clinical governance oversight.
- Monitoring clinical risk, including regular review of the relevant extracts of the Board Assurance Framework (BAF) and high-risk reports throughout the year.
- Oversight of the quality and safety priorities, including Striving for Excellence updates, Trust clinical audit and assurance reports, and action tracking via the MIAA Audit Tracker.

The committee has alerted the Board to the following risks and issues this year:

- Requested further assurance on Quality Impact Assessment for Cost Improvement Programme.
- Care Quality Commission (CQC) Section 29a notice regarding Urgent and Emergency Care and progress against actions
- Request for risk assessment in relation to current and planned resuscitation capacity in ED
- Sepsis compliance
- Progress against action in palliative care services.
- Capacity and workforce pressures within Cancer Services.
- Compliance within the safeguarding report
- Patient flow and levels of Non-Criteria to Reside (NC2R)
- Positive assurance

2.2 Membership and Attendance

The attendance from members is confirmed below.

Members	01/05/ 2025	21/05/ 2025 Extra-ordinary	03/07/ 2025	08/09/ 2025	06/11/ 2025	08/01/ 2025	05/03/ 2025
Non-Executive Director, Prof A Hassell (Committee Chair)	☑	☑	☑	☑	☑	☑	☑

Non-Executive Director, Ms S Corcoran	☑	☑	☑	☑	☒	☑	☑
Non-Executive Director, Mr P Jones	☑	☑	☑	☑	☑	N/A	N/A
Non-Executive Director, Ms A Simpson	N/A	N/A	N/A	N/A	N/A	☒	☒
Director of Nursing & Quality/Deputy Chief Executive, Ms S Pemberton	☑	☑	☑	☑	☑	☑	☑
Medical Director, Dr N Scawn	☑	☑	☑	☑	☑	☑	☑
Chief Operating Officer, Ms C Chadwick	☑	☑	☑	☑	☒	☑	☑
Deputy Director of Nursing & Quality, Ms M Kynaston	☒	☑	☑	☑	☑	☑	☑
Deputy Director of Nursing & Quality Governance, Ms F Altintas	☑	☑	☑	☑	☒	☑	☑
Deputy Medical Director, Dr I Benton	☑	☑	☑	☒	☑	☑	☑
Director of Midwifery, Ms N Macdonald	☑	☑ (via Microsoft Teams)	☑	☑	☑	☑	☑
Associate Director of Nursing, Planned Care, Ms F Hughes	☑	☑	☑	☒	☑	☒	☒
Associate Director of Nursing, Urgent Care, Ms D Graham	☒	☒	☒	N/A	N/A	N/A	N/A
Divisional Director of Nursing & Quality – General and Specialist Medicine, Urgent Care, Ms N Hayes	☑ (For Ms D Graham)	☑ (For Ms D Graham)	N/A	☑	☒	☑	☑
Divisional Director of Nursing & Quality – Urgent and Emergency Care, Ms G Locker	N/A	N/A	☑ (For Ms D Graham)	☑	☒	☑	☑

In addition, there were attendees who joined to present certain items.

3. Actions

A number of areas were discussed at the workshop including reporting, and relationships with other committees. The actions from the Quality and Safety Committee effectiveness review are:

Action	Responsibility	Timeframe
1. QGG and sub-group reporting: confirm which reports will report directly to QGG and which will report to Q&S via Chair's reports. Reflect changes in Terms of Reference and Workplan accordingly.	Director of Nursing and Quality/ Deputy Director of Nursing and Quality Governance	June 2026

Action	Responsibility	Timeframe
2. Terms of Reference Updates: • REMOVE 'to receive regular updates relating to the CQC' • CLARIFY responsibility related to receiving reports from the Ombudsman or if this should be included within the complaints report • ADAPT wording around complaints policy to convey adherence to the complaints policy rather than review of complaints policy and should be COMBINED with duty on complaints. • UPDATE wording on safeguarding responsibility to reflect delegation to Safeguarding sub-group with assurance to be received via a Chair's report	Director of Nursing and Quality/ Deputy Director of Nursing and Quality Governance	June 2026
3. Workplan updates: • ADD standing verbal item for Director of Nursing/Medical Director to provide 'horizon scanning' update as required. • UPDATE workplan to reflect reporting changes from QGG/sub groups.	Head of Corporate Governance/ Committee Secretary	April 2026
Meeting Effectiveness: • Invite wider attendance including AMD/ Divisional Director representation to support discussion on relevant papers. • Continue to improve quality of reporting, including Executive Summaries and committee to provide clarity on purpose of reports.	Chair/Executive Leads/Committee Secretary	Across 2026/27

4. Conclusion

The committee effectiveness review has confirmed the ongoing effectiveness of the Quality and Safety Committee. The actions identified above will be implemented and monitored.

5. Recommendation

The Board of Directors is asked to approve the report and confirm that the committee has operated effectively during 2025/26.

Appendix A – Summary Desktop review findings

TOR Duty	Items Received	Comments
Clinical Quality and Quality Impact Assessments	• System Oversight Framework / Dashboard (May) • Maternity Services Quarterly Update (May • Discharge letters within 24 hours compliance Report (May, July, Sept, Nov, Jan) • Cancer Harm Reviews Report (May, Nov, Jan • Sepsis Annual Report (May) • Integrated Performance Report (IPR) (every meeting) • Quarterly Safety Surveillance and Learning Report (July, sept, Nov – action update in Jan) • Mortality Annual Report (July) • Quarterly Mortality Surveillance Report (learning from deaths) (Sept, Jan) • Sepsis Update Report (July, Sept, Jan) • Emergency Department (ED) Resuscitation Estate Capacity (July) • Corporate Consent Report (July, Sept) • Cleaning Monitoring Update (July, Jan) • Specialised Palliative Care and End of Life Care Service Review Update (Sept, Jan) • Medical Devices Gap Analysis and Action Plan (Sept, Jan) • Paediatric Emergency Department (ED) Review June 2025 (Sept) • Medications Optimisation Annual Report (Sept) • Perinatal Services Quarterly Update (Nov • Resuscitation Annual Report (Jan) • Quality Impact Assessment (QIA) for Cost Improvement Programme Update (May) and Summary Paper (Sept, Jan) • Governor/ Non-Executive Director Walkabout Feedback (May, July)	-
Compliance and Regulation	• Review of MIAA Audit Tracker – (May, Sept, Jan) • PSIRF (MIAA Audit) Action Update Report (Sept) • CQC Section 29a Warning Notice (May) • Section 29a Warning Notice – Urgent and Emergency Care (May, November) • Urgent and Emergency Care (UEC) Action Plan – May 2025 (inclusive of Section 29a Warning Notice) (May) • Progress Update against Care Quality Commission (CQC) Section 29a Warning Notice Emergency Department (June) • NICE Compliance & Update Report (July, Sept) • Striving for Excellence (July) • Trust Clinical Audit & Assurance Annual Report April 2024 – March 2025 (July) • Trust Clinical Audit & Assurance Quarterly Report (Sept, Nov)	-

TOR Duty	Items Received	Comments
	• Communities and Partnerships (Sept) • National Safe Standards for Invasive Procedures Progress Update (Sept) • ED and UEC Update (Jan) • Maternity Incentive Scheme Year 7 Compliance and Assurance Report (Jan) • Section 29a Warning Notice – Urgent and Emergency Care (May, Nov) • Urgent and Emergency Care (UEC) Action Plan – May 2025 (inclusive of Section 29a Warning Notice) (May) • Progress Update against Care Quality Commission (CQC) Section 29a Warning Notice Emergency Department (June)	
Clinical governance and risk management	• Quality Governance Group Assurance Report (Every meeting) • Patient Safety Incident Response Framework (PSIRF) Assignment Report 2024/25 • Quality Governance Group Minutes • Quality Governance Group Workplan (July) • Quality Governance Group Terms of Reference (Sept) • Quality Governance Group Triple AAA Chairs report (Nov,Jan) • System Oversight Framework / Dashboard (every meeting) • Safety surveillance reports • Quarterly Board Assurance Framework and High Risks Report (every meeting) • Board Assurance Framework (every meeting) • Cancer Services Group Chair's Report (May, Sept • Cross Committee Considerations (Sept) • Falls Steering Group Update (Jan) • Quarter 1 2025/26 – Safeguarding and Complex Care Report	-
Patient experience	• Quality/Safety and Patient Experience Strategy Progress Update (May • Children and Young person 2024 CQC Survey results (May • Quality Account Draft 2024/25 (May) • Quality, Safety and Experience Strategy • Quality Accounts 2024/25 (July) • National Cancer Patient Experience Survey (NCPES) 2024 Results • Maternity survey results	-
Complaints and reviews	• Complaints and Concerns Annual Report (July)	-

PUBLIC – Board of Directors
19th May 2026

Report	**Agenda Item 23b.**	**Annual Committee Effectiveness Review 2025/26: Audit Committee**						
Purpose of the Report	Decision	**X**	Ratification		Assurance	**X**	Information	
Accountable Executive	Karan Wheatcroft			Director of Governance and Risk				
Author(s)	Karan Wheatcroft			Director of Governance and Risk				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X**	BAF impact – Linked to all areas of the BAF but specifically governance and BAF 8.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X**
CQC Domains	Safe Effective Caring Responsive Well led							**X**
Previous considerations	Discussion took place with Audit Committee Members on 23rd March 2026. Reviewed by Committee members via email on 8th April 2026. Audit Committee – 24th April 2026							
Executive summary	The Audit Committee has an overarching responsibility to review the adequacy and effectiveness of governance systems in the organisation; this includes reviewing and receiving assurance on the effectiveness of the Board Assurance Committees on at least an annual basis. The approach to assessing effectiveness of the Audit Committee included a desktop review of the committee agenda items against its Terms of Reference (ToR), completion of the HfMA Audit Committee Handbook questionnaires, and discussion with Committee members. Recognising the recent changes in Committee membership, the Director of Governance and Risk, and the Director of Finance completed the checklists which were then subject to scrutiny by Committee members at the discussion on the 23rd March 2026. Discussions confirmed compliance across the Committee Term of Reference and in line with best practice.							

	The agreed actions to continue to enhance effectiveness included: • To clarify the purpose of reporting regarding Freedom to Speak Up (and other processes to raise concerns) to the Audit Committee and other committees. • For external auditors, KPMG to share best practice as part of their updates (as agreed at the Private meeting) • Future consideration of transformation and real time assurance given the critical focus on transformation for 2026/27. • To continue to review and develop the way the committee receives updates and works with other Assurance Committees. • MIAA external Quality Assessment (due 2026/27) to be added to workplan. • To consider if the Quality Accounts should be included in TOR/ workplan. The new Committee Chair was keen to build his knowledge including: • To meet with the Chief Digital and Data Officer to understand the approach to digital and data governance (through the Finance & Performance Committee). • To meet with the Director of Governance and Risk, and relevant leads to understand the Trust's risk management processes. The committee effectiveness review has confirmed the ongoing effectiveness of the Audit Committee. The actions identified above will be implemented and monitored.
Recommendations	The Board of Directors is asked to **approve** the report and confirm that the committee has operated effectively during 2025/26.

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	The annual report is to be circulated as part of Audit Committee papers, with onward reporting to the Trust Board. An extract of committee effectiveness is also included in the Trust's Annual Report.

Audit Committee Effectiveness Review 2025/26

1. Executive Summary

The Audit Committee has an overarching role in providing assurance to the Board on the Trust's overall governance, risk management and internal control arrangements. This includes arrangements for the preparation of Annual Accounts and Annual Report, the Annual Governance Statement and the Board Assurance Framework.

The Audit Committee consists of three independent Non-Executive Directors, at least one of whom (the Committee Chair) is a qualified accountant. In addition to the committee members, Executive Directors and senior staff are regularly invited to attend the Committee to answer questions and inform agenda content, and internal and external auditors are also present at meetings. Private meetings with both internal or external auditors are held as and when required, and at least once a year. During the year, there have been no changes in either internal or external audit providers, who are Mersey Internal Audit Agency (MIAA) and KPMG respectively.

The Audit Committee has met 5 times during the financial year 2025/26 including an extraordinary meeting to focus on the annual financial statements and report, with good attendance demonstrated by all members and regular attendees across the year.

The committee's work has continued to focus on a wide range of work relating to governance, risk management and internal control. Risks and issues have been escalated to the Board of Directors through the Chair's Alert, Assure, and Advise (AAA) Reports.

2. Committee Effectiveness

The effectiveness of the Committee has been reviewed through:

- Review of Terms of Reference (TOR) and workplan
- Desktop exercise to confirm alignment of agendas/ papers to TOR
- Completion of HfMA Audit Committee Handbook best practice checklists
- Workshop with Committee members to discuss findings

2.1 Delivery of Objectives

During the year, the Audit Committee undertook the full range of its responsibilities, including:

- Receiving assurance on the processes underpinning the Board Assurance Framework (BAF) and review of BAF 8 in respect of governance.
- Monitoring delivery of the Risk Management Improvement Plan and receiving updates on the Out-of-Date Policies Recovery Programme.
- Scrutiny of the Annual Governance Statement and triangulation with associated sources of assurance including provider licence and code of governance compliance.
- Received and considered Internal Audit Progress Reports at all meetings, along with assurance reports on key internal audit assignments.
- Monitored progress against internal audit recommendations through Audit Tracker and Follow-Up Reports.

- Received progress reports from Internal Audit and the draft Head of Internal Audit Opinion.
- Approved the Internal audit Plan for the forthcoming year, including a 3 year strategic plan.
- Scrutinised External Audit reports, including ISA 260, significant risk updates, VFM assessments and technical updates.
- Considered the Indicative External Audit Risk Briefing for the forthcoming audit cycle.
- Reviewed Standing Financial Instructions amendments, procurement waiver reports, accounting policies, and bad debt write-offs to ensure financial governance.
- Approved or noted key financial reporting items, including the Annual Report, Annual Accounts, and Letter of Representation.
- Oversaw counter-fraud arrangements, reviewing the Annual Report, progress updates, thematic NHS Counter Fraud Authority reports, and approving the Anti-Fraud Workplan.
- Received assurance from other Board Committees (Quality & Safety, People, Finance & Performance) through agendas and Chairs' reports.
- Considered a range of external insight and benchmarking reports from internal and external audit providers to strengthen system learning and governance assurance.
- Approved updates to the Committee Terms of Reference and reviewed wider governance structures, including the governance organogram.

The committee has alerted the Board to the following issue this year:

- Out-of-date Policies (July 2025): good update and progress is being made but still only providing limited assurance due to significant number of out-dated clinical policies. Noting that guidelines and SOPs will also need to be reviewed.

2.2 Membership and Attendance

The attendance from members is confirmed below.

Members	22/04/25	24/06/25 (Extraordinary)	15/07/25	07/10/25	03/02/26
Non-Executive Director, Mr M Guymer *(Chair to Oct 25)*	☑	☑	☑	☑	N/A
Non-Executive Director, Mr P Williams *(Chair from Feb 26)*	N/A	N/A	N/A	N/A	☑
Non-Executive Director, Mrs W Williams	☑	☑	☑	☑	☑
Non-Executive Director, Mr D Williamson *(member to Oct 25)*	☑	☑	☒	☑	N/A
Non-Executive Director, Mr P Jones *(member from Feb 26)*	N/A	N/A	N/A	N/A	☑

Regular attendees included the Director of Finance; Director of Governance & Risk; Internal Audit (MIAA); External Audit (KPMG) and Anti-Fraud Specialist (MIAA).

3. Actions

The actions from 2024/25 had been completed including embedding BAF reviews; TOR and workplan updates; improved anti-fraud reporting. A number of areas were discussed

at the workshop including duties aligned with other committees (e.g. digital and data; clinical audit), relationships with other committees, and system governance.

The actions from the Audit Committee effectiveness review are:

Action	Responsibility	Timeframe
1. To clarify the purpose of reporting regarding Freedom to Speak Up (and other processes to raise concerns) to the Audit Committee and other committees.	Director of Governance & Risk to discuss with Chief Operating Officer (Executive Lead)	July 2026
2. For external auditors, KPMG to share best practice as part of their updates (as agreed at the Private meeting)	KPMG	Across the Year
3. Future consideration of transformation and real time assurance given the critical focus on transformation for 2026/27.	Audit Committee Chair and Director of Governance & Risk	September 2026
4. To continue to review and develop the way the committee receives updates and works with other Assurance Committees.	Audit Committee members	Across the Year
5. MIAA external Quality Assessment (due 2026/27) to be added to workplan.	Head of Corporate Governance and MIAA	July 2026
6. To consider if the Quality Accounts should be included in TOR/ workplan.	Director of Governance & Risk to discuss with Director of Nursing (Executive Lead)	May 2026
7. The new Committee Chair was keen to build his knowledge including: • To meet with the Chief Digital and Data Officer to understand the approach to digital and data governance (through the Finance & Performance Committee). • To meet with the Director of Governance and Risk, and relevant leads to understand the Trust's risk management processes.	Audit Committee Chair	July 2026
8. Consider how system/ partnership governance assurance would be reviewed.	Audit Committee Chair and Director of Governance & Risk	Across the Year

4. Conclusion

The committee effectiveness review has confirmed the ongoing effectiveness of the Audit Committee. The actions identified above will be implemented and monitored.

5. Recommendation

e Board of Directors is asked to approve the report and confirm that the committee has operated effectively during 2025/26.

Appendix A – Summary Desktop review findings

TOR Duty	Items Received	Comments
Governance, Risk Management, and Internal Control The Committee shall assure itself that the Trust has established and maintains an effective integrated system of governance, risk management and internal controls, across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's Objectives.	• Draft annual governance statement • Annual report and accounts • HOIA opinion • Risk management improvement plan updates • BAF opinion • Provider licence compliance • Code of governance compliance • Conflict of interest policy • Out of date policy updates • Committee Organogram	-
Internal Audit The Committee shall ensure that there is an effective internal audit function that meets the public sector internal audit standards, and provides appropriate independent assurance to the committee, accountable/ accounting officer and board.	• Internal Audit Plan (incl. fees) • Internal Audit Progress Reports • Internal audit assignment reports (various) • Management updates/ presentations against MIAA assignment reports (moderate/ limited). • Internal Audit Charter • Internal Audit Annual Report confirms compliance with PSIAS	MIAA external Quality Assessment due 2026/27 to be added to workplan.
External Audit The Committee shall review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the external auditors and consider the implications and management's responses to their work.	• External audit plan • Significant Risk Update and VFM Risk Assessment • Letter of representation • ISA 260 • External Audit report	Policy for Engagement of External Auditors (not due – reviewed in Feb 25). External audit appt (not due – took place 24/25).
Other assurance functions The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation.	• Committee agendas and AAA reports • Committee annual reports (planned April 26) • SFI review and updates approved • BAF opinion (MIAA) • BAF 8 extract and update	Committee effectiveness proposal reviewed by NEDs outside of the committee meeting/
Counter Fraud The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption	• Anti Fraud progress reports • Anti Fraud plan • Assessment against government standards included within annual report	-
Management The Committee shall request and review reports, evidence and assurances from Directors and	• Attendance and reports	-

TOR Duty	Items Received	Comments
Managers on the overall arrangements for governance, risk management and internal control		
Financial Reporting The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance. The Committee should ensure that the systems for financial reporting to the board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.	• Draft Annual Governance Statement • Annual report and accounts • Review of Accounting policies • Review of significant issues • ISA 260 • Letter of representation	-
System for Raising Concerns The Committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently, and in line with the relevant policies.	• FTSU report on speak up processes	To confirm reporting purpose for Audit Committee and other committees (including wider processes for raising concerns)
Governance and regulatory compliance The Committee shall review the organisation's process and the reporting on compliance with the NHS Provider Licence, and NHS code of governance. The Committee shall satisfy itself that the organisation's policy, systems, and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective	• NHS Provider Licence Compliance • Code of Governance Compliance • Declarations of Interest Compliance Progress Summary • Conflict of interest policy approved • Review the Register of Interests • Draft Internal Audit Plan • Significant Risk Update and VFM Risk Assessment	-

To note the Audit Committee received the completed HFMA NHS audit committee handbook: Self-assessment checklists to support this assessment.

PUBLIC – Board of Directors
19th May 2026

Report	**Agenda Item 23c.**	**Annual Committee Effectiveness Review 2025/26: People Committee**						
Purpose of the Report	Decision	**X**	Ratification		Assurance	**X**	Information	
Accountable Executive	Karan Wheatcroft			Director of Governance and Risk				
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**	BAF impact – specifically BAF 4 and BAF 8.			
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	Workshop took place on 15th January 2026. People Committee – 10th February 2026 Audit Committee – 24th April 2026							
Executive summary	The Audit Committee has an overarching responsibility to review the adequacy and effectiveness of governance systems in the organisation; this includes reviewing and receiving assurance on the effectiveness of the Board Assurance Committees on at least an annual basis. It is recognised good practice for committees to assess their effectiveness annually. The approach to assessing effectiveness for 2025/26 included a desktop review of the committee agenda items against its Terms of Reference (ToR), attendance and observation, and a workshop with Committee members. Good progress has been made against the 2024/25 effectiveness actions. Reporting has improved, the workplan has been reset and aligned with the agenda, and new areas such as Employee Relations and workforce planning have been incorporated. Delegations to new sub-committees							

	have been reviewed, and further development of the workforce dashboard is strengthening the Committee's oversight and focus. The actions from the effectiveness review include: • Continue to improve quality of reporting • Review workplan and Terms of References for the sub-committees • Revisit the review of the People Committee workplan to ensure alignment with sub-committee and Board reporting requirements • Revise wording in Terms of Reference to better reflect the scope of responsibility and removal of duplications • Meeting effectiveness in respect of clarity of purpose of agenda items and allocation of time The committee effectiveness review has confirmed the ongoing effectiveness of the People Committee. The actions identified above will be implemented and monitored. The Annual Committee Effectiveness report will be reported to the Audit Committee in April 2026.
Recommendations	The Board of Directors is asked to **approve** the report and confirm that the committee has operated effectively during 2025/26.

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	The annual report is to be circulated as part of People Committee papers.

Committee Effectiveness Review 2025/26: People Committee

1. Executive Summary

The People Committee has met six times during the financial year 2025/26 with good attendance demonstrated by all members. The purpose of the committee is to approve, oversee and scrutinise implementation of the Trust's People Strategy and assure the Board on all aspects of workforce and organisational development.

The committee's work has continued to focus on improving the workforce plan, enhancing staff experience, engagement, morale and culture, developing the Equality, Diversity and Inclusion (EDI) action plan, reviewing the education and development needs of the Trust and piloting the Leadership and Management programmes. Risks and issues have been escalated to the Board of Directors through the Chair's Alert, Assure, Advise (AAA) Reports.

2. Committee Effectiveness

The effectiveness of the Committee has been reviewed through:

- Review of Terms of Reference (TOR) and workplan
- Desktop exercise to confirm alignment of agendas/ papers to TOR
- Wider considerations (insight, assurance, foresight and hindsight)
- Workshop to discuss findings

2.1 Delivery of Objectives

During the year, the People Committee undertook the full range of its responsibilities including:

- Receiving a bi-monthly update report from the Chief People Officer highlighting key areas
- Noting a bi-monthly staff story
- Receiving presentations in relation to various deep dive topics including Sickness and Staff Survey Results
- An overview of the people and organisation development related elements of the Trust Improvement Plan
- Update on progress against the People Strategy receiving the workforce dashboard, in place of the previously received Integrated Performance Report
- Noting Freedom to Speak Up activity
- Reviewing the Board Assurance Framework for the risks associated with the work of the Committee
- Annual review of the Terms of Reference of the Committee
- Reviewing and noting of the audit tracker, detailing all reviews undertaken by Mersey Internal Audit Agency (MIAA) relevant to the Committee

- Receiving regular reports relating to equality, diversity and inclusion including Workforce Race Equality Standard and Workforce Disability Equality Standard
- Reviewing and approval of policies, where required
- Other key items included People Strategy progress, receipt of the annual report from the Guardian of Safe Working Hours, Aggression & Violence Against Staff report and Medical Staffing updates.

The Committee has alerted the Board to the following risks and issues this year:

- The Committee received an update on the C&M Bank rate alignment work, noting the Trust's commitment to ensuring safety through impact assessments and proper governance.
- The Committee were briefed on the annual workforce plan and the challenge of aligning workforce reductions with financial recovery targets.
- Progress against the annual workforce plan showed a performance gap, and the Committee requested a clearer narrative with defined actions and trajectories.
- GMC survey results highlighted ongoing challenges in Emergency Medicine, improvements in several other specialties, and the need to monitor departmental action plans alongside the 10-point plan via the Education, Learning and OD Sub Committee.
- While the Committee approved WRES, WDES and gender pay gap submissions, it acknowledged that despite improvements, the Trust remains below national averages and significant work is required.
- The Committee received an update on visa sponsorship and requested a detailed paper outlining the numbers involved and the process followed.
- The sexual safety charter action plan is progressing toward completion by March 2026, with continued national focus and recent communication from NHS England to all CEOs on expectations.

2.2 Membership and Attendance

The attendance from members is confirmed below.

Members	08.04.2025	10.06.2025	12.08.2025	14.10.2025	09.12.2025	10.02.2025
Non-Executive Director, Ms W Williams (Chair)	☑	☑	☑	☑	☑	
Non-Executive Director, Mrs P Williams	☑	☑	☑	☑ via Microsoft Teams	N/A	
Non-Executive Director, Ms H Gunawickrema	N/A	N/A	N/A	N/A	☒	
Non-Executive Director, Prof A Hassell	☑	☑	☑	☑	☑	
Medical Director, Dr N Scawn	☒	☑	☑	☑	☑	
Chief People Officer, Ms V Wilson	☑	☑	☑	☑	☑	
Chief Operating Officer, Ms C Chadwick	☑	☒	☑	☒	☑ via Microsoft Teams	

In addition, there were attendees who joined to present certain items.

3. Actions

A number of areas were discussed at the workshop including reporting, and relationships with other committees. The actions from the People Committee effectiveness review are:

Action	Responsibility	Timeframe
1. Continue to improve quality of reporting: • Clarity on purpose of paper. • Executive summary to reflect key messages of the report. • Clarity on level of assurance provided. • Streamline detail of nursing and midwifery reports. Detail to be reviewed at workforce sub-committee with high level report to People Committee.	Executive Directors	Ongoing
2. Review workplan and Terms of References for the sub-committees: • Delegate review and ratification of policies to sub-committees	Chief People Officer/ Deputy Chief People Officers	April 2026
3. Review workplan to ensure alignment with sub-committee and Board reporting requirements: • REVIEW frequency of EDI reporting • AGREE format and frequency of reporting of Violence & Aggression • ALIGN timing for FTSU reporting to People Committee with Board reporting • ADD policy schedule to workplan • REVIEW how the Committee receives reports on workforce, employee relations, recruitment, retention and employee engagement (clarity on coverage of these areas)	Committee Secretary and Chief People Officer	June 2026
4. Revise wording in Terms of Reference to better reflect the scope of responsibility and removal of duplications: • ALIGN workplan frequency to TOR ‘quarterly’ FTSU • ADD delegation of policy review and ratification to sub-committee with People Committee to have oversight of policy schedule	Chief People Officer/ Head of Corporate Governance	April 2026

Action	Responsibility	Timeframe
• REMOVE duplication of EDI responsibility and combine into one which reflect public sector requirements. • CLARIFY which responsibilities the new workforce dashboard fulfils. • REVIEW TOR to reflect focus on workforce numbers, culture and appraisals.		
5. Meeting Effectiveness: • Clarity of key items on the agenda • Improve time management of the meeting	Chair/ Chief People Officer/ Committee Secretary	Across 2026/27

4. Conclusion

The committee effectiveness review has confirmed the ongoing effectiveness of the People committee. The actions identified above will be implemented and monitored.

5. Recommendation

The Board of Directors is asked to approve the report and confirm that the committee has operated effectively during 2025/26.

Appendix A – Summary Desktop review findings

Terms of Reference Duty	Evidence of Supporting Delivery
Role and Responsibilities:	
To approve, oversee and scrutinise the implementation of the Trust's People Strategy, sub strategies and Workforce Annual Plan and associate matters.	• Chief People Officer Update (every meeting) • People Strategy 2025-28 Update (April, June, October • NHS People Promise Exemplar Programme – Closure Report (April • People Committee Workplan (every meeting) • Workforce Annual Plan and progress updates (June, August, October, December • NHS People Promise Update (June, December) • People Promise & Staff Survey (including Wellbeing Annual Report
Receive reports relating to the creation and delivery of workforce plans aligned to Trust strategies to provide assurance that the Trust has adequate staff with the necessary skills and competencies to meet the current and future needs of patients and service users, linking with education and training governance processes, including Chair reports from relevant committees.	• Approval of reviewed Terms of Reference of subsidiary groups (April) • Education, Learning and Organisational Development Sub-Committee AAA Chair's Report/Minutes • People and Culture Sub-Committee AAA Chair's Report/Minutes • Workforce Sub-Committee AAA Chair's Report/Minutes • Review of Terms of Reference (June) • Joint Local Negotiating & Consultation Committee (JLNC) Chairs report/ Minutes • Audit Committee Annual Effectiveness Review (June) • People Committee Annual Effectiveness Review (June) • Partnership Forum Chair's Report • Competency work reporting through the Education, Learning and Organisational Development Sub Committee Update (October)
To provide assurance on improvements and compliance with key statutory and NHS specific workforce, equality, diversity, and inclusion requirements.	• Quarterly Report on Safe Working Hours (April • Equality, Diversity & Inclusion (ED&I) Update and integrated action plan (April • Equality, Diversity & Inclusion (ED&I) Update including 2025 Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap (GPG) Reports
Monitor internal workforce performance indicators, through regular reporting.	• Audit tracker update (April, August, December • Workforce Metrics Dashboard (April, June, August, October, December • Deep Dive – Sickness (June) • Apprenticeship & Levy Spend Report – Quarter 1 2025/26 (August) (subsequently incorporated into workforce dashboard)
To provide assurance to the Board on workforce matters, taking account of local and national agendas and provide a focus on workforce activity in relation to organisational design, development and education, employee relations,	• MIAA Insight Wellbeing Benchmarking (April • Trade Union Facility Time Reporting (June • Job Evaluation Update (October) • Workforce Annual Plan Updates • Job evaluation • People Promise (Staff Engagement) • Leadership & Management update

Terms of Reference Duty	Evidence of Supporting Delivery
recruitment and retention and employee engagement.	
To monitor and provide assurance to the Board regarding People related high risks identified within the Board Assurance Framework.	• Board Assurance Framework and High Risks Report (every meeting) • Board Assurance Framework – additions/amendments (every meeting)
To ratify new and existing People policies and procedures, ahead of publication, seeking approval of the Board as necessary, following development and review at appropriate sub-committees (e.g., Partnership Forum).	• People Services Policy update (April) ▪ Disciplinary Policy ▪ Medical Job Planning Policy ▪ Senior Medical Staff Annual Leave Policy ▪ Temporary Staffing Policy (April • People Services Policy Update (June ▪ Flexible Working Policy ▪ Hybrid And Agile Working policy ▪ Annual Leave Factsheet ▪ Bullying & Harassment Policy ▪ Disclosure and Barring Service (DBS) Policy ▪ Recruitment and Selection Policy ▪ Managers Guide to Honorary Contracts ▪ Retirement Policy • People Services Policies (October)
To receive assurance and monitor the implementation of Equality and Diversity Statutory delegations under the single Equality Duty (2011).	• Equality, Diversity and Inclusion (EDI) Annual Report 2024/2025 (April • Equality, Diversity & Inclusion (ED&I) Update and integrated action plan (April • Equality, Diversity & Inclusion (ED&I) Update including 2025 Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap (GPG) Reports
Review the annual staff survey report including narrative comments and thoroughly considering what it tells us about the culture of the organisation, monitor actions taken and advise the Board on developments arising as a consequence by exception.	• Staff Story (April, June, August, October) • Deep Dive – Staff Survey (April) • Staff Survey Report and Action Plan (June) • Culture & Leadership (August, October) • People Promise & Staff Survey (including Wellbeing Annual Report
Ensure that through the work of the Committee attention is paid at all times to the health, safety, and well-being of staff and that the Trust has in place appropriate plans for improving and monitoring the health, safety, and well-being of staff. The Committee will have a particular focus on monitoring violence and aggression towards staff and creating a safe working environment.	• Aggression & Violence against Staff Report (October) • Sexual Safety Charter Update (December) • People Promise & Staff Survey (including Wellbeing Annual Report)
Receive annual updates from the Guardian of Safe Working, and the Director of Medical Education in	• GOSW report (April 25) • Medical Workforce – June 2025 (August) • 2024-25 Annual Submission: Appraisal, Revalidation and Medical Governance (August)

Terms of Reference Duty	Evidence of Supporting Delivery
respect of the Medical Workforce and trainee Medical Workforce.	• Leng Review Update (October • Resident Dr 10 Point Plan (October) • GMC National Training Survey 2025 Report (October) • Annual NHS England (NHSE) Self-Assessment for Placement Providers (December)
Receive bi-annual updates on Nursing Safe Staffing and Midwifery and Safe Staffing.	• Nursing Safe Staffing Report (April, August) • Maternity and Neonatal - Bi-annual Safer Staffing Report – (April, October) • Bi-annual Safer Nurse Staffing Report – September 2025 (mid-year establishment review 1 January to 30 June 2025)
Receive quarterly updates from the Freedom to Speak Up Guardian to include summary of concerns raised from the previous quarter alongside key themes and learning and how this is being triangulated.	• Freedom to Speak Up Report (April, August)

PUBLIC – Board of Directors
19th May 2026

Report	**Agenda Item 23d.**	**Annual Committee Effectiveness Review 2025/26: Finance and Performance Committee**						
Purpose of the Report	Decision	**X**	Ratification		Assurance	**X**	Information	
Accountable Executive	Karan Wheatcroft			Director of Governance and Risk				
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**	BAF impact – Linked to all areas of the BAF but specifically the actions within BAF 8.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X** **X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Workshop held on the 12th February 2026. Reviewed by Committee members via email on 6th March 2026. Audit Committee – 24th April 2026 Finance & Performance Committee – 29thApril 2026							
Executive summary	The Audit Committee has an overarching responsibility to review the adequacy and effectiveness of governance systems in organisation; this includes reviewing and receiving assurance on the effectiveness of the Board Assurance Committees on at least an annual basis. It is recognised good practice for committees to assess their effectiveness annually. The approach to assessing effectiveness includes a desktop review of the committee agenda items against its Terms of Reference (ToR), attendance and observation, and a workshop with Committee members. The summary of actions from the workshop held on 12th February include; • Continue to review and improve quality of reports							

	• Develop reporting for Transformation, efficiency, productivity and CIP • Agenda management • Review sub-committee Terms or References, workplans and reporting. • Updates to the Committee Terms of Reference and workplan The committee effectiveness review has confirmed the ongoing effectiveness of the Finance and Performance committee. The actions identified above will be implemented and monitored.
Recommendations	The Board of Directors is asked to **approve** the report and confirm that the committee has operated effectively during 2025/26.

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	The annual report is to be circulated as part of Audit Committee papers.

Committee Effectiveness Review 2025/26: Finance and Performance Committee

1. Executive Summary

The Finance and Performance Committee will have met eleven times during the financial year 2025/26, with four of these meeting being interim committee update meetings and with good attendance demonstrated by all members. The purpose of the committee is to seek assurance that all appropriate action is taken to achieve financial and operational performance objectives and regularly review financial and operational strategies and performance, investments and capital plans.

The committee's work has continued to focus on addressing operational performance, including the backlog of patients on the waiting list and ED performance; delivering on the financial plan and capital programme within a challenging operating environment; and development and implementation digital and data strategies. Risks and issues have been escalated to the Board of Directors through the Chair's Alert, Assure, Advise (AAA) Reports.

2. Committee Effectiveness

The effectiveness of the Committee has been reviewed through:

- Review of Terms of Reference (TOR) and workplan
- Desktop exercise to confirm alignment of agendas/ papers to TOR
- Wider considerations (insight, assurance, foresight and hindsight)
- Workshop to discuss findings

2.1 Delivery of Objectives

During the year, the Finance and Performance Committee undertook the full range of its responsibilities including:

- Review of financial performance including cost improvement programme.
- Finance strategy updates
- Annual planning and delivery against plan updates.
- Tracking of progress against the financial improvement support action plan.
- Consideration of the national requirements for operational and financial planning, and the approach taken by the Trust.
- Reviewing performance against the operational targets as set out in the Strategic Oversight Framework.
- Receiving digital and data updates including the Electronic Patient Record (EPR) and cyber security, Senior Information Risk Officer (SIRO) Report and Digital and Data Strategy Updates.
- Review of the capital plan and progress including specific reports relating to the Women's & Children's (W&C) Building developments.

- Receiving Chair's reports from the Information Governance and Information Security Sub Committee, Digital Transformation Group, Electronic Patient Record Group, Health and Safety Committee and Capital Management Group.
- Reviewing the Board Assurance Framework for the risks associated with finance, capital, operational effectiveness, and digital and data.
- Receiving the Trust's submission for the Emergency Preparedness Response & Resilience (EPRR) Core Standards assurance.
- Receiving proposals for major capital expenditure business cases and estates developments and their funding sources.

The committee has alerted the board to the following risks and issues this year:

- Urgent Emergency Care (UEC) performance
- 2025/26 Annual Financial Plan and delivery against plan
- A number of risks and challenges remain in relation to the Health and Safety function.
- Residual risks pending work on the Emergency Preparedness Response & Resilience (EPRR) action plan.
- Non-receipt of Deficit Support Funding
- Under-delivery of Cost Improvement Programme
- Ongoing high levels of Non-Criteria to reside patients
- Ongoing work on Risk Management Improvement Plan
- Cash position
- Increased Emergency Department attendance and exploration of funding to support Winter Planning capacity
- Planning submission and Board Assurance Statements

2.2 Membership and Attendance

The attendance from members is confirmed below.

Members	30/04/25	20/05/25 Extra-ordinary	25/06/25	27/08/25	23/09/25	04/11/25	17/11/25	17/12/25	21/01/26	25/02/26	25/03/26
Non-Executive Director, Mrs P Williams (Committee Chair)	☑	☑	☑	☑	☑	N/A	N/A	N/A	N/A		
Non-Executive Director, Ms H Gunawickrema (Committee Chair)	N/A	N/A	N/A	N/A	N/A	☑	☑	☑	☑		
Non-Executive Director, Mr P Jones	☑	☑	☑	☑	☑	☑	☒	☑	☑		
Non-Executive Director, Mr D Williamson	☑	☑	☑	☑	☒	N/A	N/A	N/A	N/A		
Non-Executive Director, Ms S Corcoran	N/A	N/A	N/A	N/A	N/A	☒	☑	☑	☑		
Chief Finance Officer, Mrs K Edge	☑	☑	☑	☑	☑	☑	☑	☑	☒		
Chief Operating Officer, Ms C Chadwick	☑	☑	☑	☒	☒	☑	☑	☑	☑		
Chief Digital & Data Officer, Mr J Bradley	☑	☑	☑	☑	☑	☑	☒	☑	☑		

In addition, there were attendees who joined to present certain items.

3. Actions

A number of areas were discussed at the workshop including reporting, committee priorities and sub committees. Progress could be seen in respect of the actions agreed as part of the 2024/25 committee effectiveness review. The actions from the Finance and Performance Committee effectiveness review are set out below.

Action	Responsibility	Timeframe
1. Continue to **review reports** in context of what makes a good report and provide feedback on reports received. Particular focus on 2 page cover and 4 page content with supporting information in appendices	All Members	Across year
2. Look at **digital** and **operational performance reporting** with the lens of insight, assurance, foresight and hindsight.	Chief Digital and Data Officer; Chief Operating Officer.	April 2026
3. Transformation, efficiency, productivity and CIP • Develop **reporting** for new lens on **transformation and Cost Improvement Programmes (CIP)** covering each initiative, agreed savings, risk and risk/impact assessment, month on month proposed savings and any variance to plan. • To confirm **productivity information through IPR** and supporting narrative as well as transformation reporting	Director of Delivery	May 2026
4. **Agenda management** and more time allocated to areas of priority	Committee Chair	Across year
5. Increased focus on **productivity, benchmarking and oversight of innovation and transformation** programs.	Committee Chair	Across year
6. Sub committees: • TOR from sub committees to be shared with F&P to ensure fit for purpose. • Review workplan and papers to consider what can be taken to sub committees to reduce the volume of papers and overload to F&P. • Support sub committees in providing strong AAA.	Head of Corporate Governance and Leads	April 2026

Action	Responsibility	Timeframe
7. **External reviews** to be considered and how we build these into the committee reporting including GIRFT/ ECIST etc.	Executive Leads	April 2026
8. Workplan updates: • Confirm **Digital** items now incorporated into SIRO report and/or separate items. • **Commercial strategy** review and update timing to be confirmed. • **Add** Digital and Data Project oversight – Capital Investments and ROI review on a quarterly basis	Head of Corporate Governance with leads	March 2026
9. TOR to be updated: • AMEND Combine **efficiency and transformation** duties • ADD **AI** explicitly • AMEND combine the **digital and data strategy** duties • AMEND for **H&S** to remain as a duty (not interim arrangement) • REVIEW **EPRR** reporting frequency (regular or bi annual) • ADD new **Transformation Board** to Sub Committees • ADD new **Director of Transformation** to membership	Head of Corporate Governance	March 2026

4. Conclusion

The committee effectiveness review has confirmed the ongoing effectiveness of the Finance and Performance Committee. The actions identified above will be implemented and monitored.

5. Recommendation

The Board of Directors is asked to approve the report and confirm that the committee has operated effectively during 2025/26.

Appendix A – Summary Desktop review findings

Terms of Reference Responsibilities	Evidence of Delivery 2025/26	New Proposals for 2026/27
Financial		
To ensure the Trust develops and maintains an appropriate financial strategy in relation to both revenue and capital.	• Annual Planning Update (including the 5-year plan) (December)	
To review the Trust's annual financial plans and annual budgetary policy and proposals before submission to the Trust Board.	• 2025/26 Annual Plan (April • Finance position – (every meeting) • Corporate Cost Reduction (June) • Financial Plan Update (September, November) • Update on Annual Planning (November) • Annual Planning Update (including the 5-year plan) (December)	
To monitor and scrutinise performance on the delivery of the annual budget as appropriate, and report into the Trust Board via both the Finance & Performance Chair's report.	• 2025/26 Annual Plan (April) • Finance position – (every meeting) • Financial Plan Update (September, November) • Update on Annual Planning (November) • Annual Planning Update (including the 5-year plan) (December)	• Replace Financial Plan Update with a Monthly Cost Improvement Plan Update (summary one pager – cost reduction initiative, plan, actual achieved, variance to plan, action plan on adverse variances (including timelines to achieve plan). • Add Capital investment tracker (quarterly update) on all Trust's capital investments, agreed date, plan utilised, any over/under plan position, Exec owner and action to close potential delays/overspend. • Thirdparty/supplier tracker – quarterly tracker (one page)

Terms of Reference Responsibilities	Evidence of Delivery 2025/26	New Proposals for 2026/27
To consider proposals for major capital expenditure business cases and estates developments and their funding sources and to make recommendations to the Board as appropriate.	• Theatres Redevelopment Outline Business Case (OBC) • Geothermal Bid Update (November)	• Geothermal Bid updates to be received through capital investment updates each quarter. Additional update should be bought in as a deep dive in November.
To commission any necessary reviews of strategic finance, operational metric, and constitutional standard performance issues affecting the Trust, and to review the results before submission to the Board.	• 2025 National Cost Collection (NCC) Post-Submission Assurance Report (August)	
To review, as necessary, the efficiency of the financial and operational control processes that support the Trust's financial statements and the disposition of its funds and assets and refer any concerns to the Audit Committee.	• Strategic Oversight Framework Report (April) • Integrated Performance Report (IPR) (June, August, November, December) • Corporate Cost Reduction (June) • Cash preservation in Q3 (November)	• Clarify relationship between Corporate Cost Reduction and CIP.
To receive regular reports on the Trust's cash position.	• Finance position – (every meeting) • Cash preservation in Q3 (November)	
To review and recommend the Trust's capital programme.	Finance position – (every meeting)	
Receive assurance of delivery against Capital Programme from Capital Management Group	• Finance position – (every meeting) • Women & Children's (W&C) New Building Project Chair's Report • Capital Management Group Chair's Report	
Operational		
To review the Trust's annual operational plan and support proposals before submission to the Trust Board.	• 2025/26 Annual Plan (April) • Update on Annual Planning (November) • Annual Planning Update (including the 5-year plan) (December)	•
To monitor all efficiency programmes, including obtaining assurance that no	• Radiology Services Oversight Report (April, August	• Every capital, CIP or any other

Terms of Reference Responsibilities	Evidence of Delivery 2025/26	New Proposals for 2026/27
efficiency programme has an unforeseen detrimental impact on quality of care (linked to the work delivered through the Quality & Safety Committee) or on the performance of the Trust especially in respect of constitutional and key operational metrics; and to make recommendations as necessary to the Board about action required in-year.	• Operations & Performance Executive Led Group (OPELG) Chair's Report • Winter planning (November)	operational decision should be assessed under a clear framework of impact on quality of care. This should be part of the updates of CIP, Digital and any other corporate investments or divestments.
To commission any necessary reviews of strategic finance, operational metric, and constitutional standard performance issues affecting the Trust, and to review the results before submission to the Board.	• PricewaterhouseCoopers (PwC) Action Plan Update (June)	• We should invite PWC/or any other relevant ICB representative to join us for June update – Special invitee only for this agenda item.
To receive reports on Health & Safety to gain assurance of compliance and completion of action plans. To note, this will be on an interim basis pending establishment of alternative governance arrangements.	• Health & Safety Update (April • Health & Safety Committee Chair's Report • Annual Health & Safety Report 2024/25 (June) • Health & Safety Six monthly Update (December)	• Health and Safety Update should become a standing item on each F&P agenda.
To receive the Trust's submission for the Emergency Preparedness Response & Resilience (EPRR) Core Assurance Standards annually, with regular update reports to be provided throughout the financial year.	• Emergency Preparedness Response & Resilience (EPRR) Core Standards Compliance (April) • Emergency Preparedness Response & Resilience (EPRR) Core Standards Annual Report (November)	•
To monitor and scrutinise performance and productivity on the delivery of the Trust's objectives; national, regional and locally set targets.	• MIAA – NHS Medical Equipment Governance Benchmarking • MIAA – 2024/25 Audit Committee Insight – Technology and Data Analytics Risk Update	•

Terms of Reference Responsibilities	Evidence of Delivery 2025/26	New Proposals for 2026/27
	• Benchmarking Framework Update (August)	
Digital & Data		
To ensure the Trust develops and maintains an appropriate digital and data strategy	• Digital and Data Strategic Programme Update (April, June, August, November • Digital and Data Strategy Update (June, December) • Digital & Data Annual Report (November)	•
To review, as necessary and receive assurance over the data quality systems and processes that support the Trust's operational performance reporting.	• Digital Transformation Group Chair's Report • Electronic Patient Record (EPR) Chair's Report • Digital Clinical Systems Programme Board (formerly EPR) Chair's Report.	•
To receive assurance relating to information governance and cyber security including the annual Data Security and Protection Toolkit submission.	• Data Governance Update (April • Senior Information Risk Owner (SIRO) Update (April, June, November, December • Information Governance & Information Security Committee Chairs Report • Information Governance Annual Report 2025 (December)	•
To review the Digital and Data Strategy and recommend it to the Board, and to monitor progress against and risks associated with the strategy and monitor other digital and data related plans.	• Digital and Data Strategy Update (June, December)	• Add a Digital and Data Strategy Deep dive to the workplan • Add a Digital Head update as a standing item on each agenda. • Add a digital investment and progress tracker (capital investment summary) as a standing agenda item.
Procurement		
To receive and scrutinise, as appropriate, reports on 'commercial' activities of the Trust and to make	• Commercial Procurement Income Group Chair's Report • Commercial Procurement Year End Report FY 2024/25 (June)	•

Terms of Reference Responsibilities	Evidence of Delivery 2025/26	New Proposals for 2026/27
recommendations to the Board as appropriate.		
To review the Trust's procurement strategy and to make recommendations to the Board.	• Trust Procurement Year End Report FY 2024/25 (June)	•
To consider any significant variations to the Trust's existing procurement methodology as set out in the Trust's Standing Orders and Standing Financial Instructions.	• Quarterly Waiver Report	•
To receive and review quarterly summary Waiver reports for tenders and quotations.	• Quarterly Waiver Report	•
Estates		
To consider proposals for major capital expenditure business cases and estates developments and their funding sources and to make recommendations to the Board as appropriate.	• Geothermal Bid Update (November) • Theatres Redevelopment Outline Business Case (OBC)	•
To oversee the development of and review the Estates Strategy annually and to monitor progress against this, throughout the financial year, which should also include the monitoring of other estates related improvement plans.	• Estates Strategy Update (April) • Estates & Facilities Divisional Group Chair's Report • Estates & Facilities High Risk Update • RIDDOR Reporting and Datix Update • Estates & Facilities General Update	•
Sustainability		
To monitor progress with the Trust's Green Plan and Sustainability Strategy.	• Anchor Institution Steering Group Chair's Report • Countess of Chester Green Plan 2025-2028 (August)	•
Commercial strategy and policy		
To review the Trust's commercial strategy and to make recommendations to the Board	*(Planned review in 2026/27 as per action plan)*	
To consider any significant variations to the Trust's	• Commercial Procurement Income Group Chair's Report	•

Terms of Reference Responsibilities	Evidence of Delivery 2025/26	New Proposals for 2026/27
existing commercial strategy or policy.		
Receive assurance of delivery of commercial strategy from the Commercial Procurement Income Group.	• Commercial Procurement Income Group Chair's Report	•
Cross Topic Duties		
To receive reports on changes in statutory and regulatory requirements that fall under the remit of the duties of the Committee.	*(Not received in 2025/26)*	
To receive assurances relating to Efficiency and Transformation programmes.	• Finance position – (every meeting) • Corporate Cost Reduction (June)	•
Where appropriate, to make recommendations to the Board on necessary actions or approvals.	*(As required)*	
Where necessary, to commission in-depth reviews and deep dives for areas of high risk.	*(External reviews to be considered for reporting in 2026/27 as per action plan)*	
Organisational controls		
In support of the Audit Committee, the Committee will report to the Audit Committee any identified risks to the adequacy and effectiveness of the Trust's financial and operational performance reporting frameworks. The Committee will also monitor and provide assurance to the Board regarding specific risks identified within the Board Assurance Framework.	• Board Assurance Framework (BAF) and High Risks Report (every meeting except interim meetings) • Risk Management Improvement Plan (April • Estates & Facilities High Risk Update • Audit Tracker update (April, August,December)	•
To examine any other matter referred to the Committee by the Trust Board.	• Thirlwall Inquiry - Financial Spend Elements Update (June, November, January)	•
To review draft Trust policies pertaining to the Committee's function prior to their being considered by the Board	*(None received – confirm delegation to sub-committees)*	

Terms of Reference Responsibilities	Evidence of Delivery 2025/26	New Proposals for 2026/27
To review, as necessary, the efficiency of the financial and operational control processes that support the Trust's financial statements and the disposition of its funds and assets and refer any concerns to the Audit Committee.	• Strategic Oversight Framework Report (April) • Integrated Performance Report (IPR) (June, August, November, December) • Corporate Cost Reduction (June) • Cash preservation in Q3 (November)	•
To receive regular reports on the Trust's cash position.	• Finance position – (every meeting) • Cash preservation in Q3 (November)	•
To review and recommend the Trust's capital programme.	• Finance position – (every meeting)	•
Receive assurance of delivery against Capital Programme from Capital Management Group	• Finance position – (every meeting) • Women & Children's (W&C) New Building Project Chair's Report • Capital Management Group Chair's Report	•

The committee also:

Approved reviewed Terms of Reference of the following Subsidiary Groups:

- Estates & Facilities Divisional Board
- Digital Transformation Group
- Digital Clinical Systems Programme Board (formerly EPR)
- Commercial Procurement Income Group
- Information Governance and Cyber Security (IG&CS) Committee
- Electronic Patient record (EPR) Programme Board
- Capital Management Group

PUBLIC – Board of Directors
19th May 2026

Report	**Agenda Item 24.**	**Use of Trust Seal: St Johns Ambulance and Countess of Chester Hospital NHS Foundation Trust**						
Purpose of the Report	Decision	**X**	Ratification		Assurance		Information	
Accountable Executive	Karan Wheatcroft			Director of Governance and Risk				
Author(s)	Nusaiba Cleuvenot			Head of Corporate Governance				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			**X**	Aligned to Constitution requirements for application of the Trust Seal.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X**
CQC Domains	Safe Effective Caring Responsive Well led							**X**
Previous considerations	Not applicable.							
Executive summary	To notify the Board of Directors of the use of the Trust Seal and request approval in retrospect as per the Trust Constitution requirements.							
Recommendations	The Board of Directors is asked to **approve** the use of Trust Seal in retrospect.							

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

Use of Trust Seal

1. Executive Summary

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

2. Background

As per the Constitution, the use of the Trust Seal must be approved by the Director of Finance or nominated officer and authorised in writing the Chief Executive Officer (CEO) or nominated officer. The Board will receive a report of all sealings for approval.

3. Use of Trust Seal

Date Seal Applied	Document	Signatories
27/03/2026	St Johns Ambulance and Countess of Chester Hospital NHS Foundation Trust • Underlease • Agreement to Lease • Deed of Variation • Licence for alterations (between COCH &SJA) •	Karen Edge, Director of Finance; and Nigel Scawn, Medical Director

4. Recommendation

The Board is asked to **approve** the application of the Trust Seal in retrospect.