

**Public meeting of the Board of Directors Agenda
(published items)**

Tuesday 29th September 2026, 09.00 – 12.00
Women & Children's Building Seminar Room

Chair	Mr N Large, Trust Chair
Apologies	Ms C Chadwick, Chief Operating Officer and Mr J Bradley, Chief Digital & Data Officer
In attendance	Ms S Brown, Deputy Chief Operating Officer (on Ms C Chadwick behalf), Mr D Reilly, Director of Digital (on Mr J Bradley behalf), Ms J Cooper, Associate Director of Nursing (Safeguarding and Complex Care) (Item 3.) and Ms N Macdonald, Director of Midwifery (Item 13.)

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
		Thirlwall Inquiry Report (verbal)	Chief Executive Officer		For noting
09.05	2.	Declarations of Conflicts of Interest with agenda items (verbal)	Trust Chair		For noting
09.08	3.	Service Showcase – Safeguarding Annual Report (attached) 4 - 47			
09.30	4.	Patient Story (to be presented on the day)			
09.40	5.	Minutes of the previous meeting held on 21 st July 2026 (attached)	Trust Chair	48 - 75	For approval
09.45	6.	To consider any matters arising and action and decision log (attached)	Trust Chair	76 - 81	For noting
09.50	7.	Chief Executive Officer's Report (attached)	Chief Executive Officer	82 - 86	For noting
10.00	8.	Trust Chair's Update (verbal)	Trust Chair		For noting
10.08	9.	a) Board Assurance Framework (attached)	Director of Governance and Risk	87 - 99	For noting
		b) Significant Risks Report (September 2026) (attached)	Director of Governance and Risk	100 - 109	For noting
Quality of Care					
10.10	10.	Care Quality Commission (CQC) Report and Action Plan (Medical Care, Urgent & Emergency Care, and End of Life services) (attached)	Director of Nursing & Quality	110 - 120	For assurance & decision
10.20	11.	Inpatient Survey Results (2025 Survey) (attached)	Director of Nursing & Quality	121 - 128	For noting

10.30	12.	Quality & Safety Committee Chair's Report – 3 rd September 2026 (attached)	Chair Quality & Safety Committee	129 - 131	For assurance
10.35	13.	Perinatal Services Quarterly Update – Quarter 1 2026/27 (attached)	Director of Midwifery	132 - 142	For assurance
Operational Performance					
10.40	14.	Integrated Performance Report (IPR) (to follow) Operational Performance Quality Safety People Finance	Deputy Chief Operating Officer Director of Nursing & Quality Medical Director Chief People Officer Chief Finance Officer		For assurance
Comfort Break 11.00 – 11.10					
11.10	15.	Winter Planning 2026/27: Board Assurance Template (attached)	Deputy Chief Operating Officer	143 - 151	For decision
11.20	16.	Operational Management Board a) Operational Management Board Chair's Report – 23 rd July 2026 (attached) b) Terms of Reference Update – Operational Management Board (OMB) (attached)	Chief Executive Officer Chief Executive Officer	152 - 154 155 - 161	For assurance For ratification
Finance, Use of Resource and Performance					
11.30	17.	Finance & Performance Committee Chair's Report – 20 th August 2026 (attached) and 22 nd September 2026 (verbal)	Finance & Performance Committee Chair	162 - 163	For assurance
Leadership, Improvement Capability, Organisation Development and People					
11.35	18.	People Committee Chair's Report – 11 th August 2026 (attached)	People Committee Chair	164 - 166	For assurance
11.40	19.	2025-6 Annual Submission: Appraisal, Revalidation and Medical Governance (attached)	Medical Director	167 - 188	For decision

Items for noting					
11.48	20.*	Items for noting and receipt (attached): <u>Sent under separate cover:</u> Minutes of Committee Meetings: a) Approved minutes of the Quality & Safety Committee – 2nd July 2026. b) Approved minutes of the People Committee – 9th June 2026. c) Approved minutes of the Finance & Performance Committee – 24th June 2026 and 20th August 2026. d) Approved minutes from the Operational Management Board – 28th May 2026. e) Research & Innovation Committee Chair's Report 7th September 2026 and 16th July 2026 Minutes (attached) Other items: f) Board of Directors Workplan 2026/27.	Trust Chair		For noting
Other items					
11.50	21.	Any Other Business (verbal)	Trust Chair		For noting
11.55	22.	Questions from Governors and members of the Public relating to items on the meeting agenda - <i>Questions to be submitted in writing in advance of the meeting to:</i> <u>coch.membershipenquiriescoch@nhs.net</u> <i>by Thursday 24th September 2026</i> Future Dates: 24th November 2026 26th January 2027 16th March 2027	Trust Chair		For noting
12.00	23.	Closing remarks (verbal)	Trust Chair		For noting

Next Meeting: Tuesday 24th November 2026 at 9.00, Women & Children's Building Seminar Room

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

PUBLIC – Board of Directors
29th September 2026

Report	Agenda Item 3.	Service Showcase - Safeguarding and Complex Care Annual Report						
Purpose of the Report	Decision		Ratification		Assurance	X	Information	
Accountable Executive	Sue Pemberton			Director of Nursing & Quality / Deputy Chief Executive				
Author(s)	Jill Cooper			Associate Director of Nursing (Safeguarding and Complex Care)				
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 BAF 11 Transformation			X X X	Failure to maintain effective safeguarding arrangements poses a significant risk to the Trust. Without robust systems, the organisation could fall short of its statutory and regulatory duties, potentially compromising patient safety and public confidence. This report provides assurance that the Trust is actively mitigating these risks through strong leadership, continuous improvement, and system-wide collaboration.			
Strategic goals	Patient and Family Experience							X
	People and Culture							
	Purposeful Leadership							
	Adding Value							X
	Partnerships							
CQC Domains	Population Health							
CQC Domains	Safe							X
	Effective							
	Caring							
	Responsive							
CQC Domains	Well led							X
Previous considerations	Not applicable.							
Executive summary	The 2025/26 Safeguarding and Complex Care Annual Report provides assurance that the Countess of Chester Hospital NHS Foundation Trust continues to meet its statutory safeguarding responsibilities and maintain robust governance arrangements across safeguarding children, safeguarding adults, maternity safeguarding, domestic abuse and complex care. The report demonstrates continued compliance with national legislation, statutory guidance and safeguarding competency frameworks, supported by strong executive leadership, effective partnership working and well-established governance structures. During 2025/26, safeguarding and complex care activity increased significantly across all areas of the service, reflecting both the increasing complexity of patient need and improved recognition of safeguarding concerns by staff. The Trust has continued to strengthen safeguarding							

practice through targeted training, policy development, enhanced supervision, improved business intelligence and a continued focus on person-centred care. Safeguarding training compliance remained above the agreed 90% threshold across all safeguarding disciplines, providing assurance regarding workforce capability and statutory compliance.

The Trust has further strengthened its response to patients with complex needs through improvements in Mental Capacity Act and Deprivation of Liberty Safeguards practice, reasonable adjustments, domestic abuse support, learning disability and autism services, dementia care and mental health governance. The report also evidences strong multi-agency engagement, active participation in safeguarding reviews and continued contribution to strategic safeguarding partnerships.

The report concludes that the Trust continues to provide safe, effective and legally compliant safeguarding and complex care services, whilst identifying clear priorities for 2026/27 to support continued improvement and assurance

Safeguarding children activity increased significantly, with 2,123 safeguarding referrals received during 2025/26, representing the highest level of activity recorded and reflecting improved recognition and escalation of safeguarding concerns across the organisation.

Adult safeguarding referrals increased to 1,468 referrals, demonstrating sustained staff awareness and a strong safeguarding culture, with particular increases in domestic abuse, self-neglect and complex safeguarding presentations.

The Trust maintained safeguarding training compliance above the agreed 90% target across all safeguarding disciplines, including safeguarding adults, safeguarding children, Prevent and Oliver McGowan Mandatory Training.

The biennial NHS Safeguarding Commissioning Standards self-assessment was completed across 64 domains, demonstrating a strong level of compliance with only three areas identified for further development.

The Paediatric Liaison Nurse role has become fully embedded, strengthening safeguarding oversight within the Emergency Department and improving multi-agency communication and information sharing.

Maternity safeguarding activity increased, with implementation of the Pan-Cheshire Pre-Birth Assessment Framework, continuation of the Hope Box initiative and development of a revised Female Genital Mutilation pathway.

Domestic abuse services were strengthened through the introduction of routine screening in Emergency Department triage, ongoing delivery of the Trust IDVA service and active participation within MARAC arrangements supporting individuals and families affected by abuse.

Complex Care activity continued to rise, with 596 referrals received. Key achievements included completion of the NHS Learning Disability Improvement Standards self-assessment, implementation of electronic DoLS processes, expansion of reasonable adjustment arrangements and continued rollout of Oliver McGowan Mandatory Training.

Mental Capacity Act activity increased substantially, with 3,889 mental capacity assessments completed and 1,277 urgent Deprivation of Liberty

	Safeguards applications submitted, reflecting growing complexity within the patient population and improved legal compliance. The Trust remained an active partner within the safeguarding system, contributing to Safeguarding Adult Reviews, Child Safeguarding Practice Reviews and Domestic Abuse Related Death Reviews, ensuring learning is identified and embedded into practice. Internal safeguarding governance continued to mature, with 90 internal strategy meetings undertaken during the year, providing increased scrutiny, oversight and organisational learning in relation to safeguarding concerns and allegations management. Clear priorities have been established for 2026/27, including strengthening MCA and DoLS governance, improving safeguarding practice within the Emergency Department, enhancing adult safeguarding threshold application, implementing a new FGM pathway and strengthening safeguarding education and workforce development
Recommendations	The Board of Directors is requested to: • Note the assurance provided within the 2025/26 Safeguarding and Complex Care Annual Report. • Note the significant increase in safeguarding and complex care activity across the Trust. • Note the continued compliance with statutory safeguarding responsibilities, training requirements and governance arrangements. • Support the identified priorities for 2026/27, including strengthening MCA and DoLS governance, safeguarding practice within the Emergency Department, adult safeguarding threshold application, maternity safe sleep assessment, FGM pathway implementation and continued development of learning opportunities for all staff.

Corporate Impact Assessment	
Statutory/regulatory requirements	This report provides assurance that the Trust continues to meet its statutory safeguarding responsibilities, in line with regulatory and professional standards. It specifically supports compliance with the NHS Safeguarding Assurance Framework and commissioning standards, reinforcing the Trust's commitment to safe, high-quality care.
Risk	Failure to maintain effective safeguarding arrangements poses a significant risk to the Trust. Without robust systems, the organisation could fall short of its statutory and regulatory duties, potentially compromising patient safety and public confidence. This report provides assurance that the Trust is actively mitigating these risks through strong leadership, continuous improvement, and system-wide collaboration.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Public Board papers

Safeguarding & Complex Care

Annual Report

2025/26

Jill Cooper – Associate Director Safeguarding & Complex Care

Supported by Kerry Conway- Named Professional for Safeguarding Adults/ MCA

Laura Ates- Named Nurse Safeguarding Children

Table of Content	Page
1. Introduction	1
2. Summary	1
3. Safeguarding Leadership and Organisational Accountability	2
4. NHS Safeguarding Commissioning Standards	3
5. Safeguarding Policies	3
6. Incidents	4
7. Audits	4
8. Safeguarding Activity	5
• Safeguarding Children Activity	5
• Maternity Safeguarding Activity	14
• Safeguarding the Vulnerable Adult Activity	18
• Complex Care Activity	26
9. Training	35
10. Multiagency Reviews	37
11. Allegation Management	37
12. Partnership Working	38
13. Conclusion	39
14. References	39
15. Appendix	41
• Appendix 1 Safeguarding and Complex Care Governance Structure	41
• Appendix 2 Terms of Reference for Safeguarding Assurance Committee	42
• Appendix 3 Safeguarding & Complex Care Priorities Implementation	45
Action Plan 26/27	

1. Introduction

This Safeguarding and Complex Care Annual Report aims to assure the Board that the Countess of Chester NHS Foundation Trust (the Trust) has established the necessary frameworks and taken appropriate actions to meet its statutory responsibilities. These responsibilities are outlined under Regulation 13 of the Health and Social Care Act 2008, the Care Act 2014, the Children's Acts of 1989 and 2004, the statutory guidance "Working Together to Safeguard Children" (2026), and the Intercollegiate Document for Roles and Competencies for Health Care Staff (2024. 2025), particularly regarding safeguarding training compliance.

The report provides an overview of the Trust's activities, compliance, and learning in the safeguarding and complex care domains from 1st April 2025 to 31st March 2026, demonstrating how the Trust has fulfilled its statutory and regulatory obligations

2. Summary

The Trust is dedicated to fulfilling its safeguarding responsibilities and fosters a robust organisational commitment to maintaining high standards in safeguarding and complex care practices. The workforce is well-versed in the significance of their roles in ensuring the safety and protection of children, young people, and adults at risk of harm who access the Trust's services.

Throughout 2025/26, the Trust has consistently enhanced and reinforced its safeguarding and complex care arrangements to ensure they remain effective and comply with both local and national standards.

3. Leadership and Organisational Accountability

The Director of Nursing and Quality serves as the executive lead for safeguarding and complex care, providing leadership across the organisation to ensure these agendas remain a priority for the board. Supporting the Director of Nursing are the Deputy Director of Nursing and Quality and the Associate Director of Nursing (Safeguarding and Complex Care), who assist both strategically and operationally. They actively participate in safeguarding partnership arrangements, including the Safeguarding Children Partnership (SCPs), Local Safeguarding Adult Board (LSAB), Domestic Abuse Board, and Learning Disability Board across Cheshire West and Chester. The Associate Director of Nursing and the Named Lead Professionals also engage in various subgroups of these boards.

Statutory named professionals ensure that the Trust's policies, processes, and safeguarding arrangements align with local and national guidance and legislation. They provide operational leadership to the team, which includes:

- Named Nurse for Safeguarding Children
- Named Doctor for Safeguarding Children
- Named Midwife for Safeguarding and Trust Domestic Abuse Lead
- Lead Professional for Safeguarding Adults / MCA lead

The Safeguarding and Complex Care Team comprises specialist nurses who, despite their expertise, strive to develop a core skill set across the safeguarding and complex care agenda to maintain service resilience and operability. The team also includes a full-time Independent Domestic Abuse Advocate (IDVA).

The Trust's safeguarding and complex care governance structure is detailed in Appendix 1. The Safeguarding Assurance Committee, chaired by the Director of Nursing and Quality, ensures that safeguarding and complex care responsibilities are met in line with the terms of reference (Appendix 2). This committee provides quarterly reports to the Quality Governance Group and the Quality and Safety Committee, a subcommittee of the Board.

In 2025/26, the Safeguarding Assurance Committee met quarterly, with attendance from all clinical divisions and partnership agencies, including the Integrated Care Board (Cheshire West Place),

Cheshire West Adult Social Care, Cheshire West Children's Social Care, and Betsi Cadwaladr University Health Board.

Several working groups within the safeguarding and complex care agenda focus on delivering identified priorities and providing challenge and assurance to the wider teams. Key functions include monitoring training compliance, benchmarking, and internal/external standards.

The Trust continues to assure the Cheshire and Merseyside Integrated Care Board (ICB) through the Safeguarding Assurance Framework (SAF), which includes quarterly data submissions on training, activity, audit, performance, and supervision. Additionally, the Trust submitted the biennial Safeguarding Commissioning Standards Self-Assessment for both adult and children's safeguarding in 2025/26, with an action plan monitored via the safeguarding governance framework.

NHS Safeguarding Commissioning Standards

In 2025/26, the Trust undertook a biennial self-assessment audit against the NHS Commissioning Standards to evaluate its compliance with legislation and statutory guidance related to safeguarding children, young people, adults at risk, and Children in Care. This audit supports the Trust's duty to provide assurance to the Integrated Care Board (ICB). The assessment covered 64 domains, and the Trust demonstrated a strong position overall, with only partial exceptions of noncompliance in 3 areas.

Following the audit, an action plan was developed to address these outstanding areas and monitor progress. This plan is reviewed quarterly by the Trust's Safeguarding Assurance Committee, reflecting the Trust's commitment to maintaining high safeguarding standards and continuous improvement

Safeguarding Policies

The Trust maintains a comprehensive suite of safeguarding and complex care policies, which are regularly updated to reflect changes in practice, departments, and legal requirements. These policies are accessible to staff via SharePoint. The Safeguarding and Complex Care Team also oversees several other Trust policies to ensure compliance with safeguarding standards.

Key policies include:

- Safeguarding Children and Children in Care
- Safeguarding Adults at Risk Policy
- Prevent
- Domestic Abuse
- Female Genital Mutilation (FGM) Pathway
- Modern Slavery / Human Trafficking Statement
- Mental Capacity Act and Deprivation of Liberty Safeguards
- VIP and Celebrities Policy
- Safer Recruitment
- Freedom to Speak Up Policy
- Physical Intervention and Restraint Policy
- Enhanced Therapeutic Observations of Care Policy
- Discharge Policy

- Chaperone Policy
- Accessible Information Standards Policy

In addition, during 2025/26 the Safeguarding and Complex Care Team has been significantly influential in shaping and improving Trust-wide practice, particularly through its contribution to the Violence and Aggression Policy and practice framework, and the Enhanced Therapeutic Observation Policy. This work has strengthened the Trust's ability to respond more effectively to patients with complex needs, supporting safer, more person-centred care.

Incidents

The Associate Director of Nursing for Safeguarding and Complex Care takes part in the daily Senior Quality, Safety, and Site Position Meeting, where significant incidents are reviewed. The team also attends the twice weekly Trust Safety Huddle to provide updates on safeguarding and complex care activity and to respond to any concerns raised by other departments. Safeguarding and complex care incidents are managed through the DATIX system, with close collaboration between the team and Heads of Nursing to address any serious issues. The team is also actively involved in the Patient Safety Incident Response Framework (PSIRF) and participated in After Action Reviews during 2025/26 where safeguarding or complex care featured in the incident.

4. Audits

Throughout 2025/26, the Safeguarding and Complex Care Team actively engaged in a wide range of audits, both internally and in collaboration with external partners. This includes participation in multiagency audits with the Safeguarding Children Partnership and Local Safeguarding Adult Board, ensuring a joined-up approach to safeguarding across the system.

Key learnings from these audits have been disseminated through Trust-wide communication bulletins, supporting continuous improvement and shared understanding. Audits span the full safeguarding and complex care agenda, with findings used to inform practice development and meet the data requirements of strategic partners.

Overview of Safeguarding and Complex Care Audits

Corporate Audits	Audits completed included safeguarding training compliance, NHS Safeguarding Commissioning Standards self-assessment, LeDeR reporting and learning, National Audit of Dementia, safeguarding assurance framework submissions, and Trust-wide review of safeguarding and complex care risks.
Safeguarding Adults	Audits completed included adult safeguarding referrals, Section 42 referral thresholds, Making Safeguarding Personal, pressure ulcer safeguarding decision-making, self-neglect cases, safeguarding incidents, Adult Social Care information requests, and learning from Safeguarding Adult Reviews.
Complex Care	Audits completed included Mental Capacity Act assessments, best interest decision-making, DoLS applications, Mental Health Act documentation, learning disability and autism flags, dementia care, and LeDeR referrals.

Maternity Safeguarding	Audits completed included routine domestic abuse enquiry, DASH/RIC completion, ICON messaging, Safe Sleep advice, safeguarding supervision, pre-birth planning, unborn baby referrals, and multi-agency strategy meeting activity.
Domestic Abuse	Audits completed included routine enquiry, DASH/RIC completion, IDVA referrals, MARAC activity, high-risk domestic abuse cases and staff disclosures.
Safeguarding Children	Audits completed included safeguarding children's referrals, Children's Social Care referrals, CP-IS alerts, children in care processes, children nursed on adult wards, child protection medicals, child exploitation activity, children attending ED with mental health or substance misuse concerns, perplexing presentations, and multi-agency safeguarding audits.

5. Safeguarding Activity

Safeguarding the Unborn, Children and Young People

Key Achievements in 25/26

- Mobilised and embedded the Paediatric Liaison Nurse role, strengthening oversight of ED attendances and improving identification of safeguarding concerns.
- Strengthened partnership working with CWP, improving coordination across mental health, children in care, and complex discharge pathways.
- Delivered the Children in Care Action Plan and Pledge, aligning with ICB standards and improving access and outcomes for vulnerable children.
- Increased use and reliability of CP-IS, improving identification of children with safeguarding plans or looked after status.
- Strengthened governance through DATIX reporting, thematic review and targeted audit following missed referrals.
- Delivered targeted safeguarding training on neglect, risk outside the home, long-term conditions and perplexing presentations, improving staff confidence and professional curiosity.
- Enhanced safeguarding supervision, including regular peer review and support for complex cases.
- Maintained strong multi-agency engagement, contributing to Safeguarding Children Partnership priorities including exploitation, online harm and neglect.
- Improved recognition of risk from adult presentations, particularly parental mental health and substance misuse.
- Sustained high levels of safeguarding activity, reflecting a positive culture of escalation and vigilance across the Trust.
- Strengthened response to emerging risks, including rising mental health presentations and ketamine misuse, supported by improved data and partnership working.
- Standardised referral processes through briefings and communications, reducing missed opportunities and improving staff compliance.

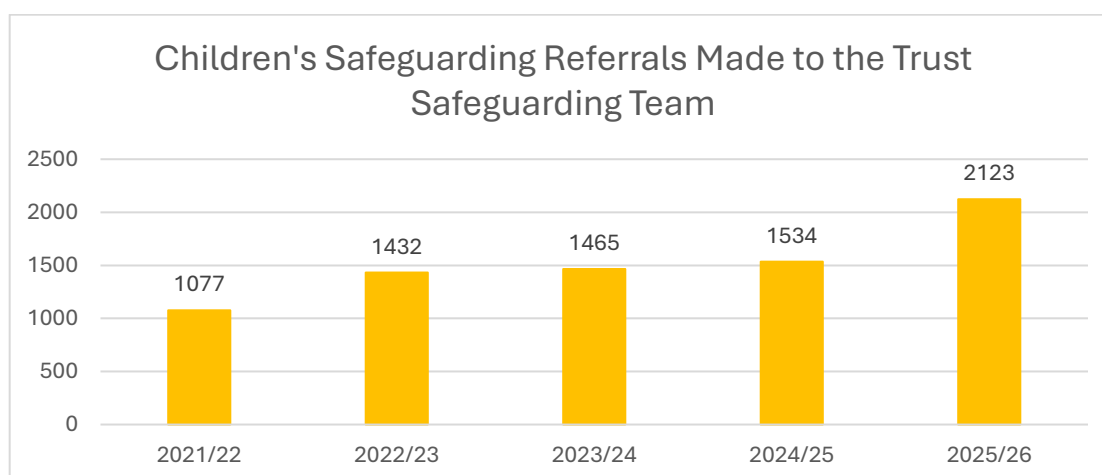
- Improved timeliness and oversight of Initial Health Assessments, supporting better care planning for children in care.

Safeguarding Children Activity Analysis – 2025/26

The chart below demonstrates a continued increase in safeguarding children's referrals to the Trust Safeguarding Team, with a significant rise in 2025/26 to 2,123, compared to 1,534 in 2024/25. This represents the largest year-on-year increase observed and reflects both increased demand and improved identification of safeguarding concerns across the organisation.

This upward trend reflects the growing visibility and proactive engagement of the Safeguarding Team, alongside improved staff confidence in recognising and responding to concerns. Sustained training, communication and presence have reinforced a culture of vigilance and shared responsibility.

The scale of this increase has had a direct impact on team capacity and workload. As a result, there is a need in 2026/27 to review current approaches, including consideration of safeguarding thresholds and the development of targeted education for staff, to ensure referrals remain appropriate, proportionate and sustainable.



Nature of the Referrals Received

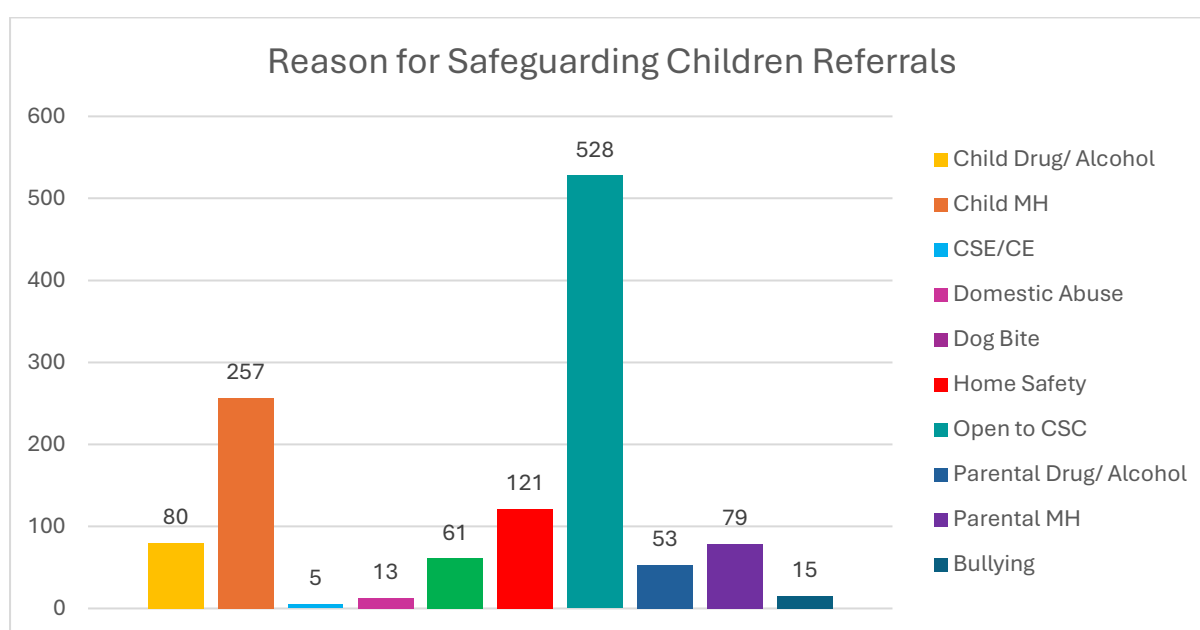
The Safeguarding Team routinely reviews referral data to identify emerging themes, inform practice development and strengthen partnership working.

During the reporting period, 1,646 safeguarding referrals were received. Children already open to Children's Social Care accounted for over half of all referrals (50.9%), providing assurance that vulnerable children continue to be effectively identified through safeguarding screening processes and use of the Child Protection Information Sharing (CP-IS) system.

Child mental health concerns (13.6%) and home safety concerns (12.1%) were the next most common referral categories, reflecting both the complexity of presentations seen within acute services and staff awareness of wider safeguarding risks. Mental health concerns (child and parental) were identified in over one-fifth of referrals (21.6%), rising to almost one-third when combined with drug and alcohol-related concerns, reinforcing the importance of a whole-family approach to safeguarding.

Referrals relating to dog bites (4.9%) exceeded those for bullying and parental substance misuse, identifying a potential opportunity for preventative public health initiatives. Domestic abuse and child exploitation referrals remained low; however, these concerns are often embedded within broader safeguarding presentations and may not be reflected as standalone categories.

Overall, the referral profile demonstrates a strong safeguarding culture across the Trust, characterised by effective risk identification, robust screening processes and appropriate escalation of concerns. The predominance of referrals relating to children already known to services, mental health needs and wider family vulnerabilities indicates that staff continue to adopt a holistic and child-centred approach to safeguarding practice. Future work will focus on understanding patterns of repeat referral, strengthening recognition of contextual safeguarding risks and supporting preventative approaches to reduce avoidable harm within families and communities.



Children and Mental Health Difficulties.

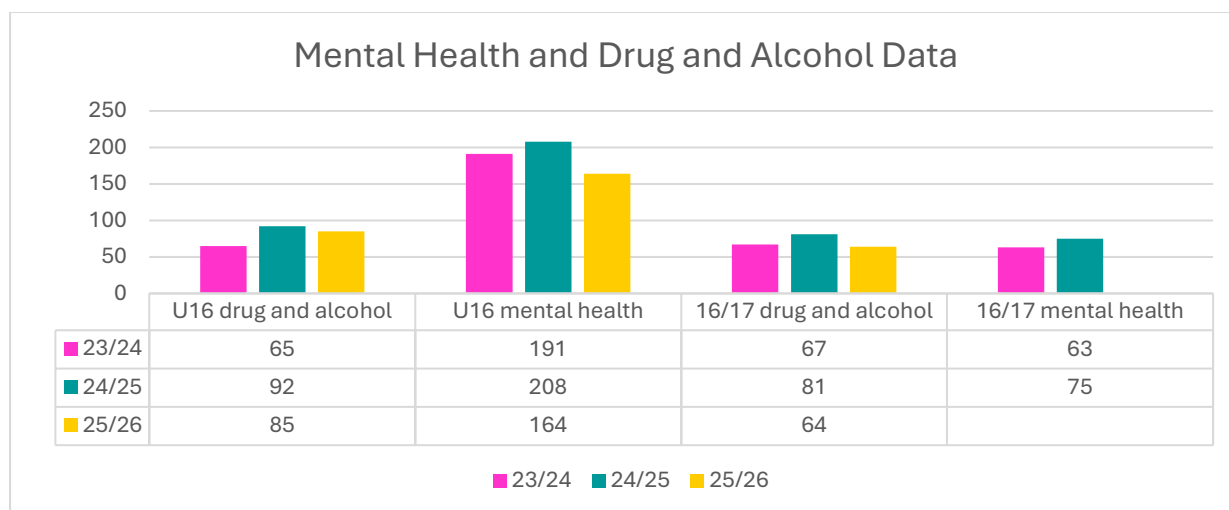
In 2025/26, the Safeguarding Children Partnership continued to request data on all children attending the Emergency Department (ED) with mental health concerns or drug and alcohol-related issues in addition there was a separate request for those children who had attended due to ketamine misuse. This data was produced by the Trust's Business Intelligence Team using relevant clinical coding and submitted to the Partnership to support wider multi-agency oversight and thematic analysis.

The chart below presents the data shared with the Partnership.

The 2025/26 data demonstrates continued demand in relation to children presenting to ED with mental health and substance misuse concerns. The inclusion of ketamine-related attendances as a separate data request reflects increasing partnership focus on this emerging area of risk. The

Safeguarding Team has highlighted these trends through Partnership reporting routes to support further analysis, shared learning and targeted system-wide responses.

The Safeguarding Team continues to work closely with CAMHS to support timely information sharing, risk assessment and safe discharge planning for children and young people presenting with mental health needs. Evidence within patient records demonstrates ongoing collaboration between services. The team also supports continuity of care by facilitating the timely upload of CAMHS mental health assessments to children's EPR+ records, ensuring that relevant information is accessible to clinicians involved in the child's care.



Children on Adult Wards

The Safeguarding Team remains committed to ensuring that high standards of care are upheld for children, typically aged 16 or 17 who are admitted to adult clinical areas. To support this, the team receives a daily report identifying all children currently placed in adult settings.

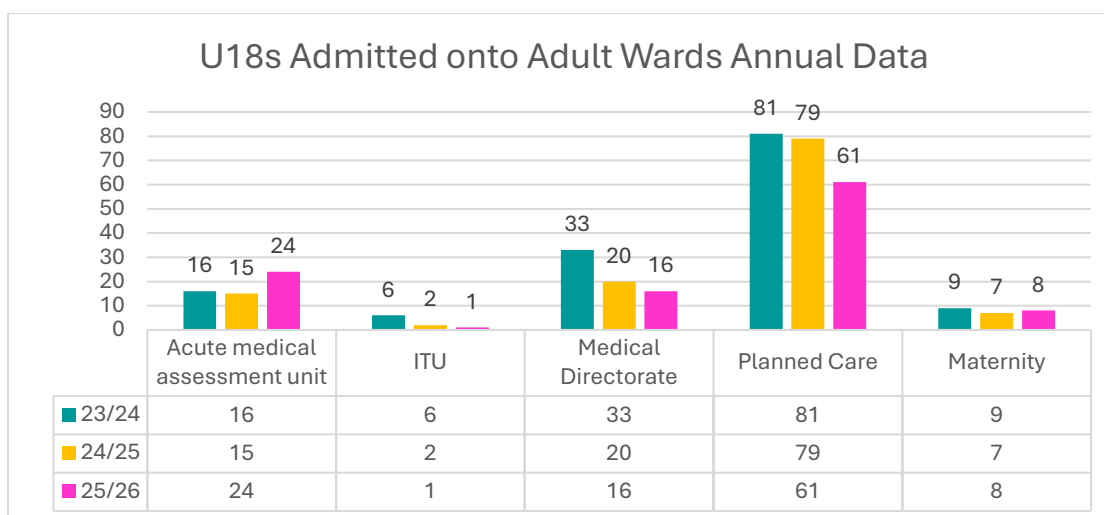
Each case is reviewed to ensure the young person's needs are being met. This includes considerations such as:

- Allowing a parent or carer to stay with the young person where appropriate
- Allocating a side room when available
- Coordinating a safe and timely discharge plan

The chart below illustrates the number of children admitted to adult clinical areas during 2025/26 compared to previous years

Young people attending planned care settings often include those undergoing surgical procedures such as appendicectomy, vascular, or orthopaedic interventions. These admissions are typically short, with most discharges occurring within 48 hours.

For those admitted to the Intensive Therapy Unit (ITU), the Safeguarding Children Team ensures direct contact is made during their stay to support their care and wellbeing.



CPIS in the Emergency Department

The Child Protection Information Sharing (CP-IS) programme continues to support safeguarding practice by enabling the secure sharing of information between Local Authorities and healthcare providers. This ensures that children subject to a Child Protection Plan or those in the care of a Local Authority are identified promptly when they present to unscheduled care settings.

In 2025/26, there were 265 CP-IS-triggered contacts, indicating sustained utilisation of the system. This reflects increasing staff awareness and confidence in recognising CP-IS alerts and taking appropriate safeguarding action.

Key considerations

Flintshire

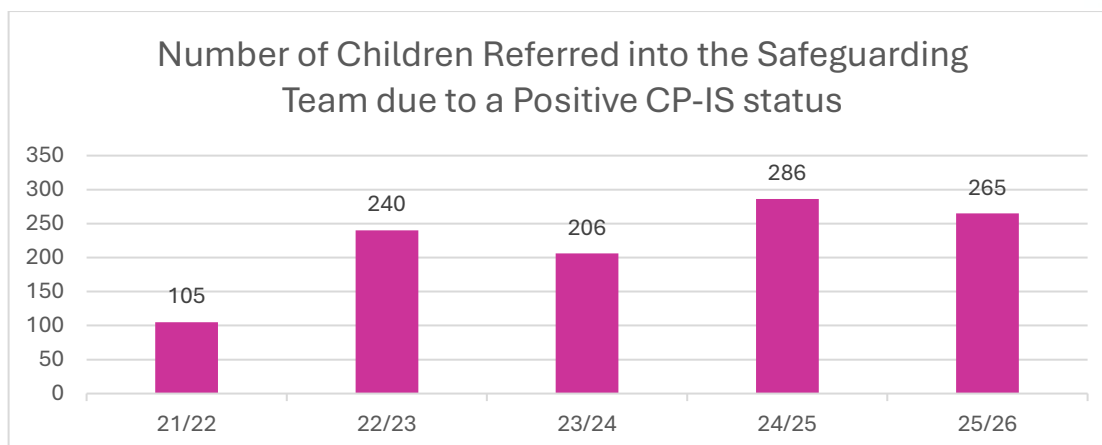
CP-IS functionality remains unavailable for children resident in Flintshire. This continues to present a safeguarding risk, as staff are unable to access real-time safeguarding indicators for this cohort. Despite the publication of the Safeguarding Child Practice Review highlighting this risk, it remains unresolved and has now been formally escalated onto the Trust's risk register.

System visibility and local mitigation

CP-IS remains primarily embedded within unplanned care settings via the NHS Spine. To mitigate limitations in visibility, the Trust safeguarding team continues to utilise the Cheshire West and Chester Local Authority CP-IS database to manually apply and remove safeguarding alerts within EPR+, ensuring that relevant information is visible to clinicians across the organisation.

Future development (2026/27)

Work is progressing to extend CP-IS functionality beyond the Emergency Department. From a Trust perspective, this will include implementation within community paediatric services and the Paediatric Assessment Unit, strengthening whole-system visibility and supporting earlier identification of safeguarding concerns across all paediatric care pathways



Child Exploitation

The Safeguarding Team continues to play an active role in addressing child exploitation through attendance at the monthly Child Exploitation Operational Group (CE-Ops) in Cheshire West and Chester, chaired by Cheshire Police. These multi-agency meetings focus on children and young people assessed as being at medium or high risk of exploitation.

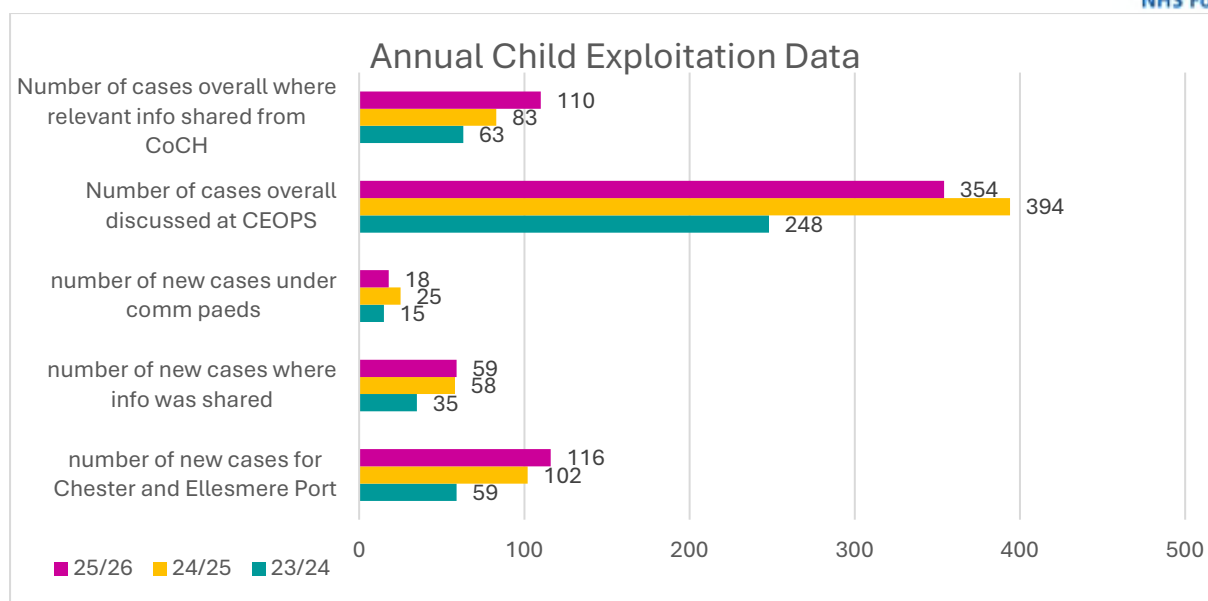
During 2025/26, the Trust has maintained a strong contribution, with further increases across all areas of activity. The number of cases where relevant information was shared by the Trust rose to 110 (from 83), and the number of cases discussed at CE-Ops remained high at 354, reflecting sustained demand and ongoing complexity within this cohort.

There has also been an increase in new cases within Community Paediatrics (18), alongside a rise in new cases where safeguarding information was shared (59). In addition, new cases relating to Chester and Ellesmere Port increased to 116, indicating growing local demand and system pressure.

Children discussed continue to include those presenting to the Emergency Department with intoxication, mental health concerns or substance misuse, as well as those known to Community Paediatrics for neurodivergent conditions, reflecting national concerns regarding increased vulnerability to exploitation within this group.

For all children identified as being at medium or high risk, the Safeguarding Team ensures that appropriate alerts are applied to EPR+, enabling staff to recognise risk and respond appropriately.

The continued rise in activity has had a significant impact on the workload and capacity of the Safeguarding Team, with increasing case complexity and demand for multi-agency information sharing. This reinforces the importance of sustained focus on early identification, effective partnership working and robust internal processes to support children at risk of exploitation.



Referrals to Children's Social Care

The table below outlines the number of referrals made by the Trust to Children's Social Care. Referrals are submitted where a child is identified as requiring additional support under Section 17 of the Children Act 1989, or where there are concerns that a child is at risk of, or has experienced, significant harm under Section 47.

Within the Trust, referrals continue to be made for a range of safeguarding concerns, most commonly non-accidental injury, domestic abuse, parental substance misuse, parental or child mental health, neglect and perplexing presentation.

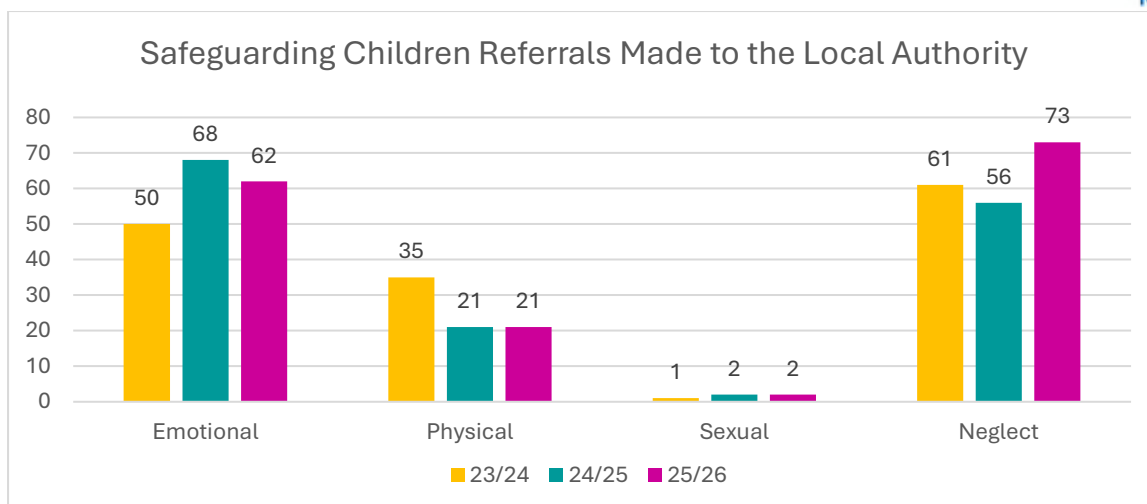
The Safeguarding Team works closely with Children's Social Care colleagues, using consultation processes to ensure referrals are appropriate, proportionate and supported by robust information. In line with statutory guidance, all referrals are categorised under emotional, physical, sexual abuse and neglect, enabling consistent practice and thematic analysis.

The data demonstrates a continued pattern in referral themes, with neglect and emotional abuse remaining the most common categories, followed by physical abuse, and low numbers of sexual abuse referrals. This reflects both local demand and national trends in safeguarding need.

In 2025/26, the Trust made a total of 154 referrals to Children's Social Care. Of these, 120 related to Cheshire and 34 to Flintshire, reflecting the Trust's primary catchment but also highlighting ongoing cross-border safeguarding activity.

As in previous years, referral activity remains stable following earlier reductions. This position is supported by improved staff awareness of safeguarding thresholds and strengthened triage processes, including access to the Local Authority system (Liquid Logic), which enables concerns to be appropriately reviewed and managed prior to formal escalation where suitable.

Overall, this demonstrates a more targeted and proportionate approach to referral practice, alongside continued strong multi-agency working to ensure children at risk receive the right level of intervention



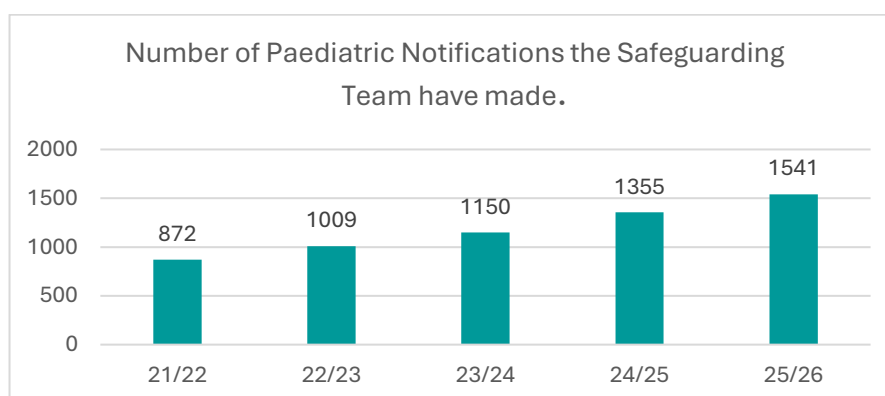
Liaison with Other Agencies

The Paediatric Liaison Nurse role is now embedded within the Trust and has settled well, becoming a key part of the safeguarding system. In 2025/26, there were 1,541 paediatric liaison notifications, reflecting sustained demand and the volume of safeguarding information shared with community services.

The role continues to support effective communication with partners, including Health Visitors, School Nurses, SCIE, CAMHS and Ancora House, ensuring continuity of care for vulnerable children and young people.

Within the Emergency Department, the Paediatric Liaison Nurse has added significant value, acting as an additional layer of oversight. The role has identified cases where safeguarding processes were not fully followed and ensured these were escalated and appropriately managed, reinforcing safe practice. This aligns with earlier findings that the role strengthens oversight and identifies missed safeguarding referrals.

Plans for 2026/27 include targeted teaching and training within ED to reinforce safeguarding processes, improve consistency, and reduce the risk of missed or inappropriate practice



Perplexing Presentations

Children presenting with perplexing or medically unexplained symptoms continue to be a complex area of safeguarding practice. In 25/26 the team worked 4 cases where perplexing presentation of children was an issue. This is a significant reduction compared to the previous year when there were 10 referrals. These cases often involve subtle or unclear concerns that require careful, multi-disciplinary exploration. Through increased supervision sessions with a wide range of hospital professionals, the Safeguarding Team has been able to identify emerging issues more effectively. These sessions have provided valuable insight into clinical observations and concerns, enabling the team to recognise safeguarding risks that may not have been immediately apparent. While this proactive approach has strengthened early identification and intervention, it has also significantly increased the team's workload and demand for specialist input from a wide range of hospital clinicians.

Safeguarding Children Supervision

Under the Children Acts of 1989 and 2004, safeguarding supervision must be available to all staff who work directly with children and their families. The Trust adheres to this statutory and contractual obligation through its Safeguarding Children's Policy, which outlines the principles and expectations for effective supervision. All staff providing supervision have completed accredited and recognised training.

A range of supervision methods are used across the Trust, including one-to-one, group, peer, and ad hoc supervision sessions. In 2025/26 the range of staff accessing supervision expanded to include midwives, community paediatric nurses, dietitians, therapists, and ward-based nursing staff. All midwifery cases involving Children's Social Care are reviewed through supervision every three months.

The Named Doctor for Safeguarding Children facilitates monthly peer review sessions, where doctors present and discuss safeguarding cases they've managed. This is inclusive of both community and hospital paediatricians. These sessions are well attended and have recently been extended to include safeguarding nursing colleagues.

Additionally, the Safeguarding and Complex Care Team receive supervision every six weeks from their line manager. Named professionals also receive supervision from Designated Professionals within their respective specialties.

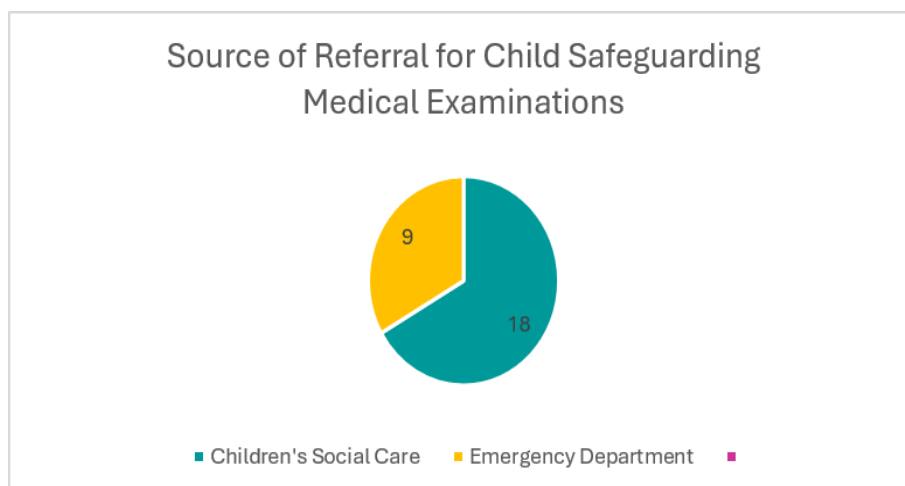
Child Protection Medical Examinations

This section summarises the clinical activity and performance data relating to child protection medical examinations undertaken by hospital and community paediatricians during 2025/26.

A total of 29 child protection medical examinations were completed during 2025/26, compared to 37 in 2024/25. Whilst this represents a reduction from the previous year, activity remains broadly consistent with longer-term trends, with 31 examinations undertaken in 2022/23 and 27 in 2021/22. The chart below illustrates the sources of referral for these medical examinations.

Of the 29 child protection medicals completed, 18 referrals originated from Children's Social Care and 11 were initiated by the Emergency Department (ED). All children referred for medical examination were assessed due to concerns relating to physical abuse.

The number of referrals generated by ED staff remains encouraging. Following a significant increase in recent years, ED clinicians continue to identify children presenting with suspected non-accidental injuries and make appropriate referrals for further assessment. This provides assurance that safeguarding awareness remains high within the department and that staff are confident in recognising and escalating potential indicators of abuse.



Maternity Safeguarding Activity

Key Achievements 2025/26 – Maternity Safeguarding

- Implemented the Pan-Cheshire Pre-Birth Assessment Framework, supporting a consistent multi-agency approach to safeguarding unborn babies.
- Fully embedded the Hope Box initiative and secured additional funding to support families experiencing separation from their newborn baby.
- Maintained high compliance with routine domestic abuse enquiry throughout pregnancy, supporting earlier identification and intervention.
- Received positive external assurance through Safeguarding Children Partnership review activities, highlighting strong safeguarding leadership and support for staff.
- Maintained robust safeguarding supervision arrangements and achieved positive audit outcomes across key safeguarding indicators.
- Developed and implemented a revised Female Genital Mutilation (FGM) pathway to strengthen identification, assessment and safeguarding responses.
- Strengthened information sharing and multi-agency working through improved communication with GPs, Children's Social Care and partner agencies.
- Continued delivery of bespoke safeguarding training for maternity staff, supporting confidence in recognising and responding to safeguarding concerns.
- Maintained strong multidisciplinary oversight of complex pre-birth and child protection cases, supporting safe outcomes for mothers and babies.

Safeguarding within maternity services is overseen by the Safeguarding Assurance Committee and aligned with the Safeguarding Assurance Framework under the Integrated Care Board (ICB). When safeguarding concerns arise during complex pregnancies, midwives refer cases to the Trust's Safeguarding Team. The Named Midwife for Safeguarding plays a pivotal role, providing specialist guidance and support to maternity staff on all aspects of child safeguarding.

Safeguarding Activity in Maternity Services

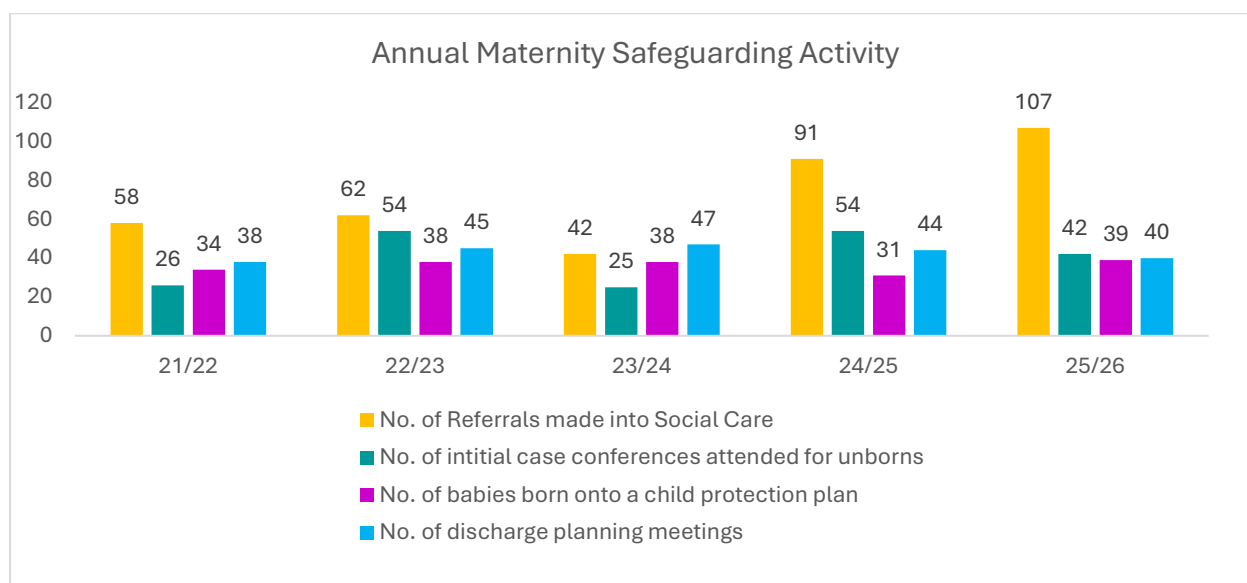
The table below demonstrates maternity safeguarding activity over the past four years, with a further increase in 2025/26. The Trust received 241 referrals from midwives for specialist advice and guidance, rising from 185 in 2024/25. Of these, 107 were escalated to the Local Authority, reflecting sustained improvement in the appropriate application of safeguarding thresholds.

This position indicates improved understanding of thresholds, with advice and guidance supporting more appropriate conversion into Local Authority referrals. Moving into 2026/27, there is an opportunity to further strengthen this through clearer and more consistent understanding of thresholds across the workforce.

Activity across the pathway remains stable, with 42 initial case conferences for unborn babies and 40 discharge planning meetings, indicating that learning from the Safeguarding Child Practice Review continues to be embedded. There were 39 babies made subject to a Child Protection Plan.

In 2025/26, four babies were removed at birth into Local Authority care. These cases remain complex and require significant support for staff, with initiatives such as the Hope Box project continuing to provide additional support.

Overall, the data reflects increasing demand alongside improved quality and appropriateness of safeguarding decision-making.



Safeguarding the Vulnerable Adult

Key Achievements in 25/26

- Successfully implemented the Self-Neglect Action Plan, including the introduction of a Self-Neglect Recognition Tool, targeted staff education and audit activity to improve identification and management of high-risk individuals.
- Strengthened safeguarding practice through the rollout of updated Level 3 Safeguarding Adults training, incorporating learning from Safeguarding Adult Reviews (SARs), self-neglect, executive functioning and complex decision-making.
- Enhanced multi-agency working through the introduction of twice-weekly Integrated Discharge Team (IDT) meetings, supporting improved communication and safer discharge planning for patients with complex safeguarding needs.
- Developed and implemented an electronic safeguarding template, improving documentation, information sharing and oversight of safeguarding activity across the Trust.
- Maintained strong strategic partnerships with Adult Social Care, police, housing services, drug and alcohol services and community providers to support coordinated safeguarding responses.
- Continued attendance at Pressure Ulcer Review Meetings strengthening governance and early identification of safeguarding concerns relating to skin integrity.
- Increased staff awareness and recognition of self-neglect and domestic abuse through targeted education and Safeguarding Adults Week engagement activities.
- Maintained active involvement in Safeguarding Adult Reviews (SARs), ensuring learning is disseminated and embedded into Trust practice.
- Continued representation at Prevent and Channel Panels and the North West Prevent Partnership Group, supporting the Trust's contribution to the wider safeguarding and counter-terrorism agenda.
- Strengthened partnerships supporting vulnerable adults experiencing homelessness, substance misuse and social exclusion, including continued engagement with housing, rough sleeping and specialist community services.
- Increased scrutiny and oversight of safeguarding concerns through regular review of safeguarding activity, emerging themes and high-risk cases with partner agencies.
- Identified self-neglect, homelessness, substance misuse, financial abuse and safeguarding concerns associated with ketamine use as emerging priorities, informing service development and training plans for 2026/27.

Safeguarding Adults Activity

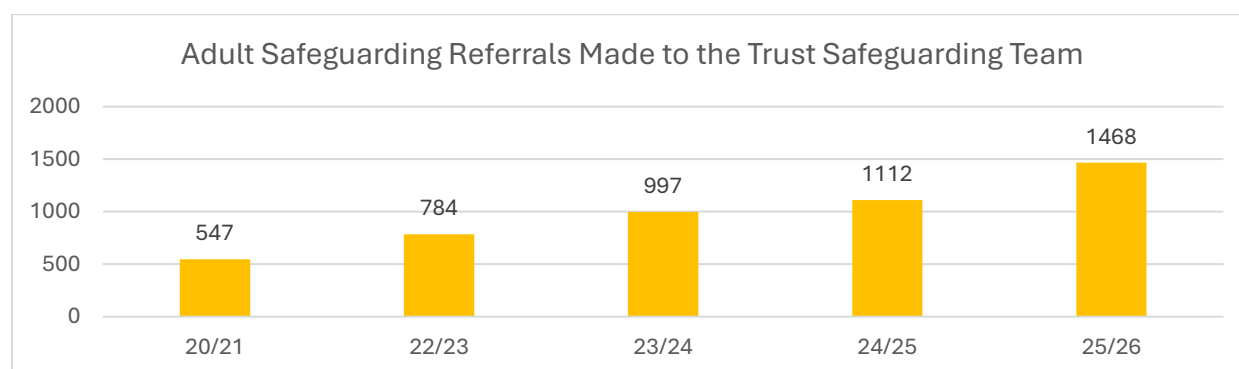
The hospital's Safeguarding Adults Team continues to provide expert advice and support on a wide range of issues affecting adults with care and support needs, including those at risk of or experiencing abuse or harm.

In 2025/26, the team received 1,468 referrals, compared to 1,112 in 2024/25, demonstrating a significant year-on-year increase in safeguarding activity. This continued growth reflects sustained staff awareness, improved recognition of safeguarding concerns, and confidence in escalating risk appropriately across the Trust.

As in previous years, a proportion of referrals did not meet the threshold for a safeguarding response. While this reflects appropriate professional curiosity and willingness to escalate concerns, it continues to highlight an ongoing challenge in ensuring consistent understanding of safeguarding thresholds across the workforce.

In response to the ongoing challenge around referral appropriateness, targeted training and communication will continue into 2026/27, alongside the development of a safeguarding thresholds document to support staff in making informed, consistent decisions and ensure referrals are timely, proportionate and aligned to risk.

Overall, this data provides assurance of a strong safeguarding culture across the Trust, with increasing activity reflecting improved recognition of risk, while highlighting a continued need to refine staff understanding of thresholds to optimise the quality and appropriateness of referrals.



Nature of the Referrals received.

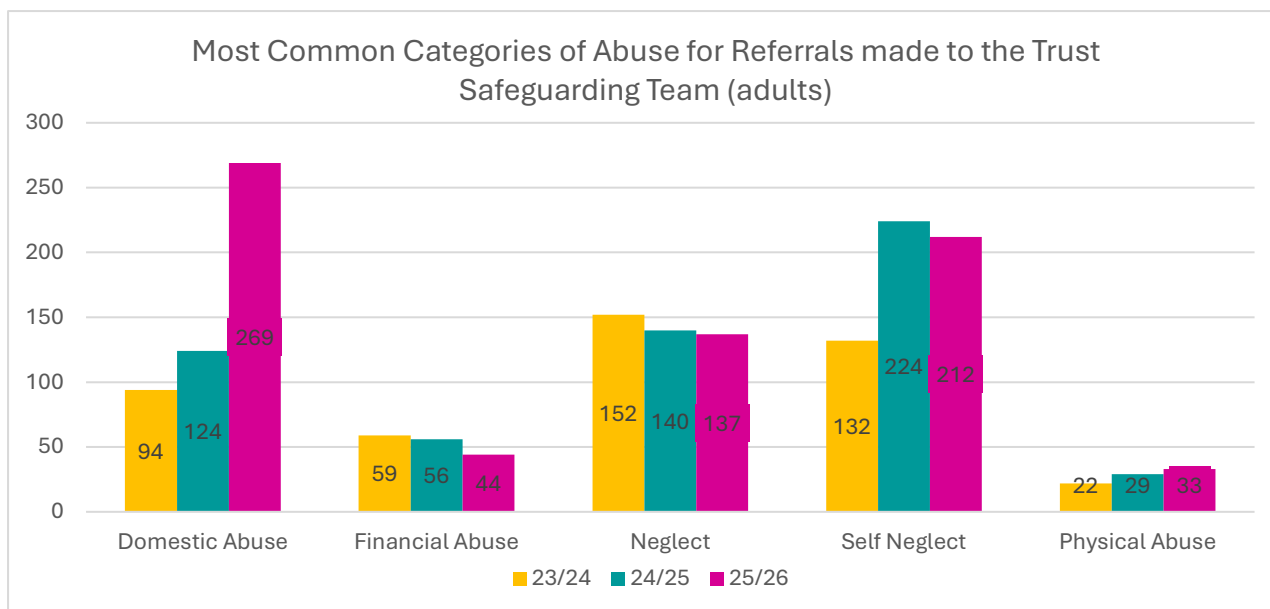
The table below reflects the nature of the referrals received into the team for adult safeguarding. The table demonstrates that the key reason for referrals are; for a disclosure of domestic abuse, financial abuse, neglect and self neglect. This supports the national and local trend of an increase in these areas. It is encouraging that staff also recognise some less common types of abuse including cuckooing, radicalisation, sexual abuse, psychological abuse and organisational abuse and made appropriate referrals to the team on recognition. This trend correlates with the Trust's commitment to improving their safeguarding training indicating the effectiveness of the training the staff receive.

The data highlights several key trends:

- Domestic Abuse referrals increased significantly, reflecting improved staff awareness and confidence in identifying and reporting abuse, supported by improved compliance in safeguarding training.
- Financial Abuse remained relatively stable, suggesting consistent recognition and reporting practices.
- Neglect saw a slight decrease, which may indicate more effective early intervention and support strategies from a community response.
- Self-Neglect showed a sharp rise—from 132 to 224 referrals. This increase is particularly notable and aligns with national trends, as well as the Trust's involvement in three

Safeguarding Adult Reviews (SARs) where self-neglect was a key theme. In response, a dedicated action plan has been developed to improve identification, assessment, and management of self-neglect across all departments.

- Physical Abuse referrals also rose, likely due to increased staff training and vigilance.



Working with Adult Social Care

In 2025/26, the Trust made 129 referrals to Adult Social Care, compared to 161 in 2024/25. These referrals are made under the Care Act 2014 when an adult has care and support needs, is experiencing or at risk of abuse or neglect, and is unable to protect themselves as a result of those needs.

Referral distribution remained consistent with the Trust's patient population, with 108 referrals (84%) made to Cheshire West and Chester and 21 referrals (16%) to Flintshire.

There has been a notable increase in safeguarding activity progressing to statutory intervention, with 29 referrals meeting the Section 42 threshold, compared to 18 in 2024/25. This indicates an increase in the complexity and severity of safeguarding concerns being identified within the Trust.

Engagement in multi-agency safeguarding processes has also strengthened, with attendance at 41 strategy meetings, more than double the 19 attended in the previous year. This reflects the Trust's ongoing commitment to collaborative working and active participation in safeguarding enquiries.

Overall, this data suggests a shift towards fewer but more complex and higher-risk referrals, providing assurance that safeguarding concerns are being appropriately identified and escalated, while highlighting the increasing acuity of adult safeguarding need within the acute setting.

The Trust received 75 information requests from Adult Social Care in 2025/26 to support external Section 42 enquiries. Although lower than the 88 received in 2024/25, this remains above previous years, with 55 requests in 2023/24 and 42 in 2022/23. This demonstrates sustained demand for healthcare information to support statutory safeguarding enquiries, despite a reduction from last year's peak.

Pressure Ulcers and Safeguarding

Pressure ulcers remain a significant safeguarding concern, as they may indicate potential neglect through either deliberate omission or an unintentional failure to provide appropriate care. Within the Trust, pressure ulcers are categorised as either Present on Arrival (POA), where skin damage is identified on admission, or Hospital Acquired Pressure Ulcers (HAPUs), which develop during a patient's hospital stay.

Throughout 2025/26, the Safeguarding and Complex Care Team continued to strengthen processes for the identification, review and management of both POA and HAPU cases, supporting the Trust's safeguarding responsibilities and alignment with Local Authority protocols.

The team received notifications of 124 HAPUs through the DATIX reporting system, compared with 78 cases in 2024/25. All cases involved either multiple Category 2 pressure ulcers or Category 3 and 4 pressure ulcers. Ongoing review has highlighted that some pressure ulcers initially recorded as HAPUs may have been present on admission but lacked sufficient documentation to evidence this. Consequently, improvement work has focused particularly on the Emergency Department (ED) to support earlier identification and robust documentation of pressure ulcers on arrival.

The Adult Safeguarding Decision Support Tool, integrated into the DATIX reporting process, continues to support consistent and proportionate decision-making. In addition, the Safeguarding Team attends weekly Pressure Ulcer Review Meetings to provide safeguarding oversight and support. Despite the increase in reported HAPUs, only two cases required referral to Adult Social Care, remaining consistent with the previous year.

For POA pressure ulcers, 207 cases were recorded in 2025/26, compared with 149 in 2024/25. This increase is likely to reflect improved identification and recording of pressure damage present on admission. Of these cases, seven were referred to the Local Authority due to concerns regarding potential neglect by external care providers, compared with five referrals in the previous year.

The continued partnership between safeguarding, tissue viability and clinical teams has strengthened oversight of pressure ulcer management, improved the accuracy of pressure ulcer classification, and ensured that safeguarding concerns are identified and escalated appropriately

Liaison with Other Agencies

The Safeguarding and Complex Care Team have set up a liaison service between each local GP surgery (both Cheshire West and Flintshire) and themselves to ensure key safeguarding information is liaised out to the GP surgery following a patient's admission. This liaison process has worked both ways and the team have been used by GPs to liaise their safeguarding concerns into the hospital to safeguard their patients during an inpatient admission. Data is not available on this process yet.

Prevent Duty

Under the Counter-Terrorism and Security Act 2015, the health sector has a statutory duty to have due regard to the need to prevent individuals from being drawn into terrorism—this is known as the Prevent Duty.

To ensure compliance with this duty, the Trust has implemented the following arrangements:

- The Safeguarding and Complex Care Team is available to provide staff with advice and support.
- A current Trust Prevent Policy and Strategy offers clear guidance to staff on how to identify and respond to concerns.
- A Prevent training programme is in place to raise awareness and build staff confidence in recognising and reporting potential risks.
- The Prevent Lead (Named Nurse for Safeguarding Children) actively participates in multi-agency meetings to support collaborative safeguarding efforts.
- The Trust submits quarterly Prevent data to the Integrated Care Board (ICB) to provide assurance and oversight.

In 2025/26, the Trust made 3 referrals to the Channel Panel and has fully engaged in all related meetings, sharing relevant information with the Channel Coordinator as required

Modern Slavery

As a Trust, we are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or supply chain. In accordance with the requirements of the UK Modern Slavery Act (2015) our Slavery and Human Trafficking Policy Statement sets out the actions taken by the Trust to understand all potential modern slavery risks and to implement effective systems and controls.

Domestic Abuse

Key Achievements in 25/26

- Introduced routine domestic abuse screening questions within Emergency Department triage, enabling earlier identification of victims and timely safeguarding intervention.
- Continued delivery of a dedicated Independent Domestic Violence Advisor (IDVA) service within the Trust, providing specialist support to patients and staff experiencing domestic abuse and strengthening links with community services.
- Maintained safeguarding alerts and flags for patients discussed at MARAC, ensuring domestic abuse risks are visible across patient records and prompt appropriate safeguarding responses for adults and children.

- Strengthened multi-agency working through active participation in Chester, Ellesmere Port and Flintshire MARAC processes, contributing information on 788 high-risk domestic abuse cases during the year.
- Continued use of the DASH risk assessment tool within EPR+, supporting consistent assessment, escalation and management of domestic abuse concerns.
- Provided specialist support to patients experiencing complex domestic abuse, including coercive control, stalking, sexual violence, pregnancy-related vulnerability, mental health concerns and substance misuse.
- Supported a trauma-informed approach to domestic abuse through partnership working with police, social care, maternity services, mental health teams and specialist domestic abuse services.
- Further strengthened the Trust's Think Family approach by ensuring domestic abuse risks are considered for all family members, including children, through safeguarding referrals, MARAC participation and information sharing processes.

The Trust remains committed to the early identification and support of individuals affected by domestic abuse, recognising the significant impact abuse can have on physical health, mental wellbeing, family relationships and safeguarding outcomes. A key component of this work continues to be the Independent Domestic Violence Advisor (IDVA) service embedded within the Safeguarding and Complex Care Team, providing specialist support to both patients and staff experiencing domestic abuse.

During 2025/26, the hospital IDVA received 208 referrals. While this is lower than the previous year's reported activity, these figures represent referrals managed specifically through the Cheshire West and Chester IDVA service and do not include the wider domestic abuse activity managed by safeguarding practitioners across the Trust. Some referrals also do not progress to an episode of support where individuals decline intervention or do not meet service thresholds.

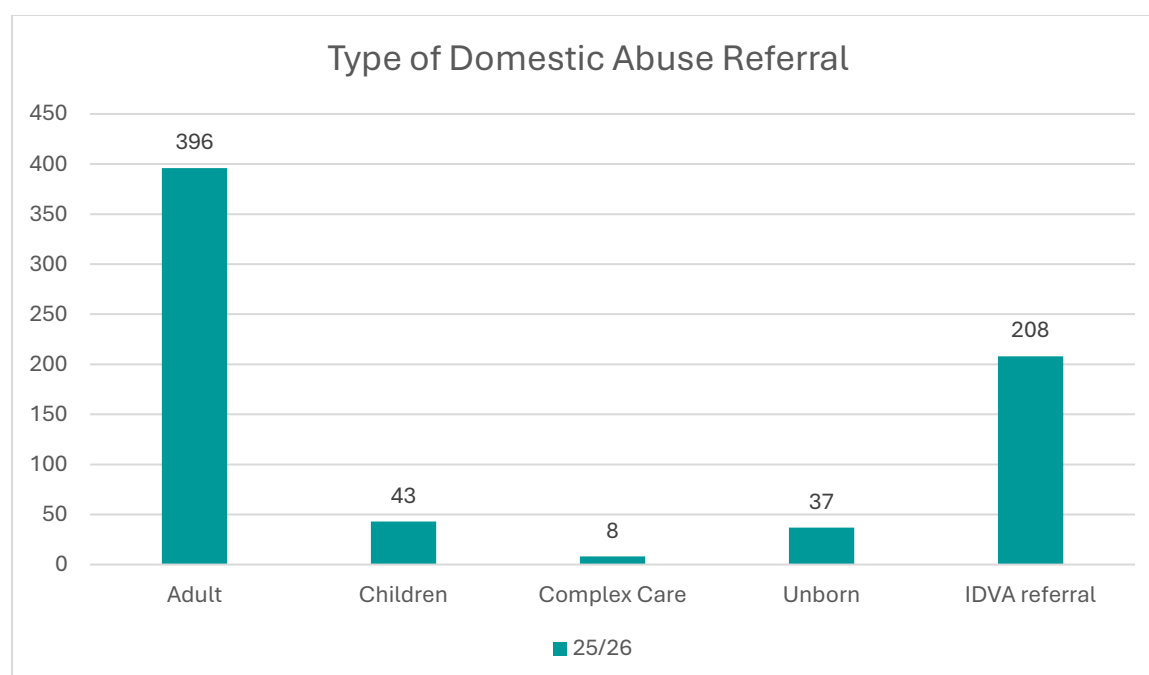
The Trust has continued to strengthen its approach to identification and disclosure. During the year, domestic abuse screening was introduced within Emergency Department triage, enabling patients to disclose abuse safely and discreetly. Any positive responses trigger a safeguarding assessment and access to specialist support where required.

The majority of referrals related to women, although the service continues to support individuals of all genders and ages. The complexity of presentations remains significant, often involving pregnancy, coercive and controlling behaviour, mental health concerns, substance misuse, stalking, harassment and risks to children within the household.

Patients discussed at MARAC continue to have safeguarding alerts applied to their records, enabling staff to recognise domestic abuse risks on attendance and ensure appropriate support and information-sharing arrangements are in place for adults and children affected by abuse

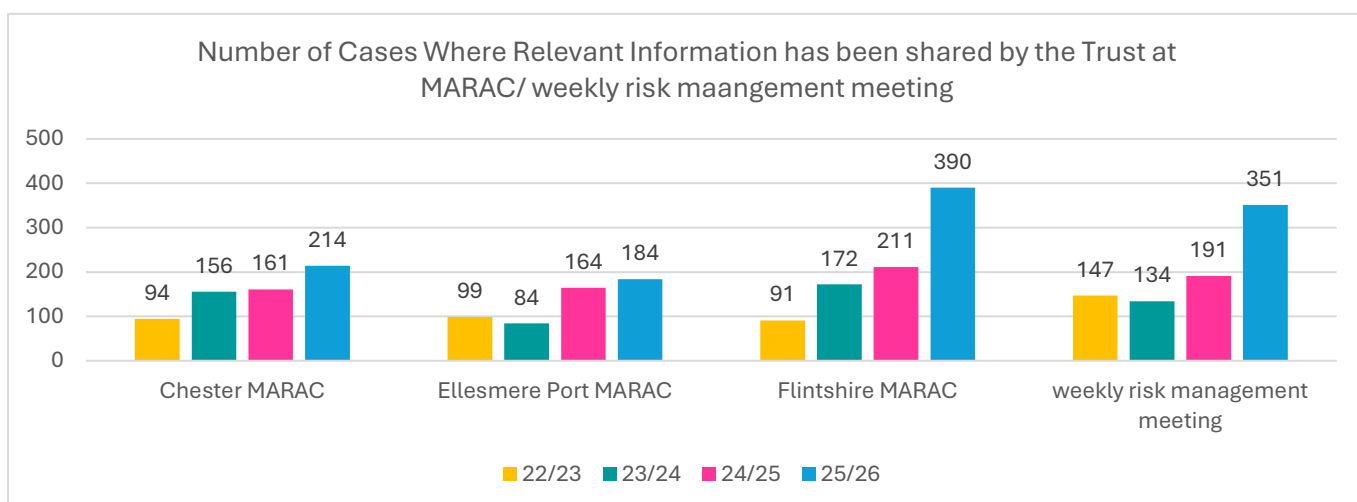
In 2025/26, there were 396 domestic abuse-related referrals, the majority of which involved adult patients (308). Of these, 43 referrals identified domestic abuse as a feature within the family home where children were present, highlighting the wider impact of abuse on children and families. There were also 37 referrals concerning unborn babies, demonstrating the continued importance of

identifying and addressing domestic abuse during pregnancy. In addition, 8 referrals involved patients with highly complex needs, reflecting the significant vulnerabilities often associated with domestic abuse and the requirement for enhanced safeguarding oversight.



The hospital's Independent Domestic Violence Advisor (IDVA) service provided support to 208 of these cases, representing a reduction from 256 cases in the previous year. Whilst the IDVA service remains a vital resource, this decrease has resulted in a greater proportion of domestic abuse cases requiring management and coordination by the safeguarding team, placing additional pressure on an already stretched workforce. These figures reinforce the need for ongoing vigilance, effective multi-agency working, early identification of domestic abuse, and robust support arrangements for those at risk.

The Independent Domestic Violence Advisor (IDVA) continues to play a central role in representing the Trust at Multi-Agency Risk Assessment Conferences (MARAC), which are held four times per month across the Trust's footprint as well as the Weekly Risk Meeting. These meetings focus exclusively on high-risk domestic abuse cases and involve the sharing of vital information about victims, perpetrators, and any children involved.



Complex Care Activity

Key Achievements in 2025/26

- Successfully developed and launched a virtual hospital tour to support patients with learning disabilities, autism and additional needs to prepare for hospital attendance and reduce anxiety.
- Celebrated Learning Disability Week across the Trust, raising awareness, promoting inclusion and strengthening staff understanding of the needs of people with learning disabilities.
- Successfully completed the NHS Learning Disability Improvement Standards self-assessment, evidencing continued progress in delivering equitable and inclusive care.
- Implemented an electronic Deprivation of Liberty Safeguards (DoLS) referral and monitoring process within EPR+, improving oversight and governance of DoLS activity.
- Sustained effective delivery of the LeDeR programme, ensuring learning from reviews continues to inform service improvement and improve outcomes for people with learning disabilities and autistic people.
- Continued rollout of the Oliver McGowan Mandatory Training Programme, with a team of trained facilitators now established and more than 500 staff trained, supporting improved understanding of learning disability and autism across the Trust.
- Dementia training has been mandated across the organisation, supporting the Trust's commitment to delivering dementia-friendly care and meeting external assurance requirements.
- Continued to promote and embed the use of Hospital Passports and reasonable adjustments, improving personalised care for patients with learning disabilities and autism.
- Delivered specialist support, education and practical interventions for patients with complex needs, enabling reasonable adjustments and reducing barriers to accessing healthcare.
- Strengthened multidisciplinary working across acute, community and specialist services to support safe care, complex discharge planning and improved patient experiences.
- Further developed the Complex Care Team as a trusted expert resource, supporting staff to deliver person-centred care for patients with learning disabilities, autism, dementia and other complex needs.

The Complex Care team provides specialist advice and support for a wide range of issues relating to the Complex Care agenda. This, in the main is for those patients where, there are challenges in accessing care or delivering care due to a cognitive impairment such as a Learning Disability, Autism and or dementia as well as those patients with mental health challenges.

In 2025/26, the Complex Care Team received 596 referrals, representing a continued increase in demand for specialist support compared to 492 referrals in 2024/25. This growth reflects both the increasing complexity of the patient population and greater awareness across the Trust of the support available through the service.

The referral profile demonstrates a shift in demand. Mental Health Act-related activity represented the highest proportion of referrals (169), indicating sustained demand for support with patients requiring assessment, detention or treatment under legal frameworks. This is followed by behaviour-related referrals (107), highlighting the ongoing need for specialist input in managing behaviours that challenge, often associated with neurodevelopmental conditions, mental health needs, or impaired capacity.

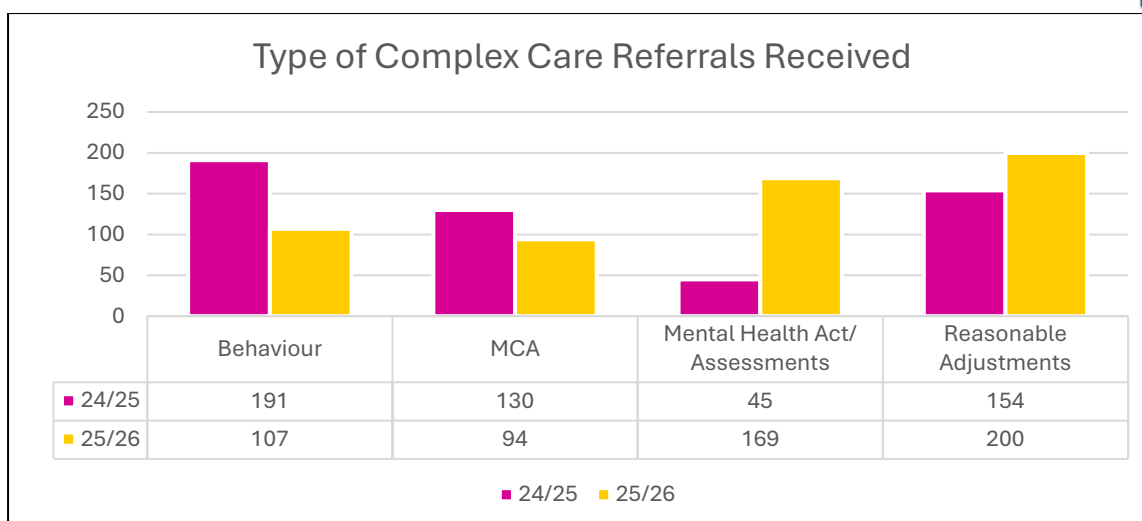
Referrals relating to complex Mental Capacity Act (MCA) issues totalled 94, reflecting continued demand for expert support with decision-making, best interest processes and safeguarding considerations within acute care settings.

Reasonable adjustment activity remained high, with 200 referrals received and 228 reasonable adjustment risk assessments completed. This sustained level of activity builds on the significant increase seen in the previous year and demonstrates continued improvement in recognising and responding to the needs of patients with learning disabilities, autism and other vulnerabilities.

The nature of reasonable adjustments continues to reflect a personalised and proactive approach to care delivery, including adapted environments, flexible appointment planning, enhanced communication strategies and close coordination with carers and partner agencies.

This sustained level of activity supports delivery of the Trust's externally mandated priorities, including the Learning Disability and Autism improvement standards and Dementia-Friendly Hospital standards, demonstrating continued progress in providing personalised, equitable and legally compliant care.

Overall, the data reflects a highly complex patient cohort requiring coordinated, legally informed and person-centred care. The increasing volume and acuity of referrals provides assurance of improved identification of need, while highlighting the ongoing requirement for specialist expertise, staff support and system-wide collaboration to meet demand effectively.



Learning Disability and or Autism

An estimated 1.5 million people in the UK live with a learning disability, and over 10% are diagnosed with autism spectrum disorder. These individuals often require more frequent healthcare and are at increased risk of poorer outcomes and unequal treatment. Under the Equality Act 2010, the Trust is legally required to make reasonable adjustments for patients with learning disabilities and/or autism, regardless of whether care is planned or unplanned.

To meet these needs, the Complex Care Team, within the Safeguarding and Complex Care service, provides tailored support including accessible information, clinical guidance, support with hospital preparation, and coordination of appointments and best interest processes.

In 2025/26, governance processes continued to mature through effective use of the electronic patient record system. Patients with a recorded diagnosis of learning disability and/or autism were automatically identified through diagnostic coding, enabling daily reporting and proactive review of patients attending or admitted to the Trust.

During the year, 479 patients with a learning disability and 709 patients with autism accessed Trust services. Many patients had multiple attendances, resulting in 1,059 attendances for patients with a learning disability and 1,059 for those with autism. This represents a significant increase in activity compared to 2024/25 and highlights both rising demand and improved identification of this cohort. The number of patients with a Learning Disability and/or Autism flag indicating the need for reasonable adjustments increased to 724 in 2025/26, demonstrating continued progress in embedding personalised care approaches. For all identified patients, a reasonable adjustment flag is added to their electronic record, triggering prompts for staff to consider and implement appropriate adjustments in care delivery.

Quarterly audits continue to provide assurance against key standards, including the presence of alerts and flags, availability of hospital passports, referral to the Safeguarding and Complex Care Team, and evidence of implemented reasonable adjustments. Learning from these audits is reported

through the Safeguarding Assurance Committee and cascaded across the Trust to support continuous improvement.

Overall, this work demonstrates sustained progress in improving equity of access and outcomes for patients with learning disabilities and autism, underpinned by strengthened governance, improved identification and a proactive, personalised approach to care delivery.

Patients who have received support from the Complex Care Team, as well as those who have accessed wider hospital services, are invited to share their feedback via a form accessible through a QR code. Although response rates remain limited, the feedback received so far has included several positive reflections, highlighting both individual care experiences and broader aspects of hospital support.

Feedback from patients who have additional needs

Enjoyed the friendliness and staff have been kind to me. Nervous about going to the scan but they helped me.

Asked for reasonable adjustments on our arrival to the emergency department. Told, we wouldn't get seen any earlier than anyone else by receptionist. No room to change and wait was excessive.

Couldn't ask for better

She needs a hoist, and this was available for her. Great staff .. very supportive and helpful. Thankyou.

Grateful for the side room whilst waiting for the appointment.

STOMP (Stopping over-medication of people with a learning disability, autism or both with psychotropic medicines)

In 2025/26, the Trust continued to embed STOMP principles across clinical practice, with training delivered through F1 induction and pharmacy teams, alongside integration into ward-based pharmacy care plans.

Audit activity undertaken as part of the Learning Disability and Autism programme continues to provide assurance that prescribing practices remain aligned with national STOMP standards, with no evidence of inappropriate over-medication identified.

Learning from Lives and Deaths- People with a Learning Disability and Autistic People (LeDeR)

The Trust has implemented robust governance and reporting structures to support the Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR) programme. These ensure that reviews are completed in a timely, transparent, and person-centred manner, with clear accountability. Oversight is embedded within the Trust's Learning from Deaths framework, with monthly reports capturing key learning and informing service improvements.

In 2025/26, the Trust referred 13 patients to the LeDeR programme, an increase from 7 in 2024/25 and 2 in 2023/24. This upward trend provides assurance that processes for identifying and referring

eligible patients are becoming more embedded across the organisation, supported by stronger governance and oversight through the Learning from Deaths framework. 3 Structured Judgement Reviews (SJRs) were also received, adding further opportunity to triangulate learning from mortality review processes. Themes and outcomes from LeDeR reviews are shared with relevant clinical and operational teams, supporting targeted learning and service improvement for people with a learning disability and autistic people. The increase in referrals also highlights the need for continued monitoring to ensure that learning is translated into measurable improvements in patient experience,

The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

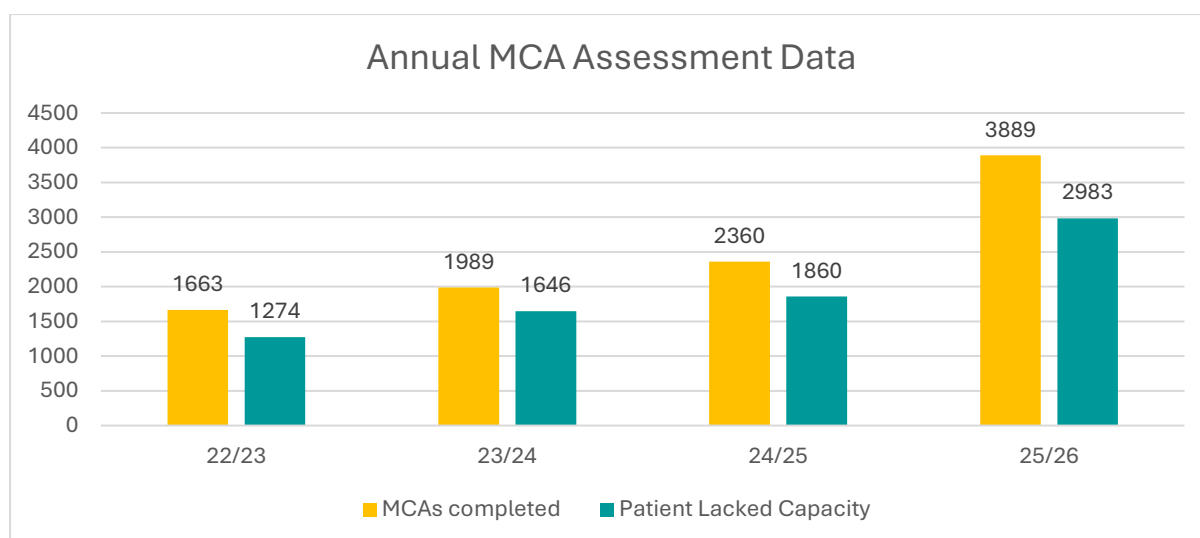
The Mental Capacity Act (MCA) protects and empowers individuals aged 16 and over who may lack the capacity to make decisions about their care and treatment. It applies to a wide range of patients, including those with dementia, delirium, learning disabilities, brain injury and other conditions affecting decision-making ability.

In 2025/26, the Trust completed 3,889 mental capacity assessments, a significant increase from 2,360 in 2024/25. This sustained upward trend reflects both the increasing complexity of the patient population and improved awareness and application of the Act within clinical practice.

Of these assessments, 2,983 concluded that the patient lacked decision-specific capacity, representing a consistently high conversion rate. This reinforces the critical role of MCA assessments in supporting safe, lawful and person-centred decision-making across the organisation.

The scale and complexity of this activity has placed increasing demand on clinical teams and the Safeguarding and Complex Care service. This has been recognised at Executive level, with escalation highlighting the operational impact and the need to ensure sufficient support, training and governance arrangements are in place.

Overall, this data provides assurance that the Trust continues to embed the principles of the Mental Capacity Act in practice, while also highlighting the growing demand associated with supporting complex decision-making in an acute setting.



Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

In 2025/26, the Safeguarding and Complex Care Team continued to strengthen delivery of the Mental Capacity Act (MCA) across the Trust. Increased visibility within clinical areas and a proactive, hands-on approach have supported staff to complete high-quality mental capacity assessments and apply the principles of the Act consistently in practice. This has been further supported by improved safeguarding training compliance and a continued focus on embedding legal literacy within frontline teams.

Where patients lack capacity and are subject to restrictions that may constitute a deprivation of liberty, during 25/26 the Trust had a legal duty to apply for DoLS authorisation to ensure care is delivered in the patient's best interests and in the least restrictive way.

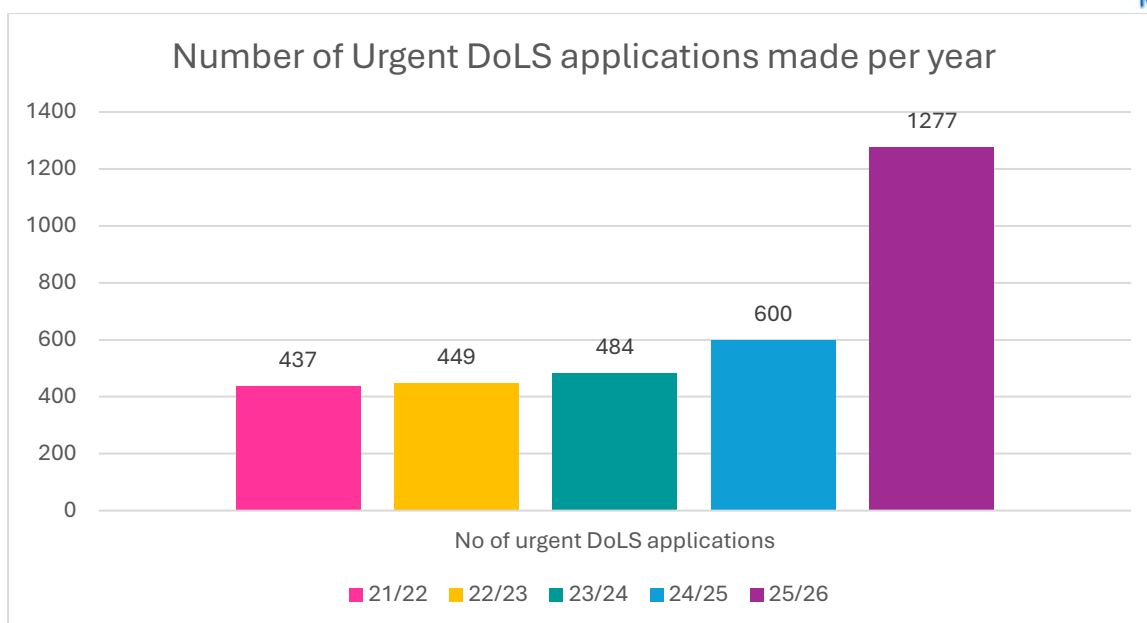
In 2025/26, the Trust submitted 1,277 urgent DoLS applications, more than double the 600 applications submitted in 2024/25, and a significant increase from previous years (484 in 2023/24, 449 in 2022/23 and 437 in 2021/22). However, only 55 standard authorisations were granted, highlighting system-wide pressures within managing authorities and delays in progression. This sustained and accelerating rise reflects both increasing patient complexity and improved recognition of deprivation of liberty within clinical practice.

To support consistent identification, a mandatory screening tool remains in place for all inpatients where the MCA applies. The Complex Care Team continues to provide oversight during the authorisation period, supporting clinical teams to ensure care is lawful, proportionate and person-centred.

Personalised care has continued to improve, with most patients subject to DoLS having a "This is Me" document or patient passport in place, supported by electronic alerts to guide care delivery. This has required sustained organisational focus and is now monitored through the MEG audit process.

Collaboration with the volunteer service has supported completion of patient passports, enhancing the quality of personalised information available.

The scale of DoLS activity continued to place significant operational demand on teams, reflecting both increasing patient complexity and the requirements of maintaining legal compliance.



In 2025/26, the Trust made 30 referrals to Independent Mental Capacity Advocates (IMCAs) for patients who lacked the capacity to make key decisions about serious medical treatment or changes in accommodation, and who had no appropriate family or friends to consult. IMCAs play a vital role in safeguarding the rights of these individuals and ensuring that decisions made on their behalf are in their best interests.

In addition, two members of the team completed Best Interest Assessor training, enhancing internal capability to support DoLS activity, ensure robust threshold application and provide effective scrutiny aligned to external managing authority expectations

Dementia

Dementia is a progressive condition affecting cognitive function and decision-making, with many patients requiring additional support during hospital care. The Trust continues to meet its legal duties under the Equality Act 2010 by ensuring reasonable adjustments are in place to support personalised care.

In 2025/26, there were 2,682 attendances where patients had a recorded diagnosis of dementia, reflecting the significant impact of this cohort within the acute setting.

The Complex Care Team continues to promote the use of the “This is Me” document to support person-centred care, capturing key information about patients’ preferences, routines and communication needs. While implementation has required sustained effort, this is now embedded within the MEG audit process to strengthen compliance and oversight.

This work supports delivery of the Dementia-Friendly Hospital standards, improving patient experience, reducing distress and enabling more personalised and responsive care

Mental Health and Mental Health Act (MHA)

Mental health forms a key component of the Trust's Complex Care agenda, recognising the intersection between mental health need, safeguarding and mental capacity. The Safeguarding and Complex Care Team provides oversight, assurance and support to clinical teams managing patients with complex mental health presentations within the acute setting.

While most individuals presenting with mental health needs are admitted informally, some require detention under the Mental Health Act (1983) where there is a risk to themselves or others and urgent treatment is required.

In 2025/26, 51 patients were detained under the Act, an increase from 33 in 2024/25. This rise reflects both increasing patient complexity and system pressures, particularly the limited availability of mental health beds, resulting in more patients being managed within the acute hospital setting. This figure excludes patients detained by other Trusts and are patients to the Trust on Section 17 leave requiring acute medical care.

Assurance processes remain robust, with all detentions subject to appropriate review and scrutiny, and documentation completed in line with Trust policy.

The Emergency Department continues to experience sustained demand from patients presenting with mental health needs, often with prolonged lengths of stay linked to delays in accessing mental health beds and specialist review. This has required strengthened oversight, including daily reviews of mental health patients, verification of care and safety plans, and ongoing audit activity to maintain patient safety.

Significant progress has been made in strengthening governance and assurance. The Mental Health Steering Group now reports into a joint committee with Cheshire and Wirral Partnership, ensuring executive oversight of risk, demand and service gaps. A revised Mental Health Act Service Level Agreement has been agreed, clarifying roles, responsibilities and escalation processes between organisations for those patients who are detained.

Work to align services with Core 24 standards has identified ongoing gaps in consultant psychiatry provision, out-of-hours cover and timeliness of mental health review. A programme of work is underway to address these through improved workforce planning, pathway redesign and system-wide collaboration.

Digital developments, including the introduction of a mental health dashboard, are improving visibility of demand, risk and performance within the Emergency Department. While data maturity remains variable, this represents a significant step forward in strengthening assurance and identifying areas for improvement.

Overall, the increase in MHA activity and sustained ED pressures highlight the growing complexity of mental health need within the acute setting. The Trust has responded through strengthened governance, improved assurance processes and closer partnership working, while recognising the continued requirement for system-wide capacity and investment to meet demand safely and effectively.

6. Training

Safeguarding education forms the foundation of safeguarding competence across the workforce. All safeguarding training delivered within the Trust aligns with the standards outlined in the Intercollegiate Safeguarding documents:

- *Adult Safeguarding: Roles and Responsibilities for Healthcare Staff* (RCN, July 2024)
- *Safeguarding Children and Young People & Children and Young People in Care: Competencies for Health Care Staff* (Intercollegiate Document, 5th edition, 2025)
- *Prevent Training and Competencies Framework* (DHSC, 2025)

The Trust's safeguarding training Key Performance Indicators (KPIs), agreed locally with the Integrated Care Board (ICB), are set at 90% compliance. Training is inclusive of all staff and delivered through a range of formats to suit different learning styles, including eLearning modules and full-day face-to-face sessions.

All safeguarding training packages are reviewed annually to ensure alignment with current legislation, statutory guidance, and learning from safeguarding reviews and incidents. In 2025/26, the Trust developed a comprehensive safeguarding training strategy, underpinned by a detailed Training Needs Analysis (TNA), to support its strategic objectives.

To assess the impact of training on staff behaviour and patient outcomes, the Trust monitors:

- Compliance with safeguarding children and adult policies and procedures
- The number of appropriate referrals made to the Safeguarding Team

Training Compliance as of 31 March 2025:

Level 1 Safeguarding Adults	92%	Level 1 Safeguarding Children	92%
Level 2 Safeguarding Adults	93%	Level 2 Safeguarding Children	93%
Level 3 Safeguarding Adults	92%	Level 3 Safeguarding Children	91%
Level 4 Safeguarding Adults	100%	Level 4 Safeguarding Children	100%

Safeguarding training compliance remained strong throughout 2025/26, with the Trust achieving compliance above the agreed 90% threshold across all areas of the safeguarding training portfolio. This included safeguarding adults and children training, Prevent training and the Oliver McGowan Mandatory Training, providing assurance that statutory and mandatory safeguarding training requirements were met.

Compliance was maintained across all divisions, supported by effective managerial oversight, staff engagement and local monitoring arrangements. Where individual gaps arose during the year, these were addressed through established divisional reporting and escalation processes, including additional oversight for Level 3 medical staff where required. Overall, the annual training position provides strong assurance that safeguarding training is embedded across the organisation.

Specialist and Bespoke Training

Staff working in maternity and paediatrics also receive enhanced Level 3 safeguarding training tailored to local and national priorities. In 2025, the focus was on perplexing presentation as well as the pre-birth risk assessment, aligned with the Safeguarding Children Partnership's priorities.

Safeguarding Children training is also delivered to all new junior doctors rotating through the Emergency Department by the Named Doctor and Nurse for Safeguarding Children. Key topics include non-accidental injuries, child exploitation, and child mental health.

Additionally, the Safeguarding and Complex Care Team has delivered bespoke training on dementia, the Mental Capacity Act (MCA), and domestic abuse. These sessions have been offered both as online "lunch and learn" bite-sized modules and in-person training. Chaperone training has become mandated.

Mental Capacity Act Training Framework

A revised Mental Capacity Act (MCA) training framework has been developed to provide a structured learning pathway aligned to staff roles and responsibilities. The programme strengthens understanding of capacity, consent, best interests, deprivation of liberty and safeguarding, supporting both legal compliance and high-quality patient care. The framework is currently being piloted with Therapy Services to evaluate its effectiveness before wider implementation across the Trust.

Dementia Training

In 2025/26, the Trust's dementia programme was formally accepted for Trust-wide rollout, with implementation planned for 2026/27 in line with Dementia-Friendly Hospital standards.

This reflects sustained progress in embedding dementia awareness and personalised care approaches across clinical areas, building on the foundations established through the pilot programme.

The Oliver McGowan Mandatory Training programme

In 2025/26, the Trust continued to progress delivery of the Oliver McGowan Mandatory Training (OMMT), with over 500 staff trained to date. A cohort of trained facilitators is now in place to support wider rollout.

Delivery has progressed at a measured pace pending further national guidance from the ICB; however, strong engagement has been maintained through regional networks, with the Associate Director of Nursing actively contributing to the monthly OMMT forum.

E-learning compliance remains high at 93%, providing assurance of baseline competence in learning disability and autism awareness across the workforce, while face-to-face delivery continues to develop in line with national direction.

7. Multiagency Reviews

During 2025/26, the Trust actively contributed to several external safeguarding reviews. Members of the Safeguarding and Complex Care Team supported these processes by submitting detailed patient

chronologies, attending multi-agency panel meetings, and working collaboratively with safeguarding partners to shape final reports and recommendations.

A Child Safeguarding Practice Review (CSPR) or Safeguarding Adult Review (SAR) is commissioned when a child or adult has died or been seriously harmed due to abuse or neglect, and there are concerns that agencies could have worked more effectively to protect them. A Domestic Abuse Related Death Review (DARDR) is undertaken when the death of a person aged 16 or over appears to have resulted from violence, abuse, or neglect by a relative, intimate partner, or household member.

The table below outlines the Trust's contributions to these reviews during 2025/26.

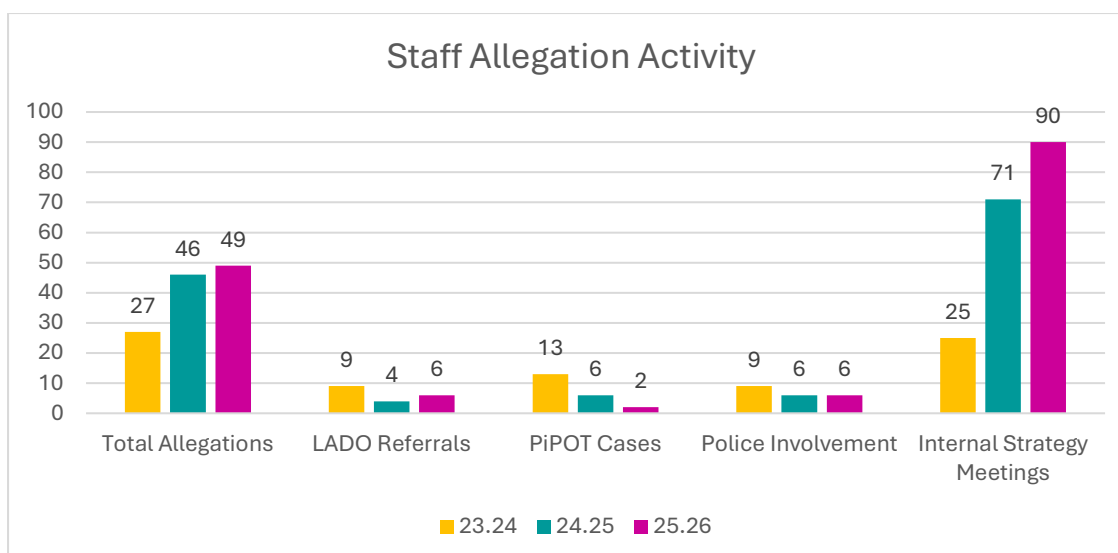
	Chronologies Submitted	Panel Membership
Child Safeguarding Practice Reviews	1	0
Safeguarding Adult Reviews	3	0
Domestic Abuse Related Death Review	4	3

The main pressure during 2025/26 has related to the increase in Domestic Abuse Related Death Reviews (DARDRs), with four chronologies submitted and Trust representation on three panels. This has required significant specialist input and has reinforced the importance of early identification, robust screening and effective information sharing in domestic abuse cases. The work undertaken during the year, including the introduction of domestic abuse screening within Emergency Department triage and continued strengthening of safeguarding processes, directly supports this learning and the Trust's wider commitment to improving recognition and response to domestic abuse risk.

8. Allegation Management

In cases where safeguarding allegations are raised against staff, the Trust adheres to established procedures, including those outlined by Cheshire West and Chester's LADO and the PiPOT framework. The Associate Director of Nursing (Safeguarding and Complex Care) leads the coordination of internal strategy meetings and ensures appropriate escalation to external agencies when necessary, including the Local Authority, Police, professional regulators, and the Controlled Drug Accountable Officer (CDAO). Executive oversight is maintained throughout, and a quarterly thematic report is submitted to the Safeguarding Assurance Committee.

In 2025/26, the Trust held 90 internal strategy meetings relating to allegations management, compared with 71 in 2024/25 and 25 in 2023/24. This represents a further 26.8% increase from the previous year and demonstrates a sustained rise in internal safeguarding activity. The number of allegations also increased slightly, from 46 to 49, suggesting that staff continue to recognise concerns and use established reporting routes. Although internal activity has increased, referrals to external bodies, including the LADO and PiPOT processes, have remained stable. This provides assurance that concerns are being considered at the right level, with external escalation used appropriately where thresholds are met. Overall, the data indicates a maturing internal allegations management process, supported by effective collaboration between Safeguarding, HR and operational teams, and a culture that promotes early discussion, proportionate response and transparency.



9. Partnership Working

The Trust is a well-established and active partner within the multiagency safeguarding framework, playing a central role in promoting the safety and wellbeing of both children and adults. In 2025/26, the Trust contributed to a wide range of multiagency safeguarding activities, including child death reviews, multiagency practice reviews, and thematic audits. These contributions not only demonstrate the Trust's commitment to safeguarding but also ensure that learning from complex cases is shared and embedded across the wider health and care system.

The Trust continues to be a key voice in strategic safeguarding discussions, with representation on several high-level boards and partnerships. The Director of Nursing and Quality (Executive Lead for Safeguarding), or their deputy, attends the Cheshire West and Chester Safeguarding Children Partnership key meetings and the Local Safeguarding Adult Board. The Associate Director of Nursing for Safeguarding and Complex Care also represents the Trust on the Cheshire West and Chester Domestic Abuse Board and the Learning Disability Partnership Board.

Named Professionals within the Safeguarding and Complex Care Team ensure consistent representation across all relevant partnership subgroups. Their involvement is not only strategic but also operational, enabling timely escalation of specific patient concerns where safeguarding risks are identified. In all such cases, the patient remains at the centre of decision-making, ensuring that safeguarding actions are proportionate, person-centred, and aligned with multiagency protocols.

10. Conclusion

The 2025/26 Safeguarding and Complex Care Annual Report evidences a significant increase in activity across all areas of the agenda, reflecting both the growing complexity of patient needs and the Trust's strengthened safeguarding culture. This rise is underpinned by improved staff knowledge, confidence, and visibility of the Safeguarding and Complex Care Team, alongside a broader societal shift in the volume and nature of safeguarding concerns presenting in acute care.

The report highlights the delivery of key workstreams that have resulted in:

- Strengthened governance and executive oversight
- Statutory compliance through named professionals and robust partnership engagement

- Clear, accessible policies and procedures
- Streamlined referral and escalation processes
- A proactive approach to learning, with incidents and reviews informing continuous improvement

The Trust's active participation in multiagency reviews, audits, and strategic boards demonstrates its commitment to collaborative safeguarding and system-wide learning. The increase in internal strategy meetings, alongside a reduction in external escalations, reflects a maturing safeguarding infrastructure with well-understood thresholds and timely, proportionate responses.

This report provides assurance that the Trust continues to meet its statutory safeguarding responsibilities and remains committed to delivering safe, person-centred care for all patients, particularly those who are most vulnerable. The priorities identified for 2026/27 will build on this foundation, ensuring that safeguarding and complex care remain embedded in clinical practice and aligned with both local and national expectations.

Key Priorities Moving Forward

The service has identified areas for further strengthening and improvement, with clear objectives for 25/26 (Appendix 3). These priorities are reviewed quarterly at the safeguarding and complex care assurance committee and reflect the strategic objectives of both the Trust and external bodies (mainly the Local Safeguarding Adult Board and Safeguarding Children Partnership).

11. References

HM Government (2025) [Working together to safeguard children 2025: statutory guidance \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)

Prevent Training and Competencies Framework (DHSC, 2025)

RCN (2025) Adult Safeguarding: Roles and Responsibilities for Healthcare Staff

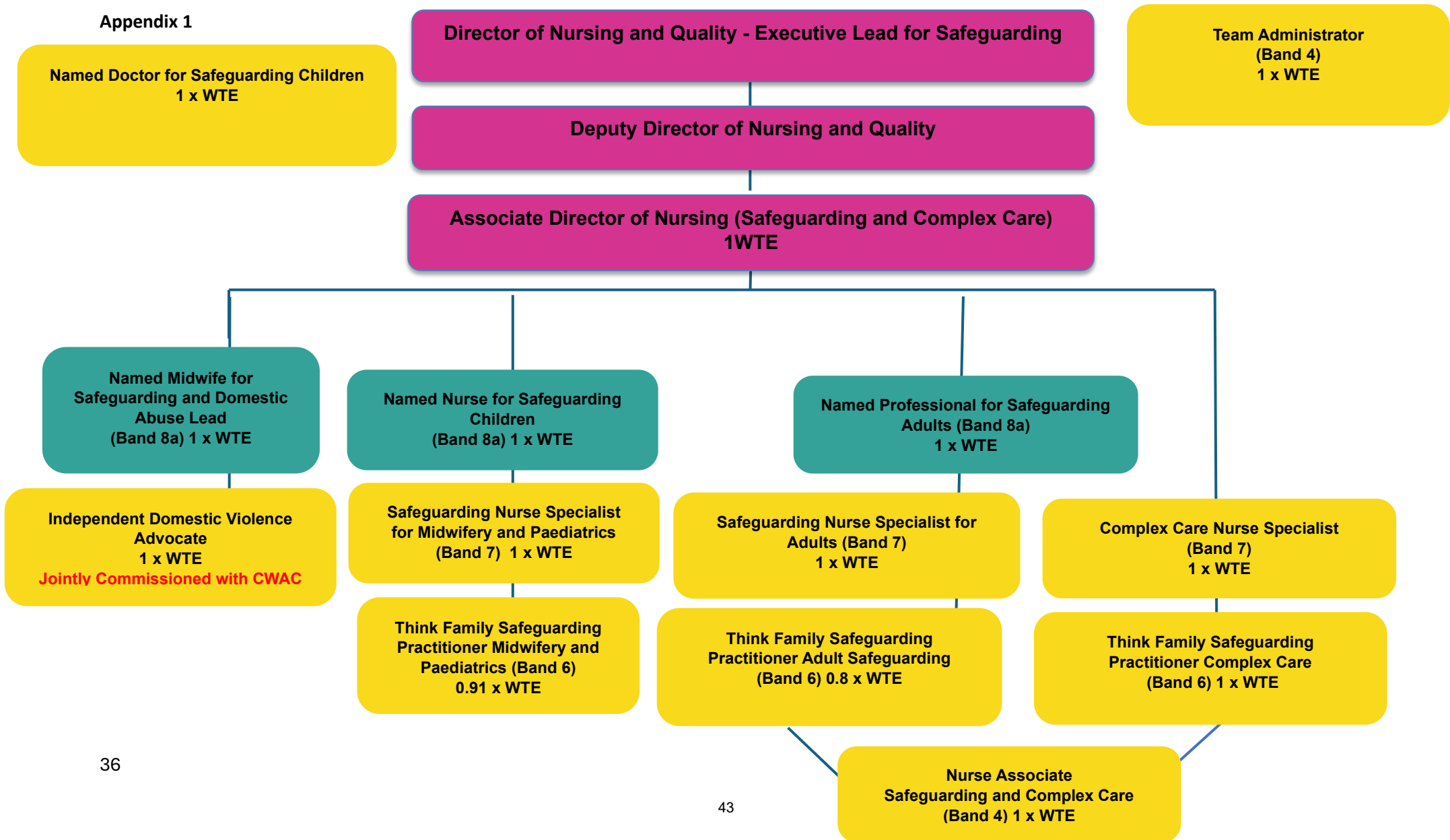
RCN (2024) Safeguarding Children and Young People & Children and Young People in Care: Competencies for Health Care Staff (Intercollegiate Document, 5th edition, 2025)

Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern - GOV.UK (www.gov.uk)

Safe Lives, <https://safelives.org.uk/health-pathfinder> (2020) a domestic abuse charity.

SAFEGUARDING AND COMPLEX CARE

Appendix 1



Appendix 2- TERMS OF REFERENCE

Safeguarding & Complex Care Assurance Committee

Constitution	The Trust Board hereby resolves to establish a Safeguarding & Complex Care Assurance Committee (formerly the Think Family Safeguarding Steering Group), which has no executive powers other than those specifically delegated in these Terms of Reference.
Purpose	The Safeguarding & Complex Care Assurance Committee reports to the Quality Governance Group and is responsible for ensuring that Safeguarding is a strategic objective within the Trust providing strong leadership and divisional accountability by making Safeguarding integral to care.
Membership	The following member are required to attend: Director of Nursing & Quality (Executive Lead and Chair) Associate Director of Nursing, Safeguarding & Complex Care (Vice Chair) Named Nurse for Safeguarding Children & Operational Service Lead Named Midwife & Lead for Domestic Abuse Named Professional Safeguarding Adults Named Dr. Safeguarding CoCH Medical Lead for Adult Safeguarding Divisional Director of Nursing – Planned Care Divisional Director of Nursing – Urgent Care Divisional Director of Midwifery – Women and Children’s Independent Domestic Violence Advocate Safeguarding and Complex Care Team members Head of Quality Head of Nursing – Planned Care Head of Nursing – Urgent Care (ED) Head of Nursing – Urgent Care Head of Nursing- Ellesmere Port Head of Nursing- Paediatrics Inpatient Lead Therapist Designated Doctor for Safeguarding Cheshire West Representative from Betsi Cadwaladr health Security Manager & Local Security Management Specialist Senior Manager, Adult Safeguarding, Cheshire West & Chester Council Senior Manager, Children’s Safeguarding, Cheshire West & Chester Council CWP – Operational Lead Urgent Care First Response Service NHS Cheshire CCG
Attendance	The minutes of the meeting will record the names of the members attending and apologies given.
Quorum requirements	A quorum shall consist of a minimum of 7 members, 1 of which must be the Director of Nursing & Quality or the Associate Director of Nursing,

	Safeguarding & Complex care, in order to Chair the meeting. There must also be at least 1 Senior representative from the Safeguarding & Complex Care Team, 1 representative from each key area (Women & Children's, Planned Care, Urgent Care, ED) and 1 external partner member from either the CCG or LA. Other members unable to attend should endeavour to send a representative able to contribute to the business of the meeting.
Frequency of meetings	The committee will meet quarterly, although additional ad-hoc meetings may be arranged where necessary to deal with any issue which requires an early response. Emergency meetings are subject to: • Consent of the Chairperson. • When a written request from a group member is received.
Responsibilities & Objectives	• To ensure that safeguarding standards are monitored, and reporting mechanisms are properly established and working throughout the Trust so assurance can be given to the Board . • To ensure that the Trust has an effective and robust safeguarding and complex care strategy. • To provide an annual assurance report to the Board of Directors on all issues relating to Safeguarding (Adult & Children) and Complex Care. • To ensure systems and processes are in place to detect, prevent and respond to concerns about abuse or neglect and ensure that lessons learnt from incidents are disseminated across the Trust. • To approve policies and procedures relating to safeguarding issues and ensure that these are impact assessed to meet the requirements of specific at-risk groups. • To ensure that statutory requirements are met and responding to external enquiry/ recommendations in relation to safeguarding. • To ensure that the Trust is reporting effectively to external agencies when we have safeguarding concerns. • To review all high-level reports/recommendations and national documents relating to safeguarding and provide a response to the Quality Governance Group. • Monitor action plans to support implementation of these within Divisions and the improvements made through a standing agenda item. • To share progress against identified Safeguarding & Complex Care priorities. • To receive update reports from Safeguarding & Complex care working groups. • To review patient experience feedback from a variety of sources to inform future direction and ensure that the patients and family voice is heard.

	• Ensure that improved communication occurs from team to team through incident discussion and monitoring so that the Trust is more responsive to safeguarding issues that may be linked across the Trust and/or require Trust-wide action and shared learning. • To receive details of safeguarding DATIX Incidents, SCP & LSAB Serious Case Reviews, Safeguarding Children Partnership (SCP) multi-agency case reviews, Practice Learning Reviews (PLR), Domestic Abuse Homicide reviews and incidents reported to the Strategic Executive Incident System (StEIS) and the National Patient Safety Agency (NPSA) and ensure that there is Trust-wide shared learning to improve practice and prevent events such as these reoccurring. • To receive relevant updates from the SCP and LSAB main Boards and relevant subgroups as appropriate. • To ensure that a robust 'Transition' process from Children's to Adults services is in place throughout the Trust. • Discuss and resolve issues relating to adults at risk and children so improving their care pathway and ensuring improved outcomes. • Lead a corporate approach to any required change. • To ensure that the safeguarding of children, young people and adults at risk are recognised as a corporate issue.
Administration	The PA to the Deputy Director of Nursing & Quality shall act as administration for the committee to include papers and minuting arrangements.
Accountability & Reporting arrangements	The committee reports to the Quality Governance Group. A Chairs report will be produced after each meeting, and this will be received at QGG. The Safeguarding & Complex Care Assurance Committee Annual Report will be received by the Board of Directors.
Review arrangements	The Terms of Reference shall be reviewed on an annual basis and/or if there are any changes in legislation or direction which affect the purpose of the group.
Document owner	Director of Nursing & Quality/Executive Lead for Safeguarding.

Appendix 3

Safeguarding & Complex Care Priorities Implementation Action Plan 26/27

Service Specific	Priority Action
Strategic	To design and implement a structured safeguarding placement programme for nursing students that enhances early professional competence in recognising, assessing, and responding to safeguarding concerns across adults, children, and complex care pathways.
Complex Care	Develop and implement a ward-based “Boredom Box” programme to support therapeutic engagement for patients with additional needs.
	To strengthen the Trust’s approach to Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) activity by embedding a consistent, system-wide framework that enables timely, lawful and high-quality decision-making. This will ensure staff are supported to apply MCA principles confidently, manage increasing demand proportionately, and deliver safe, person-centred care in line with statutory requirements.
Children	To improve the consistency and quality of safeguarding practice within the Emergency Department by implementing a structured, system-wide framework that supports timely identification, appropriate escalation, and effective management of safeguarding concerns.
Adults	Implement a structured programme to improve staff knowledge and confidence in recognising safeguarding adult concerns, with a clear focus on applying Section 42 thresholds.
Maternity	Implement a standardised safe sleep risk assessment for all families, with targeted safe sleep action plans for those identified as high risk.
	To launch a new Female Genital Mutilation (FGM) pathway for midwives, supported by a completed Standard Operating Procedure (SOP) and an associated training package to ensure consistent, safe practice.

MINUTES OF THE PUBLIC BOARD OF DIRECTORS

Tuesday 21st July 2026, 09.00 – 13.15

Women & Children's Building Seminar Room

Members	19/05/26	21/07/26				
Trust Chair, Mr N Large MBE	☒	☒				
Chief Executive Officer, Ms J Tomkinson OBE	☒	☒				
Non-Executive Director, Mr P Jones	☒	☒				
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				
Non-Executive Director, Mr P Williams	☒	☒				
Non-Executive Director, Ms A Simpson	☒	☒				
Non-Executive Director, Mr M Oldham	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, Mrs K Wheatcroft	☒	☒				

Chief People Officer, Ms V Wilson	☒	☒				
Director of Transformation & Productivity, Mr D Nash	☒	☒				
In attendance	19/05/26	21/07/26				
Head of Corporate Governance, Mrs N Cleuvenot	☒	☒				
Director of Midwifery, Ms N Macdonald	☒ (Item 11)	N/A				
Director of Clinical Research, Mr P Bamford	☒ (Item 18)	N/A				
Deputy Director of Nursing & Quality, Ms M Kynaston	☒ (Item 3)	☒ (Item 11b)				
Practice Development Nurse, Ms K Jones	☒ (Item 3)	N/A				
Directorate Manager Planned Care, Mr K Smith	N/A	☒ (Item 3)				
Consultant Urology, Dr S Das	N/A	☒ (Item 3)				
Ward Manager - Ward 42, Ms L Hunter	N/A	☒ (Item 4)				
Associate Director of Pharmacy - Medicines Optimisation, Ms H Stokes	N/A	☒ (Item 15)				
Divisional Director Urgent Care, Mr T Jackson	N/A	☒ (Item 18)				
Associate Director of Estates and Facilities, Mr A Hope	N/A	☒ (Items 22 & 23)				
Head of Midwifery, C Davis	N/A	☒ (Item 11a)				
Deputy Medical Director, Mr I Benton	N/A	☒				

Observers in attendance:

- John Jones – Public Governor
- Liz Kewin Divisional Director – Women & Children's
- Aimee Johnson, Business Development Manager – Xyla
- Zoe Tidman, Health Services Journal
- Kenneth Makusha, Healthcare Account Manager – Fortinet
- Mark Green – OKA People

Agenda No.	Agenda item	Action
1.	Welcome, apologies and Chair's opening remarks The Chair welcomed Board members and attendees to the meeting. Apologies were noted for Mr D Nash, Director of Transformation & Productivity; Dr N Scawn, Medical Director; and Mrs S Corcoran, Non-Executive Director. Mr I Benton, Deputy Medical Director was in attendance on behalf of the Medical Director. The Chair welcomed Mr M Oldham, Non-Executive Director to his first Board meeting following his appointment.	
2.	Declarations of Conflicts of Interest with agenda items There were no declarations of interest to note.	
3.	Service Showcase Mr K Smith (KS), Directorate Manager for Planned Care, and Mr S Das (SD), Urology Consultant, presented the Urology Service Showcase, providing an overview of the Urology Transformation Programme and the progress made in moving the service from recovery to a high-performing and sustainable model. The Board heard that a business case was approved in 2024 in response to significant challenges within the service, including a substandard on-call model, workforce shortages, poor cancer and RTT performance, increasing demand, high clinical risk and non-compliance with GIRFT recommendations. A comprehensive transformation programme was subsequently implemented across six workstreams: workforce, pathways, diagnostics, regional collaboration, innovation and governance. Members noted the significant improvements achieved, including delivery of the Faster Diagnosis Standard improved 18-week RTT performance, elimination of 52-week waits, sustained high performance against diagnostic cystoscopy standards and improved patient flow, reducing average inpatient occupancy from 16.5 to approximately 8–10 patients. The programme had also delivered a more financially sustainable operating model through a substantial reduction in recurrent expenditure The Board was advised that the service was the highest-performing provider in Cheshire and Merseyside for the Faster Diagnosis Standard and ranked 18th nationally out of 118 providers, placing it within the top quartile nationally. Board members also noted improvements in quality and safety, with concerns raised reducing by 63.5% in the first six months of 2026 compared to the same period in 2025. Strong incident reporting and governance arrangements remained in place, with no severe harm incidents reported since 2023. The presentation concluded with an outline of the next phase of development, including the creation of a clinically led five-year strategy focused on clinical excellence, research and innovation, workforce sustainability, meeting future demand and continuous improvement. The	

	ambition is for the service to become a recognised leading Urology service within the NHS. SD reflected on the significant cultural transformation achieved within the service over the last three years and expressed his pride in the team and the support received from the Executive Team. He highlighted the importance of continued investment in workforce development, collaboration and innovation to sustain progress, noting that the service was now attracting high-calibre candidates and was well positioned for future success. Mrs W Williams (WW), Non-Executive Director congratulated the team on the turnaround achieved and the clear vision articulated for the future. Referring to the challenges previously experienced within the service, WW asked about the key factors that had enabled the transformation. SD responded that staff engagement had been fundamental to the programme's success, with new consultants bringing positivity, enthusiasm and a shared commitment to further developing the service. Mr P Jones (PJ), Non-Executive Director thanked the team for the presentation and asked how the lessons learned from the transformation programme could be applied across other services within the Trust. In response, Ms C Chadwick (CC), Chief Operating Officer expressed her pride in the achievements of SD and KS, noting that a key factor had been the willingness of leaders to address professional and working relationship challenges and bring teams together around a common purpose. CC advised that learning from the programme would be shared more widely across the organisation and highlighted plans for KS to utilise this experience in supporting improvement within other services. The Urology transformation was considered an exemplar of successful service turnaround. Mr M Oldham (MO), Non-Executive Director sought assurance regarding the relationship between future investment and efficiency gains achieved through the programme. KS advised that efficiencies delivered within the service had offset investment requirements, with activity plans adjusted to support delivery of the business case. The programme had exceeded its financial objectives, delivering savings in excess of those originally anticipated. Mr J Develing (JD), Director of Strategy and Partnership shared positive feedback received from other patients about the service. He emphasised the importance of ensuring that future service delivery continued to meet the needs of the local population and supported opportunities for greater collaboration with partner organisations to achieve this. Ms J Tomkinson (JT), Chief Executive Officer thanked SD and KS for the presentation and commended the transformational progress achieved. JT noted that the two leaders most closely associated with the programme would shortly be moving into new roles, JT sought assurance regarding the sustainability of the improvements delivered. Members noted the importance of ensuring that the positive culture established within the service remained embedded and that succession arrangements supported the continuation of progress. The Chair on behalf of the Board congratulated the Urology team on the significant improvements achieved and thanked all staff involved in delivering the transformation programme.	
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	The Board noted the Urology Service Showcase. <i>KS and SD exited the meeting.</i>	
4.	Patient Story Ms L Hunter (LH), Ward Manager for Ward 42, presented a patient story regarding a patient who experienced a prolonged hospital stay following colorectal surgery, complicated by post-operative delirium and delays in securing an appropriate placement following medical optimisation for discharge. The Board heard how staff provided compassionate, person-centred care throughout the admission, supporting the patient's wellbeing, dignity and independence while continuing to advocate on his behalf. The story highlighted challenges in complex discharge planning, particularly where discharge arrangements changed and communication across agencies was not fully aligned. Key learning centred on the importance of clear communication, accurate documentation and regular review of discharge plans to avoid unnecessary delays. The Chair on behalf Board thanked LH and the Ward 42 team for sharing the story and recognised the dedication and compassion demonstrated by staff throughout the patient's care. The Board noted the patient story. <i>LH exited the meeting.</i>	
5.	Minutes of the previous meeting held on 19th May 2026 The minutes of the previous meeting held on 19th May 2026 were approved as a true and accurate record of the meeting.	
6.	To consider any matters arising and action and decision log Action 1- the updated IPR would be shared in September following recent updates to the National Oversight Framework. Action 2 – there was no further update on this action and the Chair requested an update on the 0.8WTE trainee contract position in September. Action 3 – it was noted that the GIRFT update was on the agenda. Action closed. Action 7 – it was confirmed that the Charitable Funds Committee effectiveness review would take place in September. The remaining actions were closed.	
7.	Chief Executive Officer's Report The Chief Executive Officer's report was received and taken as read. Ms J Tomkinson (JT), Chief Executive Officer highlighted that the Trust had recently been recognised as one of the ten most improved NHS organisations nationally, reflecting the significant progress achieved across quality, performance and leadership. The Board noted the Trust's improvement in the NHS Oversight Framework and confirmation of an improved provider capability rating from red to amber-red. Members also noted that maternity services had successfully exited the Joint Oversight and	

	Support process, reflecting sustained improvements in safety, quality and patient experience. An update was also provided on the Cheshire and Merseyside Provider Collaborative (CMPC), where Chairs and Chief Executives continued to focus on accelerating the 'left shift' agenda through collaborative working. Members noted the importance of establishing robust governance and decision-making arrangements to support delivery of system-wide transformation programmes. The Board noted the forthcoming opening of the new Chester Haematology Centre, which would provide an enhanced environment for patients receiving treatment for blood cancers and blood disorders. JT also highlighted the success of the Elevate Health Technology Showcase, which demonstrated how digital innovation, technology and cyber solutions could support greater efficiency and improved patient care. Updates were also provided on the national expansion of medical specialty training places, the need to consider the associated workforce and financial implications for the Trust, leadership development opportunities through the new NHS Leadership and Management Framework, and the appointment of Mark Oldham as Interim Non-Executive Director. JT further reported that the Trust's Hospital Sterilisation and Decontamination Unit had achieved 100% compliance across all standards following external audit, recognising this as a significant achievement for the team. Congratulations were also extended to the Hospice of the Good Shepherd on its recent Outstanding CQC rating, with plans for a visit by JT and the Trust Chair. Continued focus on patient safety, learning and continuous improvement was reiterated. Prof A Hassell (AH), Non-Executive Director congratulated JT and the organisation on the positive progress reported, noting the impact on patient care. Referring to the expansion of specialty training places, AH queried whether additional funding accompanied the increase in trainee numbers. JT advised that only limited funding was available nationally and that any additional training posts would require ongoing local financial investment. Dr I Benton (IB), Deputy Medical Director added that challenges also existed around expectations of substantive post conversion and the impact on workforce establishment and headcount planning. Mr P Williams (PW), Non-Executive Director welcomed the positive developments outlined in the report and sought assurance regarding the Trust's response to the recent heatwave, asking whether extreme temperatures were exposing wider estate infrastructure challenges that should be reflected within the Estates Strategy. JT advised that the Trust had responded well operationally; however, limitations remained within older parts of the estate where air conditioning infrastructure was insufficient. Specific mitigations had been implemented, including enhanced hydration arrangements, additional staff breaks and targeted support in high-temperature areas such as catering services. Members noted that the Estates Strategy would consider the resilience of the estate to future periods of extreme weather and climate-related challenges. The Board noted the Chief Executive Officer's Report.	
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8.	Chair's Update The Chair reflected on the significant changes across the NHS, including ICB reconfigurations and the development of provider collaboratives, noting the challenge of keeping pace with the evolving landscape. He highlighted the progress made by the Trust in responding to external scrutiny, strengthening governance arrangements, delivering transformation and increasingly focusing on its future direction. He suggested that, in the autumn, the Board should consider developing a refreshed 'vV'sion' for the Trust, reflecting its aspirations for staff and patients and complementing national and system priorities. Ms J Tomkinson (JT), Chief Executive Officer agreed, noting that the current five-year transformation strategy had been developed in a different organisational context. She advised that the Trust's ambitions had evolved significantly over the last two years and that there was an opportunity to build on the organisation's strengths, including its relationship with the University of Chester and its reputation as a valued partner providing high-quality care. Members supported further work to develop a refreshed organisational vision, informed by staff and stakeholders. Action: The Board to consider a refreshed vision reflecting its aspirations for staff and patients and complementing national and system priorities. The Chair thanked John Jones, Lead Governor for his commitment and support over the course of his 9 years as a Governor and in particular recent years, noting that this would be his final Board meeting in that capacity. The Board noted the Chair's update.	JD
9.	a) Board Assurance Framework and Risk Appetite Statement 2026/27 Mrs K Wheatcroft (KW), Director of Governance and Risk presented the revised Board Assurance Framework (BAF) and Risk Appetite Statement, noting that the framework had been aligned to the Trust's strategic goals and Medium-Term Plan. Members noted revisions to the Risk Appetite Statement, including the addition of a risk-seeking appetite for transformation and an explicit reference to regulatory compliance. A new strategic risk, BAF11 – Transformation, had been added to reflect the critical importance of delivering the Trust's transformation and productivity programme. The Board noted that 7 of the 11 strategic risks remained above the agreed risk appetite and that progress against strategic objectives was aligned to the BAF and monitored through Board committees. Mr P Jones (PJ), Non-Executive Director acknowledged the significant organisational improvements reported across the agenda and queried whether the BAF fully reflected this progress, suggesting that the number of high-scoring risks could obscure the most significant strategic concerns. He also questioned whether there was overlap between the transformation risk and existing risks within the framework. KW responded that the decision to include a separate transformation risk was taken following the Board development session where it was agreed that the Board needed a clear line of sight of transformation recognising its criticality to delivering strategic objectives in 2026/27. The risk scores are continually reviewed and	

	assurance committees would have a key role in ensuring these reflect the current position. The Chair reflected on the substantial progress made by the Trust over the last year and noted that, despite this, several BAF risk scores had remained unchanged. He questioned whether the baseline scoring had been appropriate and suggested that Board committees undertake further review of the risks within their respective areas to ensure scoring remained proportionate to the current position. In response, Ms J Tomkinson (JT), Chief Executive Officer clarified that the BAF was intended to reflect the Trust's strategic risk exposure rather than operational performance improvements. While acknowledging the significant progress achieved, she noted that many risks remained above appetite because long-term assurance was still required to demonstrate that improvements were fully embedded and sustainable. Prof A Hassell (AH), Non-Executive Director provided clarification on the role of Board Committees in reviewing the BAF, noting that committees already scrutinised their respective risk areas. Ms S Pemberton (SP), Non-Executive Director advised that although significant improvements had been made in respect of quality and safety, there remained considerable work to fully embed and sustain those improvements. Ms V Wilson (VW), Chief People Officer added that the People Committee regularly reviewed the workforce-related BAF risk and, whilst progress was evident, consistency and organisational-wide improvement were still developing. Mrs K Edge (KE), Chief Finance Officer similarly noted that the Finance and Performance Committee undertook regular scrutiny of the relevant BAF risks and that the delivery of long-term financial and transformation objectives remained a multi-year programme. The Chair thanked KW for her work in further developing the Board Assurance Framework. The Board: • Approved the 2026/27 Board Assurance Framework, including the addition of the new Transformation Risk (BAF11); • Approved the updated Risk Appetite Statement; and • Noted the progress update against the 2026/27 Strategic Objectives. b) Significant Risks Report (July 2026) KW presented the Significant Risks Report, advising that the report provided oversight of the Trust's highest operational risks, with ten risks currently rated 15 or above. Members noted that the report supported triangulation between divisional risk registers, executive oversight, Board committees and associated assurance reporting. The Board also noted the ongoing work to strengthen risk management processes, risk ownership and reporting arrangements across the Trust.	
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	VW noted that the significant risk relating to the General Surgery on-call model had a workforce dimension and requested that the risk also be reported through the People Committee to ensure appropriate oversight. Members agreed that, whilst workforce implications should be considered by the People Committee, the risk should continue to receive primary scrutiny through the Finance and Performance Committee given its operational nature. The Chair requested an update on actions being taken to address the high number of Non-Criteria to Reside (NCTR) patients, noting the ongoing impact on patient flow and hospital capacity. Ms C Chadwick (CC), Chief Operating Officer advised that discussions had continued with the ICB and wider system partners, including local authorities, NHS England, third sector organisations and Welsh partners. A recent system-wide workshop had explored alternative approaches and learning from other health systems. As a result, a multi-agency taskforce would be established, bringing together senior system leaders to develop a single system plan supported by shared data and oversight arrangements. CC confirmed that she would act as Senior Responsible Officer and Chair of the taskforce and that regular progress updates would be provided to the Board. JT emphasised the importance of translating discussions into measurable and time-bound actions. She noted that increasing numbers of patients who would be better cared for elsewhere were creating significant operational and financial pressures for both the Trust and wider system. Whilst there was clear recognition of the need for change across partners, sustainable improvement would require a different system-wide approach and stronger collective accountability. CC advised that the taskforce would initially focus on establishing clear key performance indicators and accountability arrangements. The Chair welcomed the proposed approach and noted that the development of a coordinated system response was encouraging. Mr P Williams (PW), Non-Executive Director welcomed the progress made in strengthening risk management arrangements and thanked KW and the team for their work. He acknowledged that embedding a positive risk management culture across the organisation takes time and highlighted the important role of the Risk Management Committee and divisional leadership teams. Drawing on recent discussions with a divisional director, PW commented positively on the level of ownership and understanding of risk being demonstrated. He further noted that internal audit assurance had provided confidence that the Trust was moving in the right direction with its approach to risk management. The Board noted the Significant Risks Report and the ongoing work to strengthen risk management across the Trust.	
10.	Quality & Safety Committee Chair's Report – 2nd July 2026 Prof A Hassell (AH), Non-Executive Director presented the Chair's Report, highlighting key areas of assurance received by the Committee. Members noted the recent changes to Deprivation of Liberty Safeguards (DoLS) guidance and Ms S Pemberton (SP), Director of Nursing and Quality/Deputy CEO confirmed that the implications had been communicated clearly across the Trust. Assurance was also received regarding improvements in Urgent	

	and Emergency Care performance, including sepsis management, although some areas continued to require focus. AH reported that the Striving for Excellence Annual Report demonstrated that most areas had achieved a silver rating. Members noted that standards had been strengthened, and areas were now required to sustain performance over a longer period before achieving gold accreditation. The Mortality Annual Report provided assurance that the Trust remained within expected mortality ranges. Following concerns regarding stroke mortality, both the Trust's internal review and the Sentinel Stroke National Audit Programme had confirmed performance remained within expected tolerances. Members also noted progress in reducing the backlog of cancer harm reviews and that the Committee had requested a formal briefing paper on Venous Thromboembolism (VTE) prophylaxis. The Chair welcomed improvements in 12-hour waits but queried the continued increase in Emergency Department attendances. Ms C Chadwick (CC) advised that growth was largely attributable to walk-in attendances, including a significant number of patients from Wales. Work was ongoing with partners across Cheshire West and North Wales to develop alternative pathways and reduce avoidable attendances. Mr J Bradley (JB), Chief Digital and Data Officer added that electronic triage solutions and greater utilisation of primary care services were being explored, although suitable alternatives needed to be available for patients. AH expressed concern regarding the increasing number of Emergency Department attendances, noting that the acute hospital was not always the most appropriate setting for patients and emphasising the importance of developing alternative community-based options. The Board noted the Quality and Safety Committee Chair's Report.	
11.	a) Bi-annual Safer Midwifery Staffing Report – April 2026 (year-end establishment review 1 July to 31 December 2025) The Board received the Bi-annual Safer Midwifery Staffing Report from the Ms C Davies (CD), Head of Midwifery, which provided assurance that maternity and neonatal staffing establishments remained safe, effective and compliant with Maternity Incentive Scheme Year 8 requirements, Ockenden recommendations and national workforce standards. The Board noted continued compliance with the recommended birth-to-midwife ratio of 1:27, 100% compliance with one-to-one care in established labour, and compliance with neonatal workforce standards. CD highlighted workforce transformation activity underway to review patient flow and future workforce requirements. Whilst assurance was provided that patient safety had been maintained, the Board noted increasing workforce pressures, including higher sickness levels, vacancies, increased clinical activity, an increase in reported midwifery red flags and reduced compliance with the Birthrate Plus acuity tool. Recruitment was ongoing for Band 4 and Band 5 midwives. Planned next steps included benchmarking against national standards, including Ockenden recommendations, and progressing the planned induction of labour suite. Ms S Pemberton (SP), Director of Quality and Nursing/Deputy CEO emphasised the importance of the induction of labour suite, and it was	

	confirmed that this would be reported through the relevant oversight committee. Ms J Tomkinson (JT), Chief Executive Officer queried whether the report was out of date given the reporting period covered. CD advised that the report was produced six-monthly in line with requirements; however, consideration was being given to moving to quarterly reporting in response to Ockenden recommendations. Mrs K Wheatcroft (KW), Director of Governance and Risk asked CD to explain the criteria and increase in red flag reporting to the Board. CD clarified that red flags provided assurance that staffing and acuity pressures were being appropriately identified and escalated by senior midwifery staff. Increased reporting was viewed positively as evidence of effective monitoring and escalation processes rather than an indicator of compromised safety. The Board also discussed the timeliness of reporting and noted there may be opportunities to review committee reporting cycles to ensure reports are presented to the Board more promptly. The Board: • Noted the assurance provided within this report. • Confirmed compliance with Maternity Incentive Scheme Year 8 Midwifery Workforce Establishment requirements. • Supported continued workforce planning activity to maintain safe and sustainable maternity and neonatal services. <i>CD exited the meeting.</i> b) Bi-annual Safer Nurse Staffing Report – April 2026 (year-end establishment review 1 July to 31 December 2025) Ms M Kynaston (MK), Deputy Director of Nursing & Quality presented the Bi-annual Safer Nurse Staffing Report, noting that the review covered some of the winter period and provided assurance that nursing establishments had been assessed in line with the NHS England Developing Workforce Safeguards framework. The report confirmed that staffing establishments remained appropriate across most clinical areas, with only four establishment changes recommended, all of which could be achieved through internal resource reallocation. The Board noted continuing operational and workforce pressures, particularly within the Healthcare Support Worker (HCSW) workforce, where vacancy levels, high sickness absence and the need to staff escalation areas continued to place pressure on services. It was reported that stress and anxiety associated with redeployment had been a significant contributory factor to sickness absence. Actions were in place to address this, including reducing escalation capacity where possible, strengthening recruitment pipelines through apprenticeships and local college partnerships, and improving retention initiatives. Assurance was provided that there were no significant concerns regarding the registered nursing workforce pipeline.	
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	The Chair asked about the HCSW staffing gap. SP advised that planning for winter escalation demand was underway and that the Executive Team had agreed an over-recruitment approach to help close the gap. Recruitment was progressing; however, retention remained the key challenge. It was emphasised that workforce retention was closely linked to reducing operational pressures and ensuring the hospital was functioning effectively. Apprenticeship routes were also being expanded to support future workforce sustainability. The Board noted that a previous pause in recruitment to Band 2 and Band 3 roles had contributed to current HCSW workforce pressures. Members queried whether any unfunded escalation areas remained open and sought the Integrated Care Board's view on the position. It was confirmed that unfunded escalation capacity remained in operation, at an estimated cost of approximately £250,000 per month. The Chair commented on the need for wider system support to help reduce demand, particularly through reducing attendances at the Emergency Department. In response to a question regarding whether safer nurse staffing reports would move to quarterly reporting, similar to midwifery staffing reporting, MK advised that there was currently no national requirement to do so and, given the size of the workforce, quarterly reporting would not be achievable. However, additional reviews would be undertaken if specific concerns or triggers arose. The Chair thanked the MK for the report and presentation. The Board: • Noted the assurance provided in the report. • Approved the proposed establishment changes. • Supported the continued strategic focus on workforce sustainability, reducing reliance on temporary staffing, and ensuring staffing models remain aligned to increasing patient acuity and complexity.	
12.	Safety Surveillance and Learning Report – Quarter Four and End of Year 2025/26 Ms S Pemberton (SP), Director of Quality and Nursing/Deputy CEO presented the report, highlighting that the Trust continued to demonstrate a strong learning culture supported by robust governance and oversight arrangements. The Board noted that a recent audit had provided moderate assurance and that the Trust was continuing to embed the Patient Safety Incident Response Framework (PSIRF), with a particular focus during the coming year on organisational learning, improvement and sharing learning across services. The Board noted the range of established forums supporting this work, including the Learning and Sharing Forum, Patient Safety Oversight Meetings and Patient Safety Summits. The Board heard that learning from incidents was supported through a comprehensive programme of audits, investigations and improvement workstreams. It was noted that all deaths were reviewed by the Medical Examiner, with concerns escalated through mortality review processes where appropriate.	

	Members were advised that Patient Safety Incident Investigations (PSIIs) continued to receive robust scrutiny through the weekly Patient Safety Oversight Meeting, attended by Integrated Care Board representatives to provide external oversight and approval of investigations. The importance of demonstrating how learning had resulted in changes to practice and improvements in patient safety was emphasised. SP reported that processes surrounding coronial inquests had significantly improved, with strengthened preparation, governance and oversight arrangements. The Board noted that the Trust had not received any Regulation 28 Prevention of Future Death reports for a number of years and that systems were in place to ensure learning arising from inquests and investigations was captured and shared. The Chair welcomed the report and reiterated the importance of organisational learning, recognising that learning and safety discussions also formed a key part of daily operational oversight through the Trust's 8am call. The Board: • Noted the contents of the report. • Noted the assurance that the Trust continues to promote a learning culture with evident and measurable actions to improve patient safety. • Noted the improvements and sustainability in governance and oversight workstreams across the Trust. • Noted the further improvement work underway in relation to Learning from Deaths and Mortality Reviews. • Noted the status of all StEIS/PSII reportable incidents. • Noted the feedback from the Quality and Safety Committee that future reports should include specific learning, actions and measurable outcomes.	
13.	Quality, Safety and Experience Strategy Update Quarter 4 and End of Year Ms S Pemberton (SP), Director of Nursing & Quality/ Deputy CEO presented the end-of-year update on delivery of the Quality, Safety and Experience Strategy. The Board noted progress against the Strategy's 26 priorities and received assurance that established governance and reporting arrangements were supporting delivery across core, divisional and corporate quality and safety priorities. The report highlighted measurable improvements, including reductions in C. difficile infections, bloodstream infections, falls and hospital-acquired pressure ulcers, alongside improvements in sepsis screening and governance oversight. Members welcomed the report, noting that it provided clear assurance that progress was being made against the objectives set out within the Strategy and that delivery continued to be regularly evaluated. The Board recognised the significant amount of improvement activity being undertaken across the organisation and the positive progress demonstrated against a number of priority areas. Ms J Tomkinson (JT), Chief Executive Officer commented on the timeliness of reporting, noting that where information was of significant value to the	

	Board it should be presented as promptly as possible, whilst recognising the need for reports to progress through the committee structure before reaching the Board. Prof A Hassell (AH), Non-Executive Director advised that the report had been subject to detailed scrutiny by the Quality and Safety Committee and agreed that it provided strong assurance regarding progress against the Strategy and associated improvement programmes. The Board: • Noted the progress against the Quality, Safety and Experience Strategy. • Noted the updates and improvements in both performance and governance across the Strategy's priorities. • Confirmed that future reporting on the Strategy would be provided on a bi-annual basis.	
14.	Mortality Annual Report 2025/26 The Board received the Mortality Annual Report, including confirmation that mortality indicators remained within the expected range, with both HSMR and SHMI reporting within statistical tolerance. The report provided an overview of mortality performance, learning from deaths and the Trust's approach to identifying and reviewing statistical outliers. The Board noted that 100% of deaths continued to be independently scrutinised by the Medical Examiner service. Members heard that the report highlighted both areas for improvement and examples of good care. Learning themes identified through mortality reviews included documentation, deteriorating patients, communication, adherence to guidelines and environmental factors. Mr I Benton (IB), Deputy Medical Director noted that feedback from mortality reviews was often balanced by significant positive learning, particularly relating to compassionate care, communication, end-of-life care and multidisciplinary team working. Weekly scrutiny and feedback from the Medical Examiner service continued to support learning and improvement. The Board was advised that work was underway to improve triangulation of learning across the organisation through the development of a consolidated dataset bringing together learning from mortality reviews, incidents, complaints and other patient safety information. This would support a more comprehensive understanding of recurring themes and opportunities for improvement. Ms J Tomkinson (JT), Chief Executive Officer emphasised the importance of triangulating learning across all available data sources to strengthen organisational learning and assurance. She sought clarification on whether the backlog of mortality reviews had been cleared. IB advised that a backlog remained; however, the review criteria were being reconsidered to ensure resources were targeted appropriately. He also highlighted emerging learning themes identified by the Medical Examiner relating to the prioritisation and location of deaths. Prof A Hassell, Non-Executive Director welcomed the learning identified within the report but queried how assurance was provided that learning was	

	translated into practice improvements. It was noted that this would continue to be scrutinised through the Quality and Safety Committee. Mr P Jones (PJ), Non-Executive Director queried the purpose of the report as described on the cover sheet, noting that it should be considered an assurance document rather than just for information. The Board noted the contents of the Mortality Annual Report 2025/26.	
15.	Controlled Drugs (CDs) Annual Report 2025/26 Ms H Stokes, Associate Director of Pharmacy – Medicines Optimisation presented the annual report, providing assurance that the Trust remained compliant with Controlled Drugs Regulations and had effective systems and processes in place for the safe management of controlled drugs. The Board noted that 288 controlled drug incidents were reported during 2025/26, a 9% increase on the previous year, which was considered indicative of a positive reporting culture and increased learning. No significant themes of concern were identified. The Board noted that the Emergency Department reported the highest number of unaccounted-for losses, with a notable increase in Quarter 4. It was explained that many discrepancies were subsequently reconciled through investigation, although delays in follow-up could affect this. Additional monitoring arrangements had therefore been implemented. Members heard that controls for higher-risk controlled drugs had been strengthened, and a new business intelligence dashboard introduced to improve oversight of lower schedule drugs by comparing medicines supplied against medicines administered. There were also improvements to external intelligence reporting, including the introduction of electronic patient record alerts for patients of concern. The report highlighted improved compliance with safe and secure storage standards, increasing from 87% to 89% during the year. The number of clinical areas achieving 100% compliance rose from four in Quarter 1 to thirteen in Quarter 4, and the Trust's Home Office Controlled Drugs Licence was successfully renewed during the year. Mr M Oldham (MO), Non-Executive Director welcomed the positive report and sought assurance regarding any areas of concern. Mr P Williams (PW), Non-Executive Director also noted that internal auditors had identified some discrepancies in quality spot checks. HS explained that a new QR code reporting process had been introduced, enabling wards to report issues directly into a central inbox and providing a clear audit trail for follow-up actions. The Board sought and received assurance regarding compliance levels across clinical areas and heard that the report demonstrated sufficient compliance and improvement across the organisation. The Chair also queried how many reported incidents remained unresolved. It was explained that a significant proportion of incidents were subsequently closed following investigation, particularly incidents initially recorded as unaccounted-for losses, which were often reconciled through further review. Clarification was provided that 'accounted for' referred to situations where a	

	discrepancy was later explained through investigation and records reconciliation. The Chair thanked the Associate Director of Pharmacy for the report and presentation. The Board noted the assurance provided within the report with regards to the safe management of controlled drugs within the organisation. <i>HS exited the meeting.</i>	
16.	Integrated Performance Report (IPR) Operational Performance • ED four-hour performance was 65.2%, positively exceeding the June plan of 63.1%. • ED 12-hour performance was 19.7%, which was marginally better than plan. • Ambulance handover performance remained strong, with average handover times of 25 minutes, significantly better than plan. • RTT 18-week performance was 67.5%, exceeding the target of 60% and plan by 5.4 • There were no patients waiting over 65 weeks and 52-week waits reduced to 0.7%, better than plan • Faster Diagnosis Standard (FDS) performance was 84.3%, exceeding the national target of 80% for the third consecutive month. • Cancer 62-day performance was 85%, exceeding the target of 75%. • Diagnostic performance improved to 84.0%, above plan. • The Board noted continued reductions in corridor care, zero Never Events, zero StEIS incidents and strong appraisal compliance. • Areas requiring ongoing focus included RTT waiting list growth, Cancer 31-day performance, VTE compliance, sepsis performance, mandatory training compliance and delayed discharges. Ms J Tomkinson (JT), Chief Executive Officer congratulated teams on the positive performance reported across a range of operational measures and asked whether the current position provided sufficient resilience to manage anticipated summer capacity pressures and annual leave. Ms C Chadwick (CC) Chief Operating Officer advised that the Trust had exceeded its year-end trajectory, finishing above the planned RTT position, and that significant planning had been undertaken to account for summer leave. As a result, performance was expected to remain stable and the Trust was well placed to manage seasonal pressures. JT queried how elective activity would be maintained during periods of leave and referred to the use of annualised job plans. CC confirmed that robust theatre scheduling software was in place to maximise capacity utilisation and maintain activity levels. Mrs W Williams, Non-Executive Director raised concerns regarding increased breaches within skin cancer pathways and sought assurance regarding mitigation plans. CC advised that a detailed recovery plan was in	

	place, including insourcing activity and pathway reviews. Some breaches were attributable to patient choice, whilst workforce shortages within plastics services remained a contributory factor. The Chair sought assurance that RTT performance was being subject to detailed scrutiny through the committee structure. CC confirmed that performance was reviewed regularly through the Finance and Performance Committee and a range of operational performance forums. The Chair concluded by congratulating the Emergency Department team for their performance, recognising the achievement in sustaining improvements despite record attendances and continuing operational pressures. Quality • Reduction in falls overall year-to-date, with zero falls resulting in harm reported in June. • Hospital-acquired pressure ulcers reduced in June, alongside a reduction in pressure ulcers present on admission. • Sustained improvement in complaints performance, with reductions in both complaints received and open complaints. • Friends and Family Test positive response rates remained high, although a slight decrease was noted during transition to the new feedback platform • Maternity quality indicators remained stable, with no maternal deaths or stillbirths reported and governance arrangements providing strong assurance Safety • Zero Never Events, zero StEIS reportable incidents and zero mixed-sex accommodation breaches were reported in June. • Mortality indicators (SHMI and HSMR) remained within the expected range, providing assurance regarding quality of care. • Registered and unregistered nurse staffing fill rates remained above target at 96.9% and 96.4% respectively. • Infection control performance remained broadly positive, with a reduction in C. difficile and E. coli cases, although one MRSA case was reported during the month. • Areas requiring continued focus included VTE 14-hour compliance, sepsis clinical assessment and antibiotic compliance, assessment screening compliance and ongoing management of pressure ulcer prevention. People • Staff turnover remained low at 7.0%, below the Trust target of 10%, indicating good workforce retention	
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	• Sickness absence increased to 5.5%, above the 5% target, with stress and anxiety remaining the most common cause of absence. • Appraisal compliance remained above target at 82.5% against the 80% target. • Mandatory training compliance reduced to 88.4%, below the 90% target, largely due to the introduction of revised Conflict Resolution training requirements • Agency nursing spend remained low, with only 19 agency nursing shifts used during June and nursing agency spend representing just 0.7% of the nursing pay bill year to date. The Chair queried the low levels of mandatory training compliance reported within the Corporate Non-Clinical Division. Ms V Wilson (VW), Chief People Officer advised that these were relatively small staff groups and that lower compliance was largely associated with staff who did not routinely access computers as part of their role. Managers receive monthly reports and actions are taken to follow up on non-compliance. The Chair also referred to red-rated areas within the safer staffing data and sought assurance regarding any associated risks. Ms S Pemberton (SP), Director of Nursing and Quality confirmed that staffing gaps were an everyday operational challenge; however, this did not mean services were operating unsafely, as a range of mitigation measures were implemented to maintain safe staffing levels. Action: Mr J Bradley (JB), Chief Digital and Data Officer to confirm whether the staffing tables reflect positions before mitigation actions had been applied. Finance • Month 3 and year-to-date financial performance was delivered in line with plan, with a year-to-date deficit of £5.6m as planned. • Income performance was ahead of plan, supported by non-recurrent income and continued delivery of operational activity assumptions within the Medium-Term Plan. • Pay expenditure remained broadly in line with budget, with the main pressure arising from industrial action cover costs. Workforce numbers remained stable and aligned with expenditure. • Capital expenditure remained on track, with business cases progressing and delivery forecast to be achieved by year-end. • The Trust's cash position remained strong, supported by deficit support funding and higher-than-planned cash balances. • Deficit Support Funding (DSF) had been received for Quarter 1 and approved for Quarter 2, providing confidence in the Trust's financial position and delivery plans. • The principal financial risk remained delivery of the Cost Improvement Programme (CIP), with schemes developing during Quarter 1 and planned delivery increasing significantly from Quarter 2 onwards	JB
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	Mrs K Edge (KE) Chief Finance Officer advised that finance reporting had been incorporated into the Integrated Performance Report to provide a more integrated view of organisational performance. Month 3 and year-to-date financial plans had been achieved despite a number of cost pressures, primarily relating to industrial action, which had been mitigated through other favourable variances. The Board noted that Deficit Support Funding had been received for Quarter 1 and approved for Quarter 2. It was acknowledged that this reflected a level of confidence in the organisation's plans and financial management. Members also heard that income performance remained slightly ahead of plan and that underlying contract performance continued to align with the assumptions set out within the Medium-Term Plan. KE reported that pay expenditure remained broadly in line with budget, with variances largely attributable to industrial action costs. Workforce expenditure continued to be triangulated against workforce establishment and WTE data. Members also noted that capital expenditure remained on track and that the Trust's cash position was currently strong, although some funding would require repayment later in the financial year. The Board was advised that delivery of the Cost Improvement Programme remained the main area of concern. Whilst Quarter 1 targets had been intentionally modest to allow schemes to be developed, planned delivery increased significantly from Quarter 2. Detailed reviews were being undertaken to align CIP forecasts with the overall financial forecast and identify any emerging risks. The Chair welcomed the clear financial summary and noted that CIP delivery remained the principal risk being scrutinised through the Finance and Performance Committee. He stressed the importance of providing early visibility to the Board should delivery concerns emerge. Mr M Oldham (MO), Non-Executive Director queried the apparent upward trend in the pay run rate. KE explained that future expenditure assumptions were linked to planned CIP delivery and that detailed modelling was being undertaken to understand the interdependencies between workforce, productivity and savings plans. Ms J Tomkinson (JT), CEO noted that a big risk to CIP delivery was dependent upon reducing escalation capacity, managing medical staffing costs and delivering agency and variable pay reductions. Members recognised that some mitigating actions may be required during the year and that support from system partners would be needed to address underlying urgent and emergency care pressures. The Board noted the Integrated Performance Report.	
17.	Operational Management Board Chair's Report – 28th May 2026 Ms J Tomkinson (JT), CEO presented the Operational Management Board (OMB) report and advised that a wider OMB and Clinical Leads session had taken place in June and had been well attended and productive. The Board noted that discussions at OMB aligned with the performance, quality and operational issues reported elsewhere on the agenda, providing	

	assurance through triangulation with the Integrated Performance Report and other Board reports. Members were advised that there were no new significant issues requiring escalation to the Board. Existing risks were well understood, clearly articulated and subject to appropriate oversight. OMB continued to provide an effective forum for divisional discussion, challenge and performance oversight. The Board noted the OMB Chair's report.	
18.	Getting It Right First Time (GIRFT) Clinical Operating Standards Urgent Emergency Care (UEC) Mr T Jackson (TJ), Divisional Director for Urgent Care presented an update on delivery of the GIRFT Clinical Operating Standards and progress against key Urgent and Emergency Care priorities. The Board heard that the introduction of the Rapid Assessment and Treatment (RAT) model, supported by nurse-led triage and enhanced patient streaming, had improved front-door flow and reduced the median time to initial assessment to eight minutes, consistently achieving within the 15-minute standard. Increased utilisation of the Urgent Treatment Centre and greater overnight redirection to alternative services had also contributed to improved patient flow and Emergency Department performance. The Board noted that Emergency Department attendances continued to rise significantly, with June 2026 attendances 20% higher than June 2024. Despite this, four-hour performance had improved to 64.8%, with median time to initial assessment and median time to be seen both at their strongest recorded levels. Six priority areas had been identified for the UEC leadership team, including demand management, reducing 12-hour breaches, productivity, budget management, specialty opportunities and further improvements to streaming and initial assessment processes. TJ also outlined progress against the GIRFT Clinical Operational Standards, highlighting achievements in 24/7 laboratory services, NEWS2 compliance, senior clinical advice and admission avoidance, expansion of same day emergency care pathways and implementation of real-time performance dashboards. Ongoing priorities included imaging capacity, senior clinical review timescales, specialty ownership of patients, frailty pathways and workforce sustainability. Workforce constraints remained the principal strategic risk, particularly in relation to achieving a seven-day consultant in-reach model. Prof A Hassell (AH), Non-Executive Director commended the presentation and specifically highlighted the ED attendances graph as a clear and accessible way of illustrating demand trends. The Board discussed the continuing increase in Emergency Department attendances. The Chair noted that whilst significant focus was placed on four-hour and twelve-hour performance metrics, there remained no single system-wide measure or ownership of demand entering the system.	

	Mr J Develing (JD), Director OF Strategic Partnership highlighted local primary care performance data and observed that same-day face-to-face GP access remained comparatively low in some areas. TJ explained that the GIRFT standards represented a set of good practice principles and that, whilst not every standard needed to be achieved at 100%, they provided a valuable framework for prioritising and improving services. The Board noted the positive progress made to date and the favourable feedback received from GIRFT regarding the Trust's approach. Action: The Chair requested that JD add local GP access data alongside Emergency Department attendance data to better demonstrate the relationship between demand and wider system performance. The Chair asked what additional support was required from the Board. TJ emphasised that, whilst many challenges were system-wide, successful delivery also depended upon engagement and support from clinical teams across the organisation, with priorities differing between specialties. Dr I Benton (IB), Deputy Medical Director recognised the scale of the work underway and highlighted specialty in-reach as a key component of delivering the future non-elective care model. He noted the positive feedback already received from GIRFT and commented that overall progress was moving in the right direction. TJ noted that a further GIRFT review visit was planned for the following week. Ms J Tomkinson (JT), CEO thanked TJ for the presentation and acknowledged the significant leadership commitment required to drive improvement within the Emergency Department and urgent care services. In concluding the discussion, the Chair asked if Emergency Department attendances stabilised and the number of patients not meeting criteria to reside reduced as planned, would the Trust be well placed to achieve constitutional standards. Ms C Chadwick (CC), Chief Operating Officer confirmed affirmatively. The Board recognised the significant improvements achieved to date despite continued increases in demand. TJ noted that each additional attendance generated further clinical workload and that, where demand growth was not matched by additional resource, a performance gap would inevitably arise. The Board noted the GIRFT update. <i>TJ exited the meeting.</i>	JD
19.	Finance & Performance Committee Chair's Report – 24th June 2026 Mr M Oldham (MO), Non-Executive Director highlighted key risks relating to fire safety, cyber security and delays to the Ambient Voice Technology (AVT) programme. MO also noted that a number of assurance items had been considered separately through Board agenda reports. MO noted that the Committee had received assurance that the Month 2 financial position remained on plan, with Quarter 1 Deficit Support Funding confirmed. However, delivery of the Cost Improvement Programme (CIP) remained a key risk, particularly as planned savings increase significantly from Quarter 2 onwards. This triangulated with the earlier presentation of the Integrated Performance Report.	

	The Committee also reviewed the Board Assurance Framework and significant strategic risks, including infrastructure, urgent and emergency care performance and financial sustainability. The Board noted the Finance and Performance Committee Chair's report.	
20.	Audit Committee Chair's Report – 14th July 2026 Mr P Williams (PW), Non-Executive Director highlighted the Committee's ongoing concern regarding overdue policies, particularly clinical policies. Whilst progress had been made in reducing the backlog, further work was required to understand the risk and address policies that remained out of date. PW also noted the findings of the MIAA Quality Spot Checks Audit, which identified a high-priority recommendation relating to controlled drugs stock management and governance processes. Actions were being progressed to address the issues identified. The Committee had received assurance regarding progress against the anti-fraud work programme, including achievement of a Green rating against the Counter Fraud Standards, and from the MIAA Internal Audit Progress Report, which confirmed completion of a number of audits and continued progress in implementing audit recommendations. The Board noted the Audit Committee Chair's Report.	
21.	Annual Health & Safety Report (1st April 2025 – 31st March 2026) Mr A Hope (AHO), Associate Director of Estates and Facilities presented the Annual Health & Safety Report, advising that the Trust's health and safety management systems continued to strengthen and remained effective. AHO noted improvements in governance arrangements, contractor management processes, policy reviews and risk assessment programmes, with no evidence of systemic failures identified during the reporting period. Priorities for 2026/27 included embedding revised policies, improving departmental risk assessments and developing management competency through health and safety training. The report noted that 247 health and safety incidents were reported during the year, an increase on previous years. It was explained that increases in reporting, particularly relating to violence and aggression, were considered reflective of a stronger reporting culture, improved staff awareness and enhanced governance oversight rather than evidence of underlying systemic issues. Six moderate harm incidents had been investigated, with appropriate corrective actions and mitigations implemented. Prof A Hassell (AH), Non-Executive Director sought assurance regarding mitigation of the high-rated fire alarm replacement risk. AHO advised that additional funding had been secured through the estates programme for 2026/27, works continued to progress and comprehensive mitigating controls remained in place, including regular testing and detailed contingency arrangements. The risk continued to be closely monitored through governance processes. Mr M Oldham (MO), Non-Executive Director referred to previous discussion at the Finance and Performance Committee confirming that Cheshire Fire	

	and Rescue Service had undertaken a review without identifying significant concerns. It was agreed that this was a good piece of external assurance. MO also commented on the increase in violence and aggression incidents and their alignment with themes emerging from the staff survey and NHS Oversight Framework. It was acknowledged that, whilst reporting had increased, violence and aggression remained an important area of focus for the Trust. Ms V Wilson (VW), Chief People Officer queried the relatively high number of incidents reported within Urgent Care compared with other divisions. AHO advised that this reflected the nature of the clinical environment and patient cohort managed within urgent care services. Further discussion took place regarding sharps and inoculation injuries, with Ms C Chadwick (CC), Chief Operating Officer noting that the reported profile was broadly consistent with expectations for those types of clinical areas. The Chair sought clarification regarding reporting and oversight arrangements. It was confirmed that health and safety performance and risks were reported through the Finance and Performance Committee and supporting governance structures. The Board noted the update.	
22.	Estates Strategy Development Update Mr A Hope (AHO), Associate Director of Estates and Facilities, presented the emerging Estates Strategy and sought a Board sense-check on the proposed strategic direction. He explained that the strategy is intended to position the estate as a strategic enabler of clinical transformation, operational resilience, patient flow, workforce wellbeing and sustainability, rather than simply an infrastructure asset. The strategy aims to align estate development with future models of care, operational requirements and long-term healthcare transformation. Members welcomed the draft strategy and the clear articulation of the estate's role in supporting the Trust's ambitions. AHO noted that, if the estate were designed today, it would likely look very different; however, the strategy must work within the constraints of the existing estate footprint whilst maximising opportunities for transformation. Mr J Develing (JD), Director of Strategy and Partnerships emphasised the importance of patient flow and suggested further consideration be given to climate adaptation and digital opportunities within the sustainability agenda. AHO noted that sustainability, digital transformation and smart estate principles were key cross-cutting enablers within the strategy. Mr P Jones (PJ), Non-Executive Director queried whether the case for change should more explicitly consider future collaboration with other organisations and avoid investment in services that may ultimately be delivered differently across the system. He also questioned how decisions would be made between refurbishment and new-build options. AHO confirmed that development and constraint planning would inform future investment decisions. Members also suggested that population health needs should be reflected within the strategy and that gateway reviews may be more appropriate than fixed milestones.	

	Mrs K Wheatcroft (KW), Director of Governance and Risk highlighted the importance of ensuring the strategy is developed within the wider system context, albeit there isn't a fully developed system strategy. She also recognised the challenge of balancing tactical and operational actions against longer-term strategic estate ambitions. Mr J Bradley (JB), Chief Digital and Data Officer noted the increasing focus on neighbourhood-based care and asked how estate assets could support greater use by system partners and facilitate integrated working. He further suggested that strategic alignment should form part of the investment principles applied to future capital decisions. AHo recognised the strategy's emphasis on hospital-to-home models, neighbourhood health and wider estate optimisation. Ms V Wilson (VW), Chief People Officer welcomed the focus on staff experience and queried how staff engagement, education and training requirements could be strengthened within the strategy, including the role of facilities in supporting workforce development. Members noted that workforce wellbeing, training, education and innovation were identified as key enablers of future estate development. Mr M Oldham (MO), Non-Executive Director asked how the estate strategy would support future efficiency requirements and what level of risk the Trust was prepared to tolerate when balancing long-term investment ambitions against financial constraints. Members noted the strategy's focus on reducing critical infrastructure risk, improving resilience and supporting operational productivity. Mrs K Edge (KE), Chief Finance Officer highlighted the potential limitations of the national capital regime and funding availability, noting these should be recognised as key dependencies within the strategy. The proposed approach to developing a mature pipeline of prioritised schemes to respond to future funding opportunities was noted. Ms J Tomkinson (JT), CEO welcomed the work undertaken and encouraged continued consideration of wider system priorities, including prevention, neighbourhood health and opportunities to support communities through estate development. Members agreed that the strategy should continue to focus on using estate challenges as opportunities for innovation and transformation, ensuring the estate supports future clinical models, operational efficiency and improved patient outcomes. The Chair thanked AHo for the significant work undertaken in developing the strategy and recognised the contribution of the redesigned Estates and Facilities Team. The Board was supportive of the proposed direction of travel and noted the Estates Strategy Update. <i>AHo exited the meeting.</i>	
23.	Senior Information Risk Owner (SIRO) Annual Report Mr Bradley, Chief Digital and Data Officer, presented the SIRO Annual Report, providing an overview of cyber security and information governance activities during 2025/26. The Board noted the Trust had achieved a	

	'Standards Met' rating for the 2025/26 Data Security and Protection Toolkit (DSPT), improving from the previous year's 'Approaching Standards' position. JB recognised this as a significant achievement reflecting sustained effort across multiple teams and departments. MIAA's independent review of 12 outcomes found all met the minimum achievement level and were assessed as low risk. The Board noted continued improvements in cyber security controls, including reductions in the Microsoft Defender for Endpoint exposure score, which reached 19 against a target of below 30, indicating low exposure risk. Monthly monitoring arrangements were in place to maintain the Trust's cyber posture. Freedom of Information (FOI) request volumes remained high throughout the year, with associated pressures on performance, although breach rates had begun to improve. Information Governance training compliance had increased to 86.06%, and further work was planned to improve compliance during 2026/27. The Board noted that the Trust's overarching cyber risk remained scored at 15, reflecting the range of factors contributing to cyber risk, while NHS England's national cyber risk assessment remained at 25. Members also noted the forthcoming transition of Information Governance support arrangements from Midlands and Lancashire CSU to MIAA following changes to the CSU model. JB reminded the Board that Board cyber security training was scheduled for December 2026. Mr P Williams (PW), Non-Executive Director asked what most concerned management regarding the Trust's cyber posture, cyber resilience and staff awareness. JB advised that the primary concern was the increasing scale, sophistication and pace at which cyber threats continue to evolve. Whilst individual actions remained important, the greater risk arose from the growing capability and persistence of cyber attackers. He noted that ongoing controls, staff awareness activity and investment in cyber security measures were intended to mitigate these risks. The Board welcomed the progress made during the year and recognised the collective effort required to achieve the improved cyber assurance position whilst maintaining active oversight of information governance and cyber security risks. The Board noted the SIRO annual report.	
24.	Digital and Data Annual Report Mr J Bradley (JB), Chief Digital and Data Officer presented the Annual Report, noting it had been reviewed in detail by the Finance and Performance Committee. JB set out the continued progress across the digital portfolio, including achievement of Skills Development Network Level 3 accreditation, strong national digital maturity performance, ongoing development of the Digital and Data Strategy, and delivery of key programmes such as Ambient Voice Technology (AVT), Ophthalmology EPR and AI-enabled solutions. Capacity remained the principal risk to delivery, with increasing demand for digital support requiring careful prioritisation. Partnership working across Cheshire and Merseyside, alongside	

	engagement with the University of Chester, was highlighted as key to future delivery and innovation. JB also thanked everyone who attended the Elevate Technical Showcase yesterday noting excellent multidisciplinary attendance. Ms S Pemberton (SP), Director of Quality and Nursing/ Deputy CEO commended the significant positive cultural shift towards digital across the Trust, recognising the proactive leadership of the Digital and Data team and the increasing willingness of staff to embrace digital solutions. Mrs W Williams (WW), Non-Executive Director congratulated the team on the breadth of projects underway and asked how projects were prioritised, monitored and resourced. JB advised that progress was reported through the Finance and Performance Committee and priorities were agreed through the Digital Transformation Group. He noted that the team was not currently resourced to deliver all potential digital developments and that capacity remained a key challenge. The Chair recognised the tension between delivering cost improvement requirements and maintaining the pace of digital transformation and innovation. The Board noted the Digital and Data Annual Report.	
25.	People Committee Chair's Report – 9th June 2026 Mrs W Williams (WW), Non-Executive Director presented the People Committee Chair's Report, highlighting concerns regarding workforce numbers, which remained behind plan primarily due to continued escalation usage, despite recent improvements. The Committee also continued to monitor local Health Care Support Worker recruitment challenges and the development of a targeted local recruitment strategy. WW noted that overall sickness absence continues to improve and benchmarks positively; however, concerns remain regarding sustained pressures in hotspot areas and inconsistent application of sickness absence management processes, particularly return-to-work compliance. Ms V Wilson (VW) acknowledged the significant progress made over recent years and noted that whilst overall performance had improved, challenges remained in specific areas and improvements were not yet consistently embedded across the organisation. Members discussed concerns relating to mandatory training compliance. VW clarified that while overall compliance was improving, some training modules and clinical areas continued to fall below target, including areas such as safeguarding, resuscitation, infection prevention and control, and information governance, requiring targeted intervention. The Board noted the People Committee Chair's report.	
26.*	Council of Governors Report – July 2026 The Board received the Council of Governors report summarising items discussed at the last meeting. The Board noted the report.	

27.	Terms of Reference Updates – Assurance Committees a) Audit Committee b) Finance & Performance Committee c) Quality & Safety Committee d) People Committee The Board received all the assurance committee terms of references noting these had been reviewed and approved by each respective committee. The Board approved the updated terms of references for the Audit Committee; Finance & Performance Committee; Quality & Safety Committee; and the People Committee.	
28.	Fit and Proper Persons Policy Update Mrs K Wheatcroft, Director of Governance and Risk explained that following the ‘failure to prevent fraud’ offence coming into force on 1st September 2025 (under the Economic Crime and Corporate Transparency Act 2023), the Fit and Proper Persons Policy had been updated to better reflect examples of misconduct aligned with the new legislation. The Board reviewed and approved the updated Fit and Proper Persons Policy.	
29.*	Items for noting and receipt: <u>Sent under separate cover:</u> Minutes of Committee Meetings: a) Approved minutes of the Quality & Safety Committee – 7th May 2026. b) Approved minutes of the People Committee – 28th April 2026. c) Approved minutes of the Finance & Performance Committee – 29th April 2026. d) Approved minutes from the Audit Committee – 24th April 2026 and 23rd June 2026. e) Approved minutes from the Operational Management Board – 23rd April 2026. Other items: f) Board of Directors Workplan 2026/27.	
30.	Any Other Business There was no other business to note.	
31.	Questions from Governors and members of the Public relating to items on the meeting agenda - <i>Questions to be submitted in writing in advance of the meeting to: coch.membershipenquiriescoch@nhs.net by Thursday 16th July 2026</i> A governor observing the Public Board meeting asked about progress in system-wide working and whether responsibilities for patient care across organisations were clearly defined. In response, the Board acknowledged the importance of partners viewing patients as the responsibility of the whole system rather than individual organisations and agreed that stronger collaborative working across community, primary care and acute services	

	was essential to supporting demand management and improving patient outcomes. Future Dates: 29th September 2026 24th November 2026 26th January 2027 16th March 2027	
32.	Closing remarks The Chair sought feedback from Board members on the content and format of Board papers and agenda management. Members discussed the balance between matters considered by the Board and Assurance Committees. Ms J Tomkinson (JT), CEO commented that agendas were becoming increasingly congested and suggested consideration be given to whether some items should be reviewed initially by the Board, with detailed scrutiny undertaken by Committees where required. Members noted concerns regarding duplication of reporting across governance forums. Mrs K Wheatcroft (KW), Director of Governance and Risk emphasised the importance of achieving the right balance between Board and Committee oversight and reflected that reporting arrangements had evolved from a period when greater assurance was required regarding Committee effectiveness. Members agreed that the focus should be on ensuring the Board receives the right information at the right time, rather than all available detail. Action: An action was agreed for KW to review Committee and Board workplans to identify opportunities to streamline reporting and reduce duplication. The Board confirmed its support for the discussions held and actions agreed during the meeting.	KW

Next Meeting: Tuesday 29th September 2026 at 9.00, Women & Children's Building Seminar Room

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

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

Action Log:

Action No.	Meeting Date	Allocated to	Action Details	Action Update/ Outcome	Due Date	Status
1	29 th July 2025	Chief Digital and Data Officer	Mr J Bradley, will develop Integrated Performance Report (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 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. Update 19th May 2026 - IPR will include the development of new trajectories for the 2026/2027 period. NHS Oversight Framework (NOF) updates for this year are expected to be published tomorrow. Once this is released, they will be incorporated into the IPR to ensure alignment with national standards and expectations. It has been confirmed that the updated IPR, including the new	Sept-26	Open

Action No.	Meeting Date	Allocated to	Action Details	Action Update/ Outcome	Due Date	Status
				trajectories and integrated NOF changes, will be ready for presentation at the July Board meeting. Update 15th July 2026 – Due to the delay in publication of the new NOF guidance, development of the new metrics is taking place during July 2026 for August 2026 internal publication with expected national NOF publication for Quarter 1 data in September 2026. Update 8th September 2026 – The new NOF metrics for 2026/27 have been added to the IPR where available. Publication of first quarter NOF expected in early September 2026. Quality metrics have been reviewed and a revised metric presentation is in development.		
2.	27 th January 2026	Medical Director/Chief People Officer	Ms V Wilson and Dr N Scawn to explore 0.8 trainee contracts through Medical Staffing.	Update 22nd September 2026 – The implementation of the Patchwork medical rostering system will provide significantly improved workforce modelling and rostering functionality, enabling Medical Staffing and clinical teams to take a more proactive approach to the management of LTFT resident doctors as this cohort continues to grow. The underlying issue has been fully explored and it is believed that improved workforce planning, enabled through enhanced digital rostering capabilities, offers greater benefit than the introduction of standardised 0.8 trainee contracts	Sept-26	Open
3.	9 th May 2026	Director of Governance and Risk	Mr P Jones (PJ), Non-Executive Director, asked whether the scope of the committee	Update 10th July 2026 – This will be discussed at the Charitable Funds Committee meeting in July and timeframe agreed.	Sept-26	Closed

Action No.	Meeting Date	Allocated to	Action Details	Action Update/ Outcome	Due Date	Status
			effectiveness reviews should be extended to include the Charitable Funds Committee (CFC). It was agreed that this should be considered in future reviews.	Update 11th August 2026 – CFC Committee Effectiveness to take place as part of the September 2026 CFC		
4.	21 st July 2026	Director of Strategy and Partnerships	The Board to consider a refreshed vision reflecting its aspirations for staff and patients and complementing national and system priorities.	Update 22nd September 2026 – The Trust corporate strategy Transforming Care Together is now two years old with good progress being made, as reported through the Board Assurance Framework, against the six key strategic goals. As the National, Regional and local (ICB) landscape has changed significantly and with the publication of the Ten-year Health plan, the supporting objectives with the Trust strategy will be revised to reflect such changes. These will be codeveloped with the Board at future development days.	Sept-26	Open
5.	21 st July 2026	Chief Digital and Data Officer	Mr J Bradley (JB), Chief Digital and Data Officer to confirm whether the staffing tables (in IPR) reflect positions before mitigation actions had been applied.	Update – 17th September 2026 – These are the rates after the mitigation. Note to be added to the IPR to clarify the data used.	Sept-26	Open
6.	21 st July 2026	Director of Strategy and Partnerships	The Chair requested that JD add local GP access data alongside Emergency Department	Update 22nd September 2026 – A report has been developed with the Chair, Operational and Strategic Leads and shared with Board members at a development day session in order to provide	Sept-26	Open

Action No.	Meeting Date	Allocated to	Action Details	Action Update/ Outcome	Due Date	Status
			attendance data to better demonstrate the relationship between demand and wider system performance.	an overview of urgent care pressures. Thus, providing a narrative as to why the Cheshire West system is experiencing more urgent care pressures and A&E attendances than neighbouring systems.		
7.	21 st July 2026	Director of Governance and Risk	KW to review Committee and Board workplans to identify opportunities to streamline reporting and reduce duplication.	Update 17th September 2026 – A review of the Board workplans was completed and shared with Board members. We will continue to review papers and support Committees in managing their workplans, agendas and papers.	Sept-26	Closed

Decision Log:

No.	Meeting Date	Decision
1.	31 st March 2026	The Board approved the updates to the 2025/26 Board Assurance Framework
2.	31 st 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.	31 st March 2026	The Board approved the Trusts Workforce EDI Annual Report 2025/26 for publication
4.	31 st March 2026	The Board approved the Standing Financial Instructions.
5.	31 st 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.	31 st March 2026	The Board approved the Trust's current compliance against the Provider Licence, with a final review to take place as at 31 st March and any implications from this to be included in the Trust's Annual Governance Statement and Annual Report.
7.	31 st March 2026	The Board approved the Trust's current compliance position. (code of governance)
8.	19 th May 2026	The Board of Directors is asked to approve the reported position against the NHSE enforcement undertakings as at 31 st March 2026.
9.	19 th May 2026	The Board: • approved the Board Assurance Framework risks for 2026/27 • approved the Strategic Objectives for 2026/27
10.	19 th May 2026	The Board approved the Risk Management Policy following recommendation for approval from the Risk Management Committee.
11.	19 th May 2026	The Board approved the application of the Trust Seal in retrospect.
12.	21 st July 2026	The Board: • Approved the 2026/27 Board Assurance Framework, including the addition of the new Transformation Risk (BAF11); • Approved the updated Risk Appetite Statement; and
13.	21 st July 2026	The Board approved the proposed establishment changes. (bi-annual safer nurse staffing report)

No.	Meeting Date	Decision
14.	21 st July 2026	The Board approved the updated terms of references for all the assurance committees.

PUBLIC – Board of Directors
29th September 2026

Report	Agenda Item 7.	Chief Executive Officer's Report					
Purpose of the Report	Decision		Ratification		Assurance		Information
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 BAF 11 Transformation			X X 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 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. Significant improvements across all areas of the National Inpatient Survey

In early September, the Care Quality Commission (CQC) published the results from the national Adult Inpatient Survey. The results provide further evidence of improvement at the Countess of Chester Hospital.

The Trust has seen a significant improvement in patient experience:

- **A 58-place rise in the national rankings** (with 131 Trusts in total) overall – a substantial year-on-year improvement.
- **More than 50-place rises** in several key areas including admission to hospital, care and treatment, respect and dignity, and overall experience.
- **80% of patients rated their care 7/10 or above**, the Trust's strongest position in around seven years.
- **Improvements across all 12 categories** of questions compared with last year's results.
- **Better than the national average in six areas**, including waiting times, care and treatment, respect for individual needs, and kindness and compassion.

These results indicate that patients are experiencing noticeably better care, treatment and support across the Trust.

We remain committed to driving forward the improvements in our services.

2. NHS Oversight Framework Q1

On 7th September, NHS England published the 2026/27 Q1 ratings, with the Trust ranked at 95/134, an improvement from 98/134 in Q4 2025/26.

The metrics have been updated for 2026/27 with new metrics added and some retired, a net increase from 21 to 33 scoring metrics relevant to the Trust. All metrics are included in the Integrated Performance Report (IPR).

During 2025/26, the Trust demonstrated significant improvements made across all the targets and enhanced financial stability. Our progress in the NHS Oversight Framework (NOF) during 2025/26 was from 133/134 at Q1 to 98/134 at Q4.

3. GIRFT UEC programme continued support for COCH

On the 13th August, the Trust received a letter from Professor Tim Briggs, GIRFT UEC Programme Lead NHS England National Director for Clinical Improvement and Elective Recovery Chair of GIRFT Programme, NHS England, confirming that the Countess of Chester

Hospital will continue to receive support through the Getting It Right First Time (GIRFT) Urgent and Emergency Care (UEC) programme.

The letter recognised the work that the Trust had done and the sustained operational pressures faced with the ongoing challenges associated with delivering safe, high-quality and timely care for patients. The letter confirmed that the GIRFT team remain committed to working alongside our teams to support continued improvement across urgent and emergency care services.

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

July 2026

The CMPC Leadership Board met on 17 July 2026, and discussed:

- Staff bank arrangements
- Integrated referral management programme, single point of access and community services
- Financial pressures across Cheshire and Merseyside and the need for continued productivity improvements, efficiency delivery and robust financial control.
- An update from the UEC Board outlined ongoing challenges relating to system flow, corridor care and ambulance handover delays remaining a priority, with members highlighting the need for stronger alignment between acute, community and transformation programmes.
- Response to Ockenden recommendations.

September 2026

The CMPC Leadership Board met on 4 September 2026, and discussed:

- Winter planning and frailty
- Programme updates
- Cheshire and Merseyside Integrated Care Board updates
- System finance and performance

5. Strategic Oversight Meeting

The first Strategic oversight meeting (SOM) with the Cheshire and Merseyside Integrated Care Board took place on the 6th August 2026. The SOM is the executive-level forum through which the Integrated Care Board (ICB) discharges its statutory and contractual responsibilities to assure itself, NHS England, and the public that commissioned services are safe, effective, financially sustainable, and improving. This meeting is in addition to the operational contract management activity, which is undertaken through Contract, Quality and Performance Meetings (CQPMs).

Discussions covered a range of areas including the support needed on system wide challenges.

6. Cancer Waiting Time Performance

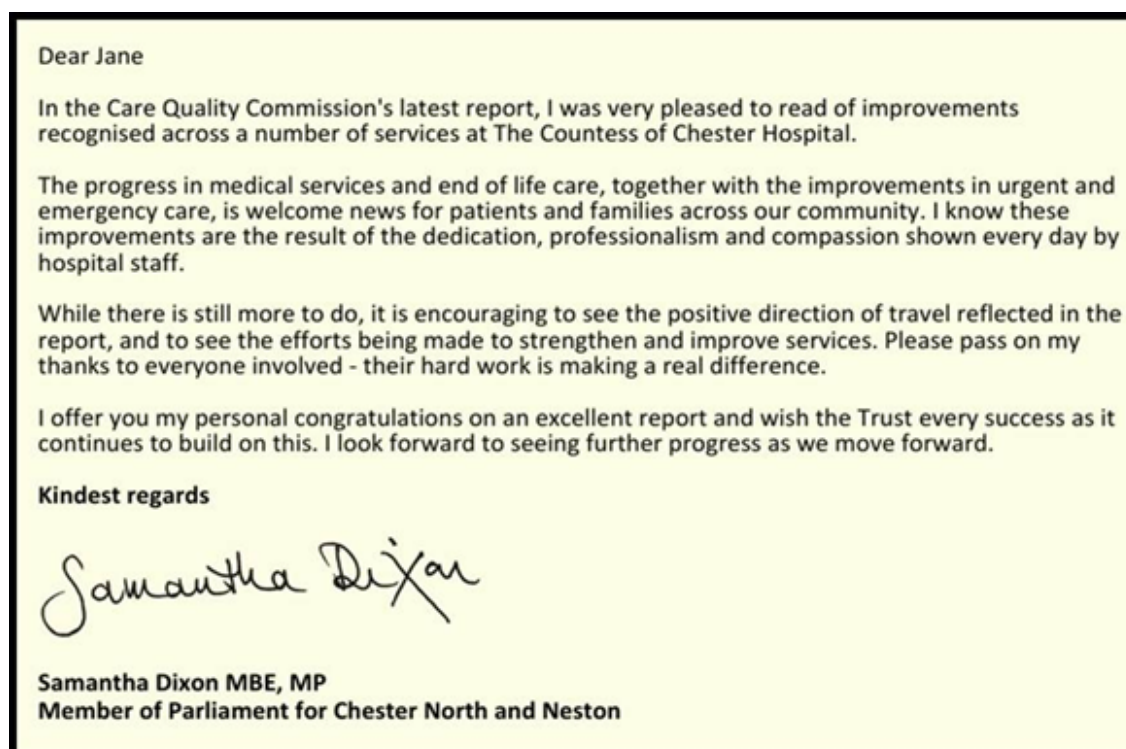
On 16 September 2026 the NHS England North West Regional Director wrote to the Trust to commend the July Cancer Waiting Times Performance. Noting that the figures highlight considerable year-on-year improvement across two of the three key metrics at The Countess of Chester NHS FT, placing the Trust among the top ten most improved nationally. The 28-day Faster Diagnosis Standard is up by 16.1 percentage points, rising from 71% to 87%, while the 31-day Decision to Treatment standard has increased by 5.3 percentage points, from 88% to 93%.

The letter also noted that this latest achievement builds on the continued improvement being seen at the Trust.

7. Local MP sends letter of congratulations

In early September, was pleased to receive a letter from our local MP, Samantha Dixon, congratulating the Trust on its latest Care Quality Commission report. She asked me to pass on her thanks to everyone for their hard work which I am pleased to do.

The letter is further recognition that our progress is being noticed. MPs, partner organisations and our local communities can see through external reviews and our latest performance data that things are changing -your hard work is making a real difference to our patients and our services.



8. Ambient Voice Technology

On 14th September our trial of Ambient Voice Technology (AVT) started with 6 clinicians. The intention is to roll out to around 500 users over the next 10 weeks as part of an extended trial of the software, enabling AI generated clinical documentation and letters. The intended benefits are to improve our documentation and correspondence as well as reduce administrative burden. The trial, supported by NHS North West, will continue until May 2027 when we will look at longer term options for embedding AVT into our clinical practices.

9. Country Park Green Flag Award

We were delighted to attend the flag raising ceremony on the 7th August to mark the Countess of Chester Country Park being recognised as one of the UK's finest green spaces after securing a prestigious Green Flag Award for the eighth consecutive year.

10. HSJ Awards Shortlists

Our new Women and Children's Building has been shortlisted for a national HSJ Award in the 'Towards Net Zero' category.

The HSJ Awards are one of the most respected awards in the NHS, celebrating the very best innovation and improvement across healthcare. More than 1,300 entries were submitted, making it one of the most competitive years on record, so reaching the final shortlist is a huge achievement for our teams.

Our Women and Children's Building is the first completed NHS building in England to meet the NHS Net Zero Building Standard, and this shortlisting recognises the pioneering work that went into creating a family-focused space for our community.

The winners will be announced in November, but we're delighted to see Chester recognised on a national stage.

11. Celebration of Achievement Event

The 2026 Celebration of Achievement event takes place on the 16 October 2026. The Award finalists have now been confirmed following receipt of a huge number of nominations making the shortlisting this year particularly difficult as there has been so much excellent work taking place across our hospitals. Congratulations to all those who were nominated and we look forward to announcing the winners on the night.

PUBLIC – Board of Directors
29th September 2026

Report	Agenda Item 9a.	Board Assurance Framework 2026/27						
Purpose of the Report	Decision		Ratification		Assurance		Information	X
Accountable Executive	Karan Wheatcroft				Director of Governance & Risk			
Author(s)	Karan Wheatcroft				Director of Governance & Risk			
Board Assurance Framework	BAF 1 Quality	X	Linked to all BAF areas.					
	BAF 2 Safety	X						
	BAF 3 Operational	X						
	BAF 4 People	X						
	BAF 5 Finance	X						
	BAF 6 Capital	X						
	BAF 7 Digital	X						
	BAF 8 Governance	X						
	BAF 9 Partnerships	X						
	BAF 10 Research	X						
	BAF 11 Transformation	X						
Strategic goals	Patient and Family Experience							X
	People and Culture							X
	Purposeful Leadership							X
	Adding Value							X
	Partnerships							X
	Population Health							X
CQC Domains	Safe							X
	Effective							X
	Caring							X
	Responsive							X
	Well led							X
Previous considerations	Not applicable							
Executive summary	The BAF was reviewed and approved by the Board in July 2026 and is aligned to the Trust strategic goals, reflects the Trust’s Medium-Term Plan, and is assessed in the context of the Trust’s risk appetite statement. This paper provides for continued triangulation with the Board agenda. The full quarterly review and update of the BAF will be reported to the Board in November 2026. The BAF risks and residual risk scores 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 IT resilience (15)							

	• BAF8 - corporate governance (8) • BAF9 - system working (12) • BAF10 - research and innovation (12) • BAF 11 – transformation and productivity (16) The Board of Directors receives the BAF each meeting with a full update completed on a quarterly basis. The Assurance Committees continue to review the BAF risks relevant to their duties and updates will be provided through Chairs reports as well as the quarterly BAF review. The publication of the Thirlwall Inquiry report will be fully considered in the Q2 BAF update, with specific reference to BAF8 as well as the wider implications from the recommendations to be assessed across the other BAF risks. A baseline assessment against the recommendations is underway.
Recommendations	The Board of Directors is asked to note the Board Assurance Framework as aligned to the Board agenda and papers received.

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

Board Assurance

Framework

2026 - 27

Risk Theme: Quality & Patient Experience													
RISK APPETITE: CAUTIOUS - Upper tolerance limit 9													
LINKS TO STRATEGIC GOALS: SG1: Patient and Family Experience; SG:3 Leadership;													
Risk description & information	Causes & consequences	Inherent risk score (C x L)	Key controls (Actions taken to manage the risk)	Board Assurance (The mechanisms we know the controls are working - reports, scrutiny meetings, committees, internal & external audits and reviews)			Residual risk score (C x L)	Within risk tolerance?	Gaps in Control / Assurance (Identified weaknesses in current management arrangements/ how we assure ourselves - or not enough information or lack of scrutiny)	Actions		Target risk score	Estimated date of achievement of target score
				Internal sources of assurance	External sources of assurance	Overall assurance level				Planned action	Progress update		
BAF1 Failure to maintain quality of care would result in poorer patient & family experience Executive Risk Lead: Director of Nursing and Quality Assurance Committee: Quality and Safety Committee Last Update: July 2026	Causes: - Inconsistent compliance with standards. - Hospital capacity not supportive of the high volume of patients presenting to the Emergency Department. - Lack of clinical engagement. - Embedding the approach to patient and family engagement Consequences: - Quality of care - Unintended harm - Poor patient experience - Regulatory compliance	4 x 5 = 20	C1) Quality priorities (Quality, Safety and Experience Strategy). Control Owner: Director of Nursing and Quality	- IPR to Board and Q&S Committee - Safety Surveillance Quarterly report - Quality and Safety Committee reports - Quality Governance Group via Q&S Committee - Patient Experience Operational Group via Q&S Committee - Operational Management Board - Quality and Safety Strategy and reporting - Infection, Prevention & Control Quarterly Report via Q&S Committee - Annual Quality Account - PLACE inspection reports - Cleaning standards compliance reports to Q&S Committee	National inpatient survey results. Healthwatch reports. Internal audit reviews. NHS Staff survey results. CQC Inspection Outcomes. Family and friends test results.	Partial	4 x 4 = 16	NO	Consistency of application of standards.	(i) Improvements will continue to be tracked through the IPR and the reports through to QGG and Q&S. (ii) Programme of ward and departmental accreditation in place. Action owner: Director of Nursing and Quality Due date: Quarterly updates	Continuing to drive improvement with an update on progress against the Quality and Safety Strategy priorities reported to the Quality and Safety Committee in March 2026. Continued monitoring through IPR and reporting with further quarterly reports against the Q&S Strategy planned across the year. In 2025/26 the Trust saw some reductions across HCAs, with IPC compliance improving. Continuous focus is required to sustain the improvements, with quarter 1 seeing an increase in c/difficile. Ward and department accreditations are demonstrating improvements with the majority of areas now accredited at Silver and some at Gold.	9	<i>To be reviewed in 2026/27</i> <i>(Improvement evidenced but not fully embedded; reduction when patient and staff feedback, and regulatory assurance demonstrates this).</i>
			C2) Quality and wider governance structures Control Owner: Director of Nursing and Quality	- Consolidated CQC and Well Led Action Plan reported to each Board of Directors - Quality and Safety Committee - Quality Governance Group via Q&S Committee	Commissioner reviews of quality (quarterly). CQC reports.	Acceptable							
			C3) CQC regulatory compliance Control Owner: Director of Nursing and Quality	- Quality and Safety Committee - Quality Governance Group via Q&S Committee - Ward accreditation reporting via Q&S - UEC action plan assurance reporting to Q&S Committee	Commissioner reviews of quality (quarterly). CQC reports.	Acceptable			UEC CQC inspection findings and response.	(i) Deliver the UEC CQC improvement Plan Action owner: Director of Nursing and Quality Due date: TBC (on receipt of CQC report)	Comprehensive action plan developed. Significant progress against the action plan with assurance provided to Q&S Committee and the Board. UEC CQC action plan progress reviewed through comprehensive report to Quality and Safety Committee. CQC report awaited for inspection of UEC, end of life care, and acute medicine.		
			C4) Approach to listening to and acting on Patient and Family Experience Control Owner: Director of Nursing and Quality	- Patient experience improvement framework - Six monthly patient experience report to QGG and Q&S Committee (including FFT) - Survey results to Q&S Committee - PLACE reporting to Q&S Committee	- Healthwatch - National Surveys	Partial			Structured approach to patient and family engagement.	Develop and deliver a programme of patient and family engagement events Action owner: Director of Nursing and Quality Due date: Q4 2026/27	Patient and family engagement events held across some services. A structured programme is currently being developed for roll out in 2026/27. Quarterly meeting with external stakeholders. Divisional plan for patient events/ activities updates to be presented quarterly. MEG being used for FFT, with QR codes, realtime responses for services. Inpatient surveys continue. 6 monthly patient experience report to QGG and Q&S. EDS action plans also included.		
BAF2 Failure to maintain safety and prevent harm would result in poorer patient care and outcomes Executive Risk Lead: Medical Director Assurance Committee: Quality and Safety Committee Last Update: July 2026	Causes: - Longer patient waiting lists (ref. Operational effectiveness). - inconsistent application of standards. - Culture and accountability - Underdeveloped partnership working arrangements to support clinical strategy delivery. - Lack of reciprocal engagement in the wider health system. - Mental health service provision in A&E and across all Trust sites - Fragile services Consequences: - Unintended harm - Extended length of stay - De-conditioning of patients	4 x 5 = 20	C1) Safety priorities (Quality and Safety Strategy) Control Owner: Medical Director	- IPR - Quality Governance Group via Quality and Safety Committee - Reports to Q&S Committee (including sepsis updates)	CQC Inspection Outcomes. National clinical audit results reported to Q&S Committee. HES data and benchmarking.	Partial	4 x 4 = 16	NO	Delivery of quality improvement safety outcomes.	(i) Improvements in compliance and safety outcomes will continue to be tracked through the IPR and the reports to QGG and Q&S. Action owner: Medical Director Due date: Q4 2026/27 (with quarterly updates)	Continuing to drive improvement with an update on progress against the Quality and Safety Strategy priorities reported to the Quality and Safety Committee in March 2026. Continued monitoring through IPR and reporting with further quarterly reports against the Q&S Strategy planned across the year. Improved RTT performance in 2025/26 impacts positively on the risk of harm.	9	<i>To be reviewed in 2026/27</i> <i>(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)</i>
			C2) Organisational learning including review of deaths Control Owner: Medical Director/ Director of Governance Risk and Improvement	- Safety Surveillance Quarterly report to Q&S Committee and Board - Quarterly Learning from Deaths report and annual mortality report via Q&S Committee and Board - Quality and Safety Committee reporting to Board - Quality Governance Group via Q&S Committee - Quarterly Learning from Deaths report and annual mortality report via Q&S Committee and Board - Quality and Safety Committee	Telstra Health (Dr Foster) benchmarking	Partial			Mental Health services including UEC CQC action plan; delivery of mental health review action plan; and clear governance for collaboration and partnership working.	Ensuring improvements in setting expectations, clarity of accountability, and consistent application. Action owner: Medical Director Due Date: Quarterly updates	Multi disciplinary Steering Group is in place and meets monthly, including external partners ie Cheshire Police. 136 protocol and action plan developed - New standards operating models in place for clinical practice and escalation. This group is working towards meeting the Core 24 mental health standards for urgent care. MOU signed with ICB, COCH and CWP. Patient Flow Group in place and overseeing work of the Mental Health Steering Group with updates through the Deputy Director of Nursing and Quality.		
				Evidence of consistent application of standards for Sepsis.	To deliver improvements in Sepsis compliance. Action owner: Medical Director Due date: Q4 2026/27 (with quarterly updates to demonstrate improved performance)	Sepsis Lead attended Board to provide an update on actions in 2025/26. Improvements progressing and focus extended to wider Trust. The impact of fast flow in ED on screening is being reviewed. NEWS trigger hard stop on EPR commenced in January 2026 and has shown improvements in compliance for this aspect of the metric. Screening compliance moved to target and focus now remains on timeliness of antibiotics.							
				Organisational Learning embedding of approach.	The production of an Organisational Learning Policy, including range of activity, forums and reporting. Action Owner: Director of Governance, Risk and Improvement Due date: Complete	The Trust has developed a range of organisational learning through PSIRF, learning from deaths, national inquiries, clinical audit, patient safety summits etc. The new organisational leaning policy captures all these opportunities, and considers how sharing of learning can continue to be maximised. Policy now approved through QGG and being embedded.							
				Mortality review backlog	Improvement plan to address historic mortality review backlog. Action owner: Medical Director Due Date: Q3 2026/27	Report to Q&S Committee. Work progressing with updates to Q&S.							
			C3) Delivery of the Clinical Strategy including options and implications for fragile services Control Owner: Medical Director		CMPC updates to Board	Partial			Delivery of the Clinical Strategy	Develop approach to providing assurance on the progress of delivery of the Clinical Strategy through Divisional Reviews. Action owner: Medical Director Due Date: Q3 2026/27	Clinical Strategy approved and launched. External engagement events held by the Director of Strategy and Partnerships (July 2025). Discussions progressing on delivery priorities and approach to updates. Divisional reviews to be re-established to support assurance on progress and opportunities.		
									Fragile services review and opportunities (including CMPC programme updates).	Identify and assess options and implications from the CMPC fragile services review. Action owner: Medical Director Due Date: Aligned to system timeframes (with quarterly updates)	Review of fragile services taking place alongside collaboration agenda through CMPC, with data collection in progressed in Q4 2025/26. Medical Director part of CMPC Clinical Reference Group. SPOA workstream will also contribute to improved referral pathways and acceptance. CMPC programme updates being developed for Provider Boards.		

Risk Theme: Operational Effectiveness													
RISK APPETITE: OPEN - Upper tolerance limit 12													
LINKS TO STRATEGIC GOALS: SG4: Adding Value													
Risk description & information	Causes & consequences	Inherent risk score (C x L)	Key controls	Board Assurance			Residual risk score (C x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions		Target risk score	Estimated date of achievement of target score
				Internal sources of assurance	External sources of assurance	Overall assurance level				Planned action	Progress update		
BAF3 Inability to deliver operational planning targets, could result in poorer patient outcomes, and result in financial and regulatory consequences to the Trust. Executive Risk Lead: Chief Operating Officer Assurance Committee: Finance and Performance Committee Last Update: July 2026	Cause: - Unable to meet the demand for services within available resources - Increased demand in suspected cancer referrals and ED attendances - Challenges in patient flow including increased number of patients that do not meet the criteria to reside - Unable to accommodate all Non-RTT follow-up patient's within due date because of lack of capacity within some clinical services Consequences: - Increased patient waits for access to services impacting on patient safety, potential/ actual harm and patient experience. - Failure to meet key targets and regulatory requirements in some areas - Sub-optimal service provision - Potential increase in complaints from family, friends and carers.	4 x 5 = 20	C1) Annual plan within the MTP with clear activity and performance reporting against trajectories and focussed improvement plans as required. Control Owner: Chief Operating Officer	- IPR to Board (each meeting), including enhanced reporting on RTT. - Finance and Performance Committee - Divisional Performance via Operational Management Board - Operations and Performance Executive Led Group via OMB - Quarterly Divisional Performance Reviews - Bi-weekly patient flow meetings.	North West performance report overseen by ICB. Contract review meetings. UEC T1 meetings - Bi-weekly with the Regional NHSE Team.	Partial	4 x 4 = 16	NO	Management of flow, consistent application of discharge requirements and significant NC2R patients requiring wider system response.	(i) ED - Whole system approach to hospital avoidance and supported primary care function. (ii) ED - Continued MADE (weekly) super MADE (bi-monthly) multidisciplinary discharge events. (iii) Flow improvement plan integrated with UEC improvement plan to drive forward clear priority actions and assess the impact. Action Owner: Chief Operating Officer Due date: Q4 2026/27 (with quarterly updates)	The Trust continues to meet the elective, cancer and diagnostic waiting targets within the MTP. Access to UEC services remains challenged due to high ED attendances and lack of progress with the reduction of patients that no longer have the criteria to reside. There is a full UEC improvement programme in progress with improved metrics of 12 hours, ambulance handover delays and time to triage. The Trust continues to work with the wider systems and local authorities to enable an improved number of complex discharges. The Trust has extended the UTC opening hours to 10pm for minor illness and injuries. The flow improvement plan has been re- aligned with a new meeting, with each area identifying priorities and taking a focus on assessing the impact of the actions taken. To ensure the whole Trust Board is aware of progress for UEC, RTT and Cancer there have been presentations at Board development sessions.	12	March 2028 <i>(Risk Score to be reviewed April 2027. Driven by UEC performance; reduction when consistent improvements in 12-hour waits and on delivering planned position for 4-hour targets.)</i>
			C2) Performance management framework and Governance Structure Control Owner: Chief Operating Officer	- IPR to Board (each meeting) - Finance and Performance Committee - including System Oversight Framework - Divisional Performance via Operational Management Board - Operations and Performance Executive Led Group via Finance and Performance Committee	North West performance report overseen by ICB. Contract review meetings.	Acceptable			Gaps in validation (non RTT) and data quality issues remain.	Increased focus on Non RTT follow up data quality, clinical validation and delivery Action Owner: Chief Operating Officer Due date: TBC (following confirmation of implementation timeframe)	C&M resources secured and have supported validation. Continue to focus on non RTT follow up and report through OPELG. The AI validation tool has been procured and implementation delayed to Q2 2026/27.		
									Long waits in Ophthalmology for Non-RTT patients who are overdue their follow-up which can lead to patient harm.	(i) Action plan to EDG with weekly review of action plan to ensure progress. Action Owner: Chief Operating Officer Due date: Q4 2026/27 (with quarterly updates) (ii) Harm review feedback to continue to be shared at QGG/ Quality Committee via Medical Director Action Owner: Medical Director Due date: Quarterly updates	Action plan for Ophthalmology reviewed at EDG and Division progressing actions with weekly review by the COO. Incident review processes continue. To ensure the whole Trust Board is aware of progress for UEC/ RTT and Cancer there have been presentations at Board development sessions. The Q&S Committee continues to be sighted on Harm review feedback.		

Risk Theme: Workforce													
RISK APPETITE: OPEN - Upper tolerance limit 12													
LINKS TO STRATEGIC GOALS: SG2: People and Culture													
Risk description & information	Causes & consequences	Inherent risk score (I x L)	Key controls	Board Assurance			Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions		Target risk score	Estimated date of achievement of target score
				Internal sources of assurance	External sources of assurance	Overall assurance level				Planned action	Progress update		
BAF4 Challenges in ensuring a high quality, engaged, diverse and inclusive workforce and culture would affect our ability to deliver patient care. Executive Risk Lead: Chief People Officer Assurance Committee: People Committee Last Update: July 2026	Causes - Poor staff morale and culture - Staff burn-out - Lack of health and wellbeing support - Increased pressures in the hospital - Failure to engage staff, listen to feedback and act - lack of effective systems and processes - Lack of accountability - Poor behaviours Consequences - Loss of goodwill and staff engagement - Short term sickness absence - Turnover hotspots - A deterioration in the physical and mental wellbeing of our workforce - Increased bank/ temp staff hours - Erosion of skills and knowledge - Reduced leadership capacity and capability - Silo working, lack of collaboration and innovation, ownership of performance and delivery - External scrutiny	5 x 4 = 20	C1) Workforce Plan delivery as part of the Medium Term Plan Control Owner: Chief People Officer	- Staffing monitored via Strategic Workforce Group and Chair's report to People Committee - Vacancy Control Panel reporting to EDG	Annual plan submitted to ICB. Monthly monitoring at ICB level	Partial	5 x 3 = 15	NO	Clarity of links to transformation programme, WTE impact and profiling.	To develop reporting aligned to transformation programme and IPR. Action owner: Chief People Officer Due date: Q3 2026/27 (with quarterly updates)	Workforce plan reporting in place for EDG, Workforce Committee and People Committee. Transformation reporting currently being developed to include WTE. Meetings taking place with ICB to review position.	12	To be reviewed in March 2027 (Reduction when staff feedback supports positive culture shift, not expected until end March 2027).
						Longer term workforce plan aligned to MTP and Trust strategy.			To ensure delivery of the workforce MTP expectations. Action Owner: Chief People Officer Due date: Q4 2026/27 (with quarterly updates)	Trust Medium Term Plan includes strategic narrative on workforce plans. Further work underway to refine and update profiling of these aligned to transformation programmes and risks.			
			C2) People Strategy delivery Control Owner: Chief People Officer	- IPR - Workforce dashboard/ SOF via People Committee - GMC Survey via People Committee - Preceptorship survey via People Committee - Staff survey action plan updates via People Committee - FTSU BI-annual update and via People Committee - Employer relations report via People Committee - People promise report via People Committee - People and Culture Sub Committee AAA report to People Committee - WRES/ WDES and gender pay gap reports via People Committee - CPO report to People Committee - Integrated EDI action plan updates to People Committee - EDI annual report to People Committee - Equality Delivery System 2 reports.	NHS Staff Survey results Pulse survey results WRES/ WDES. Gender pay gap results. Equality Delivery System 2 stakeholder engagement.	Partial			Delivery of People Strategy improvement priorities and assurance through the strategy dashboard of indicators (sickness absence/ staff engagement staff survey/ diversity) Poor staff experience. Diversity of workforce at all levels.	(i) Develop strategic dashboard for key metrics aligned to the People Strategy priorities. (ii) Deliver priority improvements within the People Strategy (relating to wellbeing, EDI, leadership development and workforce development). Action Owner: Chief People Officer Due date: Q4 2026/27 (with quarterly updates)	Dashboard development progressing. Update on delivery against year 1 of the People Strategy to the People Committee scheduled for Sept 2026. NHSE and Kings Fund culture and leadership programme, discovery and design phase complete, delivery phased linked with RCN Foundation work. Focus on targeting sickness hotpots and increasing wellbeing intervention for stress related cases. Integrated EDI action plan and priorities in place. Statutory reporting in place, positive improvements being made and review through established governance structures. Further focus on anti-racism framework progressing.		
						Training needs analysis. Consistency and equity of education offer and application. Development and delivery of action plan in respect of NETS.			(i) Training needs analysis to be developed aligned to national work. (ii) Action plan to be developed and delivered in respect of the National Education and Training Survey results. (iii) Continue to develop the training and development offer across staff groups Action Owner: Chief People Officer Due date: Q4 2026/27 (with quarterly updates)	Training needs analysis progressing alongside the national work. NETS results awaited (expected in Summer) and action plan will be developed for review and monitoring through the Education, Learning and OD Sub Committee. Manager Essentials training launched in Q1 2025/26, Additional modules including Crucial Conversations, Leading through Change and Coaching Conversations launched in Oct 25 and Leadership Essentials launched in May 26 . New appraisal framework developed and being used for appraisals. Reviewing use of talent conversations.			
			C3) Leadership and management capabilities Control Owner: Chief People Officer	- L&D Reports via People Committee - Guardian of Safe Working reports - GMC survey via People Committee - Preceptorship survey via People Committee - Apprenticeship Report to People Committee - Workforce dashbord to People Committee	NHS Staff survey results. GMC Survey results Preceptorship survey results National Education and Training Survey	Acceptable			Delivery of talent and succession planning.	Delivery of talent and succession planning. Action Owner: Chief People Officer Due date: Q3 2026/27	Board level succession plan being further developed with clarity of the action required for 2026/27.		
						Leadership capability and development.			Refresh and expansion of leadership development offer. Action Owner: Chief People Officer Due date: Q3 2026/27	Leadership framework established and programmes rolled out for clinical leaders, aspiring leaders (band 2-4) and lead managers. Compassionate leadership work with RCNF, including updated Leadership development offer.			

Risk Theme: Finance & Capital															
RISK APPETITE: OPEN - Upper tolerance limit 12															
LINKS TO STRATEGIC GOALS: SG4: Adding Value															
Risk description & information	Causes & consequences	Inherent risk score (I x L)	Key controls	Internal sources of assurance	Board Assurance	External sources of assurance	Overall assurance level	Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Planned action	Actions	Progress update	Target risk score	Estimated date of achievement of target score
BAF5 Failure to deliver financial plan and underlying financial position could impact long term financial sustainability for the Trust and system partners. Executive Risk Lead: Chief Finance Officer Board Committee: Finance and Performance Committee Last Update: July 2026	Cause: The Trust operates in an increasingly challenging financial environment in line with the national position for acute providers. This is driven by: - Increase in non elective activity delivered at premium costs; - High numbers of medically optimised and delayed transfers of care for which costs are not fully reimbursed; - Costs associated with medical and nurse bank and agency usage; - Cheshire & Merseyside system has a challenged deficit position which then relies on providers delivering significant levels of efficiency savings, whilst curtailing investment. - Identification and delivery of recurrent Cost Improvement Plan (CIP) - Different funding models limit income growth counter to the Trust needing to respond to NEL demand alongside challenging targets to deliver RTT improvements. - Lack of internally generated Capital resource Impact: - The Trust is unable to achieve a sustainable financial balance & achievement of recurrent efficiencies & deliver its strategic objectives. This will result in the requirement to borrow cash from DHSSC (with a cost associated with borrowing cash) - Low cash balances and need for cash preservation actions impacting on operational effectiveness - Inability to maintain safe and effective local services. - Increased external scrutiny from NHSE	4 x 4 = 16	C1) Medium Term plan and underlying sustainability Control Owner: Chief Finance Officer	- Trust board report (monthly) - Finance & Performance Committee - Divisional Boards via Operational Management Board (Monthly) - Capital Steering Group via F&P Committee (Monthly) - Operational Performance Executive Led Group reporting to OMB	System Financial Plan NHSE submissions NHSE monitoring returns FPRM (as required)	Partial	4 x 4 = 16	NO	Assurance of delivery of the plan given significant challenge of CIP requirement	Delivery of the Medium Term Plan Action Owner: Chief Finance Officer Due Date: Q4 for 2026/27 plan (with Quarterly updates)	Qtr 1 forecast to deliver plan. Qtr 2 required significant uptick in CIP delivery and risks are currently under review together with available mitigations.		12	March 2031 <i>(Risk Score to be reviewed November 2028 for progress and track record of delivery. Reduction when confident in CIP delivery and track record of delivering annual financial plan including deficit recovery)</i>	
			C2) Annual Budget and systems of budgetary control including additional grip and control actions comprising pay and non-pay oversight Control Owner: Chief Finance Officer	- Financial Plan (approved) - Finance Report to Board - Finance & Performance Committee - Forecast processes and reporting within finance reports	Financial Plan NHSE submissions Internal Audit reviews FPRM (as required) NHSE oversight meetings	Partial			Inquiry costs awaiting confirmation of national funding Unfunded escalation costs to maintain patients safety in light of increased levels of NC2R patient numbers	(i) Continue to work with NHSE. (ii) Provide forecasting updates for F&P complying with NHSE template approach. Action Owner: Chief Finance Officer Due date: Quarterly updates	Inquiry funding supported by NHSE for 2025/26 and discussions underway for 2026/27. System work continues on levels of NC2R and subsequent impact on escalation costs with little improvement acheived. Escalation capacity cost pressures continue but are mitigated in year by non-recurrent measures.				
			C3) Cost Improvement Programme including Quality Impact Assessments Control Owner: Chief Finance Officer	- Weekly CIP delivery group. - Finance & Performance Committee papers. - Programme Delivery Office report to Board.	Financial Plan NHSE Template Weekly returns to NHSE and provider benchmarking of progress FPRM (as required)	Partial			Delivery phase of CIP Programme, low levels of maturity and to be underpinned by productivity expectations. Slippage and risk in converting CIP opportunities to identified schemes.	Development of schemes and further movement of opportunities into identified schemes which can be transacted. Action Owner: Director of Transformation & Productivity Due date: Quarterly updates	Transformation priorities agreed. Programme structure and targets agreed. CIP Delivery Group continues with CEO as Chair. CIP workshops held and schemes for 2026/27 captured. Approach to transformation being developed. Completed Director of Transformation and Productivity recruited (March 2026) driving significant change in programme approach.				
			C4) Cash Management Control Owner: Chief Finance Officer	- Finance & Performance Committee papers.	Financial Plan NHSE Template Weekly returns to NHSE FPRM (as required)	Partial			Approach needed to mitigate the new challenges regarding cash and deficit support.	Engagement with NHSE on cash support arrangements Action Owner: Chief Finance Officer Due date: In place (with quarterly updates)	Cash risk associated with DSF withdrawal (Q2) established. Cash preservation plan developed. Monthly updates to Board.				
BAF6 Inability to achieve the capital programme within a challenging and uncertain operating environment and deliver an Estates Strategy that supports the provision of our services Executive Risk Lead: Chief Operating Officer Board Committee: Finance and Performance Committee Last Update: July 2026	Causes - Implications of NHSE and capital prioritisation process - Ageing estate and challenging backlog maintenance risks - Womens and Childrens deconstruction programme - Limited development opportunities due to space constraints Consequences - Impact on delivery of capital plan - insufficient progress on backlog maintenance - Inability to invest in innovations not currently identified in the Trust's medium term plan - Having to re-prioritise the programme if an unidentified need arises - Disruption to operational services during a complex capital programme	5 x 4 = 20	C1) Capital management governance Control Owner: Chief Finance Officer	- Finance and Performance Committee reporting to Board. - Capital Management Group via F&P Committee	ICB returns	Acceptable	5 x 3 = 15	NO	Prioritisation process for capital funding excl BAU by NHSE	Engagement in NHSE Estates forums. Action Owner: Chief Operating Officer Due date: System led timeframes (with quarterly updates)	Continue to engage with national team on prioritisation process and emerging risks.		12	2026/27 <i>(Risk score to be reviewed April 2026 following capital planning cycle. 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)</i>	
			C2) Capital planning and prioritisation Control Owner: Chief Finance Officer	- Quarterly update to the Finance and Performance Committee. - Estates Strategy.		Partial			Exploring opportunities for contingency and system capital funding. Infratrstructure risks	Continue to explore opportunities for system capital Action Owner: Chief Finance Officer Due date: Quarterly updates	Capital allocation confirmed and prioritised plan in place for 2026/27. Successful bid for £0.5m national capital to support ED/ UEC improvements with completion expected late 26/27. CDC bid underway for Blacon site. 26/27 capital planning complete and majority of business cases drawn up and approved.				
			C3) Estates strategy Control Owner: Chief Operating Officer	- Health and Safety Committee reports via Finance and Performance Committee. - Capital Management Group via F&P Committee - Estates report to Finance and Performance Committee - Estates and Facilities Committee reports via Finance and Performance Committee	Six Facet Survey. Regulatory and statutory assurance received ad hoc (e.g. fire safety, H&S etc).	Partial			Estates strategy development	To develop the Trust's Estates Strategy. Action Owner: Chief Operating Officer Due date: Q4 2026/27 (with quarterly updates)	Update on the development of the Estates Strategy planned for the Board in July 2026				
									W&C building deconstruction	Deconstruction of old Women and Children's building. Action Owner: Chief Operating Officer Due date: Q3 2026/27 (with quarterly updates)	Full decant now achieved. Deconstruction underway.				

Risk Theme: Digital & Data													
RISK APPETITE: OPEN - Upper tolerance limit 12													
LINKS TO STRATEGIC GOALS:													
SG4: Adding Value													
Risk description & information	Causes & consequences	Inherent risk score (I x L)	Key controls	Board Assurance			Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions		Target risk score	Estimated date of achievement of target score
				Internal sources of assurance	External sources of assurance	Overall assurance level				Planned action	Progress update		
BAF7 Failure to deliver transformative digital and data solutions and performant, secure and resilient infrastructure could impact on patient and staff experience and organisational productivity Executive Risk Lead: Chief Digital & Data Officer Assurance Committee: Finance and Performance Last Update: June 2026	Cause: - Failure to review and adopt innovative solutions including AI to deliver value added digital transformation - impacting ability to support CoCH, ICB and NHSE / national strategies (Consequence C1) - Failure to invest sufficiently in secure, modern, sustainable digital infrastructure, systems, services and data to enable safe, effective clinical patient care and business operations (Consequence C1, C2) - Increasing cyber risk profile with more attacks evident, including ransomware and phishing. (Consequence C3) - Failure to identify, develop and maintain the required digital & data people capability (internal plus partnerships / third parties) (Consequence C4) - Failure to adequately train Trust wide staff in cyber security awareness and information governance (Consequence C5) - Failure to adequately assess and take action regarding the quality of data within the Trust digital clinical systems (Consequence C6) - Increasing support and licence costs for key systems (Consequence C7) Consequence: C1- Trust will be reliant on systems that are not fit for purpose, impacting productivity and consequently service quality/patient experience. C2- Insecurities within the systems and infrastructure with vulnerabilities that could be exploited through a cyber-attack. C3 - Data loss and regulatory sanctions if personal data is lost, financial consequences of losing access to systems and data. C4 - Reduced level of skills and or capacity in workforce due to inability to develop or recruit staff to required level C5 - Compromised systems and infrastructure would result in business continuity measures being put in place for staff and patients. C6 - Poor data quality could lead to Trust staff making ill-informed decisions and inaccurate external reporting C7 - Increasing licence costs will impact on Trust financial position and may prevent the Trust renewing contracts and lead to removal of digital solutions	5 x 4 = 20	KC1) Digital and Data Strategy and underpinning delivery programme which aligns with internal, partner, ICS / ICB and national expectations, the Medium Term Plan (MTP) and also the 10 year health plan. Control Owner: Chief Digital & Data Officer	Updates into F&PC via Digital and Data Strategic Programme Update Strategy update to Trust Board development session (Jul 2025) and formal Trust Board (Aug 2025)	MIAA Digital strategy audit (Jan-Mar 26)	Partial	5 x 3 = 15	NO	Delivery of strategy, programme plan aligned to Medium Term Plan, formalised AI governance approach.	(i) Refresh Digital and Data Strategy informed by National Digital Maturity Assessment (DMA) and 10 year health plan for England. Action Owner: Chief Digital and Data Officer Due date: Complete (ii) MIAA to conduct audit of Digital and Data Strategy. Action Owner: Chief Digital and Data Officer Due date: Complete (iii) Publication of Digital and Data Strategy. Action Owner: Chief Digital and Data Officer Due date: Q2 26/27 (iv) Annual updates to Trust Board on strategy and SIRO report July 2026 Action Owner: Chief Digital and Data Officer Due date: July 2026	Delivery plan for strategy has been developed. Strategy to be published in Q2 26/27	12	2026/27 <i>(Reviewed April 2026. Inherent cyber risk makes it difficult to reduce this risk score)</i>
			KC2) Annual plans that deliver effective management of Cyber security threats and digital infrastructure health Control Owner: Chief Digital & Data Officer	- DSPT status presented to Finance and Performance Committee (F&PC) - SIRO report into F&PC	- Annual MIAA assurance audit on DSPT submission - Microsoft MDE score	Partial			Information Asset Owner responsibilities for "essential services". Completion of capital infrastructure investment including core network upgrade	(i) Completion of action plan relating to DSPT and Cyber Assurance Framework (CAF) Action Owner: Chief Digital and Data Officer Due date: Completed (i) IAO responsibilities to be defined and approved. Action Owner: Chief Digital and Data Officer Due date: Q3 26/27 (ii) Deliver plan to maintain infrastructure health Action Owner: Chief Digital and Data Officer Due date: Sep 2025 Phase 1 - Completed Mar 2026 Phase 2 (iii) Deliver Cyber Security protection plan Action Owner: Chief Digital and Data Officer Due date: March 2027	DSPT submission was completed in Jun 26. The Trust reported a standards met submission. Submission is being reviewed by NHS E ahead of publication of result. IAO responsibilities have been drafted with submission for approval planned at the next Information Governance/Cyber Security Committee. MIAA review of data centres has been completed and report has been shared - an action plan has been developed to ensure completion of actions related to fulfilment of recommendations . Capital funding has been secured to replace a key part of the networking infrastructure (Core network switches) in Q4 26/27 New proxy solution has been procured and will be implemented in Q3 26/27 New Privileged Access Management solution has been procured and final configuration is taking place ahead of deployment. A Cyber security programme plan for 26/27 has been developed.		
			KC3) Annual plan for investment, upgrade and optimisation of digital applications (including EPR), supporting delivery of the transformation programme Control Owner: Chief Digital & Data Officer	- Clinical digital systems progress (including EPR) reported to Finance & Performance Committee - Contract in place with EPR supplier, for upgrades over 5 years (2025-2030) - Successful EPR upgrade in Sept 2025 - Programme updates provided to Digital Clinical Systems programme board	- MIAA EPR lessons learned review (reported to Audit Committee and F&P Committee) - NHSE EPR Readiness review (reported via F&P Committee)	Acceptable			Application (including EPR) optimisation structures, engagement and assurance reporting. Formalised AI governance	Undertake optimisation programme. Participate in national EPR usability survey and develop action plan based on results. Action Owner: Chief Digital and Data Officer Due date: EPR Optimisation Phase 1 to August 2025 - complete EPR Upgrade September 2025 - complete EPR Optimisation phase 2 to Mar 2026 Ophthalmology EPR by Mar 2027 - procurement 26/27 - go live Q2/3 26/27 CRV digitisation project in progress - programme has started AVT - 12 month pilot of regional AVT solution to start Q1 26/27 - delayed now due Q2 26/27 Patient flow solution review is taking place and will complete in Q2 26/27	New Ophthalmology EPR solution has been procured, go live expected in Q2/3 26/27 Large scale EPR development work underway focusing on discharge, CRV and UEC process improvements AVT solution is currently being configured and tested ahead of planned roll out. AI governance policy has been drafted and is undergoing review ahead of publication		
			KC4) Development programme for data and analytics skills and ongoing data quality assurance Control Owner: Chief Digital & Data Officer		Clinical coding audit	Acceptable			External assurance of data quality processes	Extend data quality framework to new metrics. Action Owner: Chief Digital and Data Officer Due date: Phase 1 October 2026, Phase 2 March 2027 External audit of data quality processes - on MIAA work programme for 2026/27 Action Owner: Chief Digital and Data Officer Due date: Q3 2026/27 Adopt NCF Framework for internal service development Action Owner: Chief Digital and Data Officer Due date: Quarterly update	New NOF metrics being reviewed National Competency Framework (NCF) workstreams in progress to support recruitment, retention and professional development within the Data and Analytics teams		
			KC5) Digital and Data organisation wide awareness plan ensuring, opportunities for development of the Digital and Data team and wider workforce. Control Owner: Chief Digital & Data Officer	National staff survey	- National digital workforce survey (reported via F&P Committee) DSDN Level 3 accreditation. (April 2025)	Partial			Organisation wide Digital and Data skills enhancement programme, including local training and apprenticeships	(i) Develop a set of training opportunities for the Digital and Data team and our wider work force, improving awareness of new technologies approaches including AI and Data science Action Owner: Chief Digital and Data Officer Due date: Q4 26/27 (ii) Apprenticeship scheme for Ai and data capabilities. Action Owner: Chief Digital and Data Officer Due date: Q3 26/27	Local Target Operating Model (TOM) is being developed following reduction in WTE inline with regional headcount reduction target. AI and Data Apprenticeship schemes are being reviewed and will be offered to wider workforce Local data awareness sessions are taking place.		

Risk Theme: Governance													
RISK APPETITE: CAUTIOUS - Upper tolerance limit 9													
LINKS TO STRATEGIC GOALS: SG3: Leadership, SG4: Adding Value, SG5: Partnerships													
Risk description & information	Causes & consequences	Inherent risk score (I x L)	Key controls	Board Assurance			Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions		Target risk score	Estimated date of achievement of target score
				Internal sources of assurance	External sources of assurance	Overall assurance level				Planned action	Progress update		
BAF8 Failure to ensure effective corporate governance could impact our ability to comply with legislation and regulation. Executive Risk Lead: Director of Governance and Risk Board Committee: Audit Committee Last Update: July 2026	Causes - implementation of changes in legislation - effectiveness of governance structures - clarity of accountability, decision making and assurance reporting - new partnership arrangements developing - organisational learning and sharing Consequences - Legal and regulatory action - Board effectiveness - Public confidence	4 x 3 = 12	C1) Effective Governance Structures Control Owner: Director of Governance and Risk	- Well led action plan. - Annual report. - Committee effectiveness annual reports via Audit Committee.	- Head of Internal Audit Opinion (via Audit Committee). - VFM opinion (via Audit Committee). - CQC Reports.	Partial	4 x 2 = 8	NO	Assurance on the effectiveness of sub committee level and Divisional Governance. Delivery of the risk management improvement plan.	(i) To review and support effectiveness of Divisional governance organogram and embedding of the Accountability Framework. (ii) Embed risk management through delivery of risk management improvement plan. Action Owner: Director of Governance and Risk Due date: Q3 2026/27	Work underway to support Divisions to ensure consistency and effectiveness of governance aligned to Accountability Framework. Attended Divisional forums in Q1 and Q2 2026/27. Internal Audit review planned for later in 2026/27. Governance presentations continue to be delivered in various forums. Risk management improvement plan actions progressing, with training now developed. Moderate assurance opinion on risk management provided by MIAA. Some delays noted to training roll out and reporting development due to limited capacity and priorities within the team.	9	Target Score Achieved (Jan 2026) (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)
			C2) Compliance with relevant codes of governance, regulation and legislative requirements Control Owner: Director of Governance and Risk	- Annual report - code of governance compliance (via Audit Committee) - Provider licence compliance (via Audit Committee)	- CQC reports - NHSE reporting incl Provider capability, enforcement undertakings, MTP approval	Acceptable			Comprehensive map of regulatory compliance and assurance reporting.	Regulatory compliance and assurance map to be developed. Action Owner: Director of Governance and Risk Due date: Q4 2026/27	Regulatory compliance map being developed to be populated by Divisions and teams in 2026/27. NHSE undertakings align to delivery of established plans and have been mapped to Provider licence compliance (which will be revisited at year end). Positive assurance received on progress ay year end 2025/26.		
			C3) Partnership Governance Control Owner: Director of Governance, Risk and Improvement	- CEO report	- CMPC updates througu CEO report (joint working agreement and Leadership Board TOR approved)	Acceptable			Clarity of governance for emerging partnerships and collaborations.	To support collaborations and emerging partnerships with effective governance. Action Owner: Director of Governance and Risk Due date: As required (with quarterly updates)	Support provided on discreet projects/ developments including research developments. Engagement and contribution to collaboration governance through CMPC Director of Strategy and Company Secretary professional group. Leadership role taken on as the Convenor of the CMPC CoSec Group from March 2026.		
			C4) Public Inquiry Control Owner: Director of Governance and Risk	- Thirlwall Inquiry Updates - Legal cost updates (via F&P Committee)		Acceptable			Corporate records management lessons learned. Inquiry Report to be published.	(i) Corporate records management policy to be updated and work to support embedding and improvement. Action Owner: Director of Governance and Risk Due date: Q4 2026/27 (with quarterly updates) (ii) Response to the Inquiry report. Action Owner: Director of Governance and Risk Due date: Q3 2026/27	Corporate records management added to Information security and information governance committee, with corporate records management policy revised. We continue to understand, share and embed learning from the Inquiry, with the Inquiry report now anticipated after parliamentary summer recess.		

Risk Theme: System Working and Collaboration													
RISK APPETITE: SEEK - Upper tolerance limit 16													
LINKS TO STRATEGIC GOALS: SG1: Patient and Family Experience, SG5: Seeking Partnership Opportunities, SG6: Populations													
Risk description & information	Causes & consequences	Inherent risk score (I x L)	Key controls	Board Assurance			Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions		Target risk score	Estimated date of achievement of target score
				Internal sources of assurance	External sources of assurance	Overall assurance level				Planned action	Progress update		
BAF9 System working and provider landscape changes may present challenges in ensuring COCH is engaged with system partners, placing the Trust in the best strategic position and with aligned priorities. Executive Risk Lead: Director of Strategy & Partnerships Board Committee: Board of Directors Last Update: July 2026	Causes - Clarity of system leadership and management roles - Maturity of the ICS and emerging Neighbourhoods - Further development of Provider Collaborative - Changes in commissioning - Unclear system clinical priorities - 10 year health plan implications Consequences - Potential conflicting priorities between organisations and systems - Diversion of COCH leadership capacity - Loss of autonomy - Disruption to established clinical networks	4 x 4 = 16	C1) Take a Leadership role Control Owner: Director of Strategy & Partnerships	Chief Executive Officer reports to Board.	Regular reporting from CMPC CiC Regular reporting from Mental Health, Learning Disabilities and Community Services CiC Cheshire West Health and Well Being Board Cheshire West Partnership Group CVD events	Acceptable	4 x 3 = 12	YES	Clarity and coordination of partnership and systems engagement updates to Board	Coordinated reporting to be developed including CMPC updates. Action Owner: Director of Strategy & Partnerships Due date: Q3 2026/27	Leadership roles in place with attendance at a range of forums across C&M. Executive representation through professional groups. Discussions ongoing with CMPC regarding communications for Boards, with further updates expected in September 2026. Reporting on partnerships and system working continues to evolve.	16	Target Score Achieved <i>(Risk is within risk appetite. Further work progressing on stakeholder engagement and collaboration)</i>
			C2) Embed a Trust approach to health inequalities and prevention, and population health Control Owner: Director of Strategy & Partnerships		Cheshire West Partnership Group	Partial			Clarity and changes to stakeholders.	To update stakeholder map and actions. Action Owner: Director of Strategy & Partnerships Due date: Q3 2026/27	Stakeholder map being reviewed and updated to reflect changes. Priorities, roles and actions to be agreed.		
									Health inequalities reporting framework to meet national requirements.	Embed population health and health inequalities framework and develop reporting. Action Owner: Director of Strategy & Partnerships Due date: Q4 2026/27 (with quarterly updates)	Update on health inequalities national reporting expectations shared at EDG. Further work to do to develop reporting.		
			C3) Anchor institution workstreams (green / social value / prevention) Control Owner: Director of Strategy & Partnerships	Anchor Institute Group Chairs report to Finance & Performance Committee	ICB Net zero Group ICB Prevention Pledge Group Population Health Board National quarterly data collection via Foundary platform Anchor Institute Accreditation	Acceptable			C2AI and Cipa into action reporting.	Embed population health tools into community services as a means of managing those patients most at risk of hospital admission. Action Owner: Director of Strategy & Partnerships Due date: Q4 2026/27 (with quarterly updates)	An approach to Health Inequalities has been developed and shared with local stakeholders who have endorsed the approach. Health inequality tools are deployed in community services through the CIPHA (data into action) when assessing likelihood of risk and admission to hospital		
			C4) Collaborative models Control Owner: Chief Operating Officer/ Director of Strategy & Partnerships	CEO Report to Board. COCH/CWP Community Services updates through OMB.	CMPC reporting.	Partial			Alignment and development of Community services. Involvement and influence to support Neighbourhood developments.	(i) Progress discussions with partners regarding development and alignment of community services. Action Owner: Director of Strategy & Partnerships Due date: Quarterly updates (ii) Active involvement alongside partners in the establishment of local Neighbourhoods. Action Owner: Director of Strategy & Partnerships Due date: Aligned to system timeframes (with quarterly updates)	Support to CMPC provider strategy and alignment of community services. Discussions ongoing with CWP regarding the continued development of the community collaboration in the context of national and regional strategy. Engagement with Neighbourhood development, recognising this is at its infancy.		
									Clairty of opportunities and priorities for local collaboration.	Explore opportunities for local collaboration. Action Owner: Director of Strategy & Partnerships Due date: Quarterly updates	Continued to work with WUTH/ WCHC to develop understanding of collaboration opportunities through joint working group. Further Exec to Exec planned for July 2026 with updates to Board continuing through Board development days.		

Risk Theme: Research and Innovation													
RISK APPETITE: SEEK - Upper tolerance limit 16													
LINKS TO STRATEGIC OBJECTIVES: SG5: Partnerships													
Risk description & information	Causes & consequences	Inherent risk score (I x L)	Key controls	Board Assurance			Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions		Target risk score	Estimated date of achievement of target score
				Internal sources of assurance	External sources of assurance	Overall assurance level				Planned action	Progress update		
BAF10 Inability to deliver the Research and Innovation agenda to exploit future opportunities Executive Risk Lead: Medical Director Board Committee: Board of Directors Last Update: July 2026	Causes - Lack of leadership capacity and succession planning - Funding sources - Early stages of partnerships and strategic focus - Lack of capacity and focus on Innovation opportunities - Capacity and capability to deliver commercial research activity in the CRU Consequences - Ability to maintain R&I function - Alignment of R&I activity - Ability to secure funds and missed opportunities - Future leadership plans	4 x 3 = 12	C1) Research Strategy Control Owner: Medical Director	Quarterly Board reports. Research updates via OMB.	Annual report to RRDN. Annual reports on additional strategic funding to RRDN.	Partial	4 x 3 = 12	YES	Strategy delivery.	Delivery of the Research Strategy Action Owner: Medical Director Due date: Year 1 end of 2026/27 (with quarterly updates)	Research Strategy approved by the Board in January 2026. Update on progress provided to the Board in March 2026. Key priorities are growth of commercial income through partnership with C&M CRDC; collaborative working with Primary Care CRDC to deliver research across our PCNs including use of Trust assets; development of joint research workstreams with the University of Chester.	16	Target Score Achieved (Risk is within risk appetite. Further work progressing on partnerships to support delivery of Research Strategy)
			C2) Team structure, SOPs and expertise Control Owner: Medical Director	Quarterly Board reports. Research updates via OMB. R&D Executive Chairs Report to Board.	MHRA inspections. GCP inspections. HTA inspections. Trial specific assurance reviews.	Partial			Leadership resource and capacity.	External review of Team structure, capacity and roles, and research governance to enable delivery of strategy. Action Owner: Medical Director Due date: Q2 2026/27	External review commenced July 2026. SARD job planning has improved recognition of research PAs and as this becomes embedded we would expect greater alignment and consistency to drive research activity.		
			C3) Funding including RRDN (Regional Research delivery network) Arrangements Control Owner: Medical Director	Quarterly Board reports. Research updates via OMB.	Annual report to RRDN. Annual reports on additional strategic funding to RRDN.	Partial			Further strengthening of governance and SOPs.	Continued review of governance and SOPs (including Trust vehicle). Action Owner: Medical Director Due date: Q3 2026/27	Further work to streamline this to meet new 150 targets from NIHR which will be integral to funding going forward. List of Standard Operating Procedures (SOPs) in place and team engaged in further review and development. Progress made to develop manuals for Mobile Research Unit.		
									Lack of financial expertise embedded in the team.	To discuss financial support needs and resolve the gap. Action Owner: Medical Director Due date: Q4 2026/27 (following external review)	Continue to work with Finance Business Partner - with increased commercial growth and income intention to have a research governance/ finance role embedded in the department. This will be considered within the external review.		
									Funding levels and income streams.	Continued focus on funding streams, including securing grants and commercial funding. Action Owner : Medical Director Due date: Q4 2026/27 (with quarterly updates)	Assurance received that funding for 2026/27 will remain, not withstanding a real term reduction of circa 30% over the last 10. Improved performance evidenced on 150 targets which ensures funding likely to remain at current levels or increase next year. Work ongoing with the Universities and commercial companies on grant opportunities. Commercial Research Delivery Centre involvement live from April 2025 and anticipating greater research opportunities and commercial income through this. Recently re-drafted the research finance policy to align to research team and speciality resource and delivery, for review and approval.		
			C4) Partnership Arrangements (including academic appts) Control Owner: Medical Director	Quarterly Board reports. Research updates via OMB		Partial			Increasing academic appointments. Partnership agreements and governance.	To continue to develop our partnership arrangements, including education institutes and commercial. Action Owner: Medical Director Due date: Quarterly updates	Communication strategy developed to support awareness for partner organisations and the wider community. Current focus on building relationships and developing collaboration opportunities. Working with Communications Team to drive this forward. Framework agreed between COCH and the University of Chester (UoC) to progress partnership arrangements. Also building relationships with Primary Care Networks (PCNs) and the Primary Care CRDC to develop a regional primary care research network. Development of an SLA with Marine Lake GP Practice (lead site for Primary Care CRDC) in progress. Steps to Teaching and University Hospital status explored with the Board (February 2025). Constitution update and NED appointments complete to support progress to Teaching Hospital status. Increase in academic appointments mostly teaching through UoC medical school and focus on this continuing.		
C5) Innovation Strategy Control Owner: Medical Director	CAEG reporting to QGG and upto to Q&S.		Partial	Innovation strategy. Capacity and leadership to drive innovation.	Partnership with University of Chester to continue to be explored to support Innovation ambitions. Action Owner: Medical Director Due date: Quarterly updates	Current focus on building relationships and developing partnership opportunities. This will require leadership and resource to drive forward. Exploring innovation funds through grant applications. Operational innovation continues to be encouraged including Trust wide engagement in system led Innovation fortnight (November 2025) and shift to transformation programmes planned for 2026/27. CAEG established and operating to support new technology and practices.							

Risk Theme: Transformation															
RISK APPETITE: SEEK - Upper tolerance limit 16															
LINKS TO STRATEGIC OBJECTIVES: SG4: Adding Value															
Risk description & information	Causes & consequences	Inherent risk score (I x L)	Key controls	Board Assurance			Residual risk score (I x L)	Within risk tolerance?	Gaps in Control / Assurance	Actions		Target risk score	Estimated date of achievement of target score		
				Internal sources of assurance	External sources of assurance	Overall assurance level				Planned action	Progress update				
BAF11 Inability to deliver transformation and productivity programme would impact our ability to deliver our Medium Term Plan Executive Risk Lead: Director of Transformation and Productivity Board Committee: Board of Directors Last Update: July 2026	Causes - organisational culture and expertise - scale of change required - CIP and underlying deficit drivers - external factors and ability to influence stakeholders to drive change and improvement Consequences - Ability to deliver transformation at pace required - Underdelivery of CIP target aligned to plan profile with consequences on funding - Ability to progress CIP scheme maturity	4 x 4 = 16	C1) Transformation plan delivery as part of the Medium Term Plan Control Owner: Director of Transformation and Productivity	Finance/ CIP Board reporting Updates via OMB		Partial	4 x 4 = 16	YES	Transformation scheme maturity.	Further develop the maturity of the transformation programme. Action Owner: Director of Transformation and Productivity Due date: Quarterly updates	Continuing to drive the progress in maturity of schemes. Weekly Divisional CIP meetings in place. Fortnightly CIP delivery review meeting with Triumvirates. CIP delivery group chaired by CEO.	16	Target Score met. (New strategic risk recognising the shift to transformation needed to delivery our strategy, with processes, culture, governance and assurance developing; further reduction in scoring will be based on embedded frameworks and measurable delivery against programmes)		
			C2) Transformation programme approach and governance Control Owner: Director of Transformation and Productivity	CIP programme Reports to F&P Committee. Transformation Programme Board AAA via F&P Committee.		Partial			Programme management system and methodology.	Implement new Project management system. Action Owner: Director of Transformation and Productivity Due date: Q3	Aspire system procured and training delivered (June 2026). Agreed priorities based on scale and complexity, with population of system information in progress.				
			C3) Benchmarking framework Control Owner: Director of Transformation and Productivity		Model Health System. HED benchmarking.	Partial			Team and organisation capacity and expertise.	(i) Recruitment to team including Assoc. Director.c (ii) Training programme, engagement and transformation leads aligned to support Divisions. Action Owner: Director of Transformation and Productivity Due date: Quarterly updates	Recruitment took place in Q1, with appointment made and start date agreed. Transformation leads aligned and working with Divisions.				
									Governance and assurance reporting.	(i) Development of reporting and assurance. Action Owner: Director of Transformation and Productivity Due date: Q2 onwards (ii) Embedding the Transformation Programme Board governance and assurance reporting. Action Owner: Director of Transformation and Productivity Due date: Q2 onwards (with quarterly updates)	Board discussion took place during the Board development day in June 2026. Templates developed and assurance reporting continues to evolve. Population of Aspire will support automated reporting in the future. Transformation Board established and meeting monthly with updates from workstream groups and sub committees.				
									Data literacy, awareness and ownership of benchmarking and aligned improvement plans	Roll out of data packs aligned to NOF and transformation priority programmes with the developmet of aligned action plans and progress reporting. Action Owner: Director of Transformation and Productivity Due date: Q2 onwards (with quarterly updates)	Early data packs developed and tested with a number of specialities. These are being developed on a priority basis focussed on potential opportunity.				

Board Assurance Framework

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

5x5 risk scoring matrix:

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

Risk Appetite Levels

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

PUBLIC – Board of Directors
29th September 2026

Report	Agenda Item 9b.	Significant Risks Report (September 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	X	Potential to link to all BAF risk areas.					
	BAF 2 Safety	X						
	BAF 3 Operational	X						
	BAF 4 People	X						
	BAF 5 Finance	X						
	BAF 6 Capital	X						
	BAF 7 Digital	X						
	BAF 8 Governance	X						
	BAF 9 Partnerships	X						
	BAF 10 Research	X						
	BAF 11 Transformation	X						
	Strategic goals	Patient and Family Experience						
People and Culture		X						
Purposeful Leadership		X						
Adding Value		X						
Partnerships		X						
Population Health		X						
CQC Domains	Safe	X						
	Effective	X						
	Caring	X						
	Responsive	X						
	Well led	X						
Previous considerations	Not applicable							
Executive summary	As at September 2026, the Trust has 12 risks with a residual risk score of 15 or above. No risks with a residual risk score of 15 or above have been closed or reduced since the last report and two new risks have been escalated (due to increased scores) 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 significant 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 (September 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	5
16	7
20	0
No. Risks removed/reduced	0
No. Risks open >12 months	8

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 1st September 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 in Score
Lead Committee: Finance & Performance									
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. 5 scripts now under review and testing. A new AI waiting list validation tool is due for deployment in October 2026. Data quality scripts to help clean up waiting list data are in test, deployment date to be confirmed. Risk impacted by secretarial vacancies. Recruitment ongoing to support team	Dec 2026	Cathy Chadwick	↔
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	Digital and Data Services	5x3	15	MIAA have completed their assurance audit for Data Security Protection Toolkit (DSPT) evidence with an outcome low risk and high veracity on the elements audited. The DSPT submission for 2026 has been completed with a “Standards Met” outcome. Risk score remains at 15 whilst DSPT	Nov 2026	Jason Bradley	↔

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Change in Score
		for these areas and this risk is to hold the overarching risk of a Cyber attack.				action plan for 26/27 is reviewed and considering heightened national security concerns.. National funding has been awarded for the purchase of a new internet proxy device. A solution has been chosen and purchased, the new device is planned to be installed and active by November 2026. The device will help mitigate one of our key Cyber related risks – the exfiltration of data, by proactively monitoring and blocking (if necessary) any large scale data extraction. A Cyber Programme for 26/27 plan has been created and shared through IG/CS committee. The plan is being actively worked on, with key activities including replacement of Privileged Access Management platform, strengthening user passwords and increasing monitoring through the national Cyber & Specialist Operations Command.			
24/10/2024	3346	Trust Fire Alarm System - Non-Compliance	Corporate	4x4	16	Prioritised for capital investment in capital programme. Business case approved and phased approach to replacement of high risk areas first.	Q3 2026/27	Karen Edge	↔

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Change in Score
						2026/27 work planned but risk remains high due to nature of remaining work.			
09/02/2023	2964	High numbers of Non-criteria to reside (NCTR) patients across both Trust sites	Therapies and ICC	4x4	16	Agreed to increase to a red risk of 16 at OMB due to effect of the high percentage of (NCTR) patients across the 3 adult bed owning divisions. Failing to reduce NCTR percentage of the acute bed base to 15% creates subsequent risk in patient flow resulting in delayed ambulance handover and increased number of patients being held in ED who should be transferred to ward areas. The number of NCTR patients also requires the Trust to maintain a high level of escalation capacity at additional cost. 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. Agreement with ICB to maintain the number of pathway 2 beds, focus on reducing LOS in P2 beds at EPH and Pinetum and progressing proposal for the Trust's Rapid	March 2027	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 in Score
						response team to support Flintshire patient discharges. System Chief executive meeting convened In July to agree high level actions required to achieve target. June 2026 implementation of ward based LLOS reviews twice week using NHSE LLOS review tool, to support focused reduction of >21 LOS.			
05/06/2025	3477	High number of medical patients being managed outside of the Urgent Care bed base.	Urgent Care	4x4	16	Reduction in average number of delayed admissions supporting prompt reviews. Substantive investment in additional AIM consultants being recruited to move away from ad hoc cover, providing improved continuity of care. KPIs are tracked monthly through the electronic Acute Take list. Reduction in medical outliers due to bed reconfiguration. Overall position also reliant on reduction in NC2R position. Risk remains significant for effective high quality patient care, through risk of corridor care and usage of non-ward-based care for patients requiring admission.	March 2027	Cathy Chadwick	↔
01/01/2024	3255	Dialysis machine past the	Urgent Care	3x5	15	New dialysis machines were installed in August. The training is	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 in Score
		recommended life span resulting in more frequent repairs.				planned for 14 th September. If there are no issues, then the risk will be closed at the end of September.		Karen Edge	
29/10/2025	3541	General Surgery on-call model lacks capacity and senior oversight for timely patient reviews	Planned Care	4x4	16	There is now a dedicated surgical SHO assigned to cover SDEC and afternoon Consultant cover for SDEC will also be in place soon. Currently also progressing a business case to provide a Foundation Year 1 doctor on call for nights and weekends. The Division have identified that this is possible within their current establishment and seems to be favourable for all resident doctors including the FY1s. This will allow an increase in ward cover specifically out of hours allowing appropriate triage of deteriorating patients on the ward and release SHOs to support theatre and the acute take. Once these measures are in place then risk will be mitigated down.	Q3 2026/27	Nigel Scawn	↔
31/01/2025	3413	E.D.F. washers endoscopy decontamination unit life span	Planned Care	3x5	15	Replacement units agreed for capital spend 2026 with orders issued and installation due to be completed end Feb 2027.	March 2027	Karen Edge	★

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Change in Score
Lead Committee: Quality & Safety									
10/06/2024	3260	Risk to patient safety due to lack of adherence to NHSE 4 hour Emergency Department standard	Urgent Care	3x5	15	Continued focus on flow and UEC improvement plan, which had been reviewed and is now a full system improvement plan. Long waiting times in the Emergency Department have significantly improved during February 2025 and this has remained consistent. Work continues to reduce the waiting times for a bed to under 12 hours.	March 2027	Cathy Chadwick	↔
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. Obtained quotes for lead gowns, supported by the Capital Management Group and procurement underway. This will mitigate aspects of the risk relating to our staff.	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	VTE committee now in place. Recent changes to EPR direct users to NICE guidance for assessment and prescribing and make timely administration easier. Compliance is improving. Monitored through Quality Governance Group.	Q3 2026/27	Nigel Scawn	↔

Date added	Ref	Risk Summary	Division	Impact x Likelihood	Residual risk score	Mitigation / Actions/ Comments	Target date for closure/ reduction	Executive Lead	Change in Score
						Risk probably needs to stay until above National target.			
31/12/2025	3584	Risk of irreversible sight loss due to insufficient glaucoma capacity, admin processes and follow up delays	Planned Care	4x4	16	Partial booking, additional clinic capacity, safety-net communications and failsafe monitoring are in place. Nursing and imaging capacity has increased, although administrative vacancies and process issues continue to affect delivery. Community glaucoma and ophthalmic EPR developments are progressing. The risk remains 16 pending sustained improvement in overdue follow-ups and capacity.	Jan 2027	Cathy Chadwick	★
Lead Committee: People Committee – currently no significant risks on the Risk Register relating to the People Committee.									

PUBILC – Board of Directors
29th September 2026

Report	Agenda Item 10.	Care Quality Commission (CQC) Report and Action Plan (Medical Care, Urgent & Emergency Care, and End of Life services)						
Purpose of the Report	Decision	X	Ratification		Assurance	X	Information	
Accountable Executive	Sue Pemberton				Director of Nursing & Quality / Deputy Chief Executive			
Author(s)	Melanie Kynaston				Deputy Director of Nursing			
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 BAF11 Transformation				X X X X X	The impact of the findings and failure to respond to the recommendations in the report could affect the BAF.		
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	The Board has been briefed during the CQC inspection and reporting processes.							
Executive summary	The Care Quality Commission (CQC) undertook a comprehensive assessment of The Countess of Chester Hospital in October 2025, focusing on three core service areas: Urgent and Emergency Care (UEC), Medical Care (including Older People's Services), and End of Life Care (EOLC). The inspection demonstrates the progress made, with the overall ratings reported: • UEC – Overall rating of Requires Improvement (moving from Inadequate) • Medical Care – Overall rating of Good • EOLC – Overall rating of Good							

	The findings also recognise that improvements are required to achieve consistently high levels of assurance across all services. This paper sets out the themes and alignment to ongoing improvement work, as well as the detail action plan against the reported regulatory breaches.
Recommendations	The Board of Directors is asked to - Note the findings and response to the CQC inspection - Approve the Trust response and approach to continuous improvement aligned to existing action plans, processes and assurance mechanisms

Corporate Impact Assessment	
Statutory/regulatory requirements	CQC
Risk	Risks are aligned to several operational risks on the Trusts risk registers.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	To be circulated in Board papers.

Care Quality Commission (CQC) Report and Action Plan (Medical Care, Urgent & Emergency Care, and End of Life services)

1.0 Background

The Care Quality Commission (CQC) undertook a comprehensive assessment of The Countess of Chester Hospital in October 2025, focusing on three core service areas: Urgent and Emergency Care (UEC), Medical Care (including Older People's Services), and End of Life Care (EOLC).

In terms of broader operational context, the demand for urgent and emergency services remains high, inpatient bed occupancy continues to exceed recommended levels, and delays in accessing community and social care services place significant pressure on discharge pathways. These system-wide challenges have contributed to prolonged waits in the Emergency Department, increased use of escalation capacity and difficulties in maintaining optimal patient flow across inpatient services. The inspection therefore provides not only an assessment of current performance but also an opportunity to evaluate the continued response needed to sustained operational pressure.

This report provides a thematic analysis of The Countess of Chester Hospital NHS Foundation Trust's position following the October 2025 CQC assessment.

The purpose of the review is to identify key areas of progress since previous inspections, critically evaluate the factors contributing to current performance, and highlight priority themes for further improvement.

The full inspection findings are published on the CQC website.

2.0 Inspection findings

The overall inspection ratings by service are set out below.

Figure 1. CQC inspection ratings July 2026

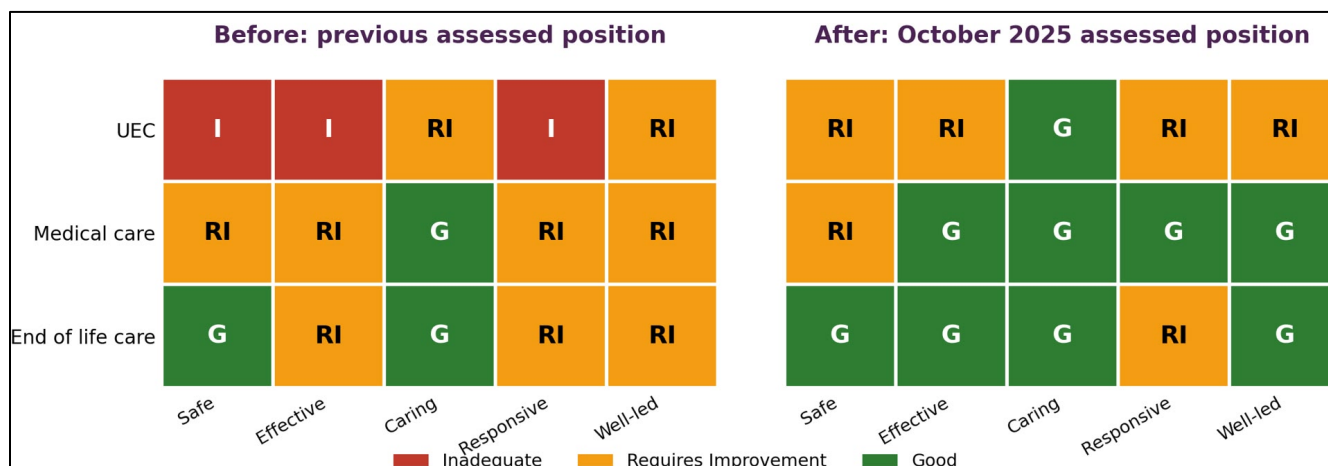
	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED	OVERALL
Medical Care (incl. older people's care)	Requires Improvement (Oct 25) ↔	Good (Oct 25) ↑	Good (Oct 25) ↔	Good (Oct 25) ↑	Good (Oct 25) ↑	Good (Oct 25) ↑
End of life care	Good (Oct 25) ↔	Good (Oct 25) ↑	Good (Oct 25) ↔	Requires Improvement (Oct 25) ↔	Good (Oct 25) ↑	Good (Oct 25) ↑
Urgent and emergency services	Requires Improvement (Oct 25) ↑	Requires Improvement (Oct 25) ↑	Good (Oct 25) ↑	Requires Improvement (Oct 25) ↑	Requires Improvement (Oct 25) ↔	Requires Improvement (Oct 25) ↑

The analysis demonstrates that the Trust has established strong foundations for future improvement. Inspectors consistently recognised compassionate care, positive staff behaviours, improved multidisciplinary working, enhanced partnership arrangements and a developing culture of learning and improvement. Significant advancements were noted in Medical Care and EOLC, whilst UEC showed marked progress from its previous regulatory

position. However, the assessment highlights the need for greater consistency and reliability in operational delivery.

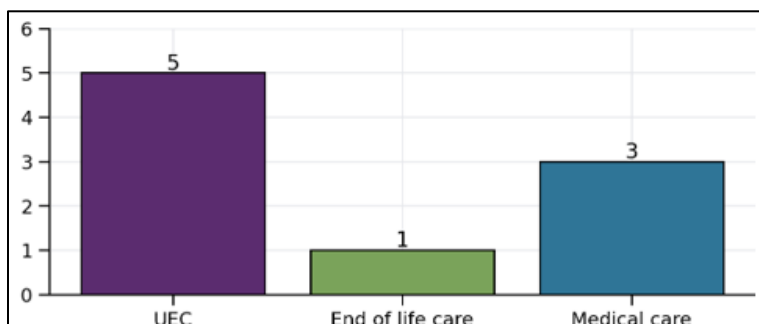
Recurrent themes relating to workforce resilience, timely discharge, environmental safety, compliance with safety standards and proactive governance indicate that further work is required to translate improvement initiatives into consistent, sustainable and measurable outcomes.

Figure 2. CQC rating movement by inspected core service



A comparison of regulatory breaches demonstrates areas for improvement across the three assessed services.

Figure 3. Regulatory breach burden by inspected service



A summary of the reported breaches and action being taken is provided in Appendix A.

2.1 Urgent and Emergency Care (UEC)

The inspection identified notable improvements across UEC, demonstrating progress since the previous assessment and evidence of organisational responsiveness to regulatory concerns.

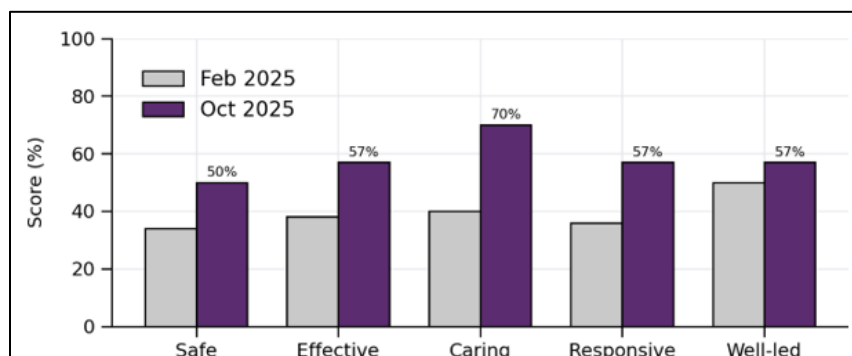
Urgent and emergency services		
Overall	Requires improvement	●
Safe	Requires improvement	●
Effective	Requires improvement	●
Caring	Good	●
Responsive	Requires improvement	●
Well-led	Requires improvement	●

Most significantly, the Safe domain improved from *Inadequate* to *Requires Improvement*, reflecting enhanced safety processes, stronger incident learning arrangements, and visible action taken to address previously identified risks. Inspectors reported that the service had developed a proactive culture of safety, with effective incident reporting, improved safeguarding systems, and stronger engagement with regional partners to support innovation and patient flow. There was also evidence of improved oversight of mental health presentations, significant reductions in time to triage, and improvements in equipment governance and stock control.

Further improvements were evident in operational performance and patient experience. The inspection highlighted substantial reductions in ambulance handover delays,

Inspectors also identified significant improvements in departmental culture, noting that staff consistently demonstrated compassionate, respectful and supportive behaviours towards patients and colleagues. Consequently, the Caring domain improved from *Requires Improvement* to *Good*, with patients describing noticeable positive changes in their experience of care.

Figure 4. UEC improvement in key question scoring from February to October 2025



Although the service demonstrated a positive trajectory of improvement and greater organisational commitment to change, the inspection highlights several areas where further sustained improvement is required, to achieve consistently high-quality care and reduce ongoing risks to patients.

All areas of improvement form part of the established UEC Improvement Programme and progress against actions is monitored through divisional quality, safety and performance meetings, with any escalations made through the divisional governance structure. In addition, Quality and Safety Committee (sub-board) receive an oversight and assurance report bi-monthly to monitor and evaluate progress.

Further details can be found in Appendix A.

2.2 Medical Care

The inspection identified substantial improvement across Medical Care, with the overall service rating improving from *Requires Improvement* to *Good*, alongside improvements in the Effective, Responsive, and Well-led domains.

Medical care (Including older people's care)		
Overall	Good	
Safe	Requires improvement	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Good	

The inspection additionally highlighted the impact of targeted quality improvement and system-wide transformation initiatives aimed at enhancing patient flow, reducing harm, and supporting recovery. Improvements were noted in the management of patient transitions through daily operational oversight, strengthened discharge processes, expanded Same Day Emergency Care (SDEC) services, development of Hospital at Home pathways, rapid response services, and enhanced collaboration with community partners. Inspectors observed a clear culture of continuous improvement, evidenced through innovations in stroke care, pressure ulcer prevention, wellbeing programmes, dementia care, and rehabilitation support.

Despite significant improvement, the inspection identified that further improvement is required to ensure that high standards are consistently achieved across all areas of Medical Care.

All areas of improvement form part of established improvement programmes and progress against actions is monitored through divisional and corporate quality, safety and performance meetings, with any escalations made through the divisional governance structure or corporate governance framework.

Further details can be found in Appendix A.

2.3 End of Life Care

The inspection identified significant improvements within EOLC, resulting in the overall service rating improving from *Requires Improvement* to *Good*, with notable improvements in the Effective and Well-led domains.

End of life care		
Overall	Good	●
Safe	Good	●
Effective	Good	●
Caring	Good	●
Responsive	Requires improvement	●
Well-led	Good	●

Inspectors found evidence of stronger leadership, more robust governance arrangements, and enhanced multidisciplinary collaboration across inpatient services and specialist palliative care.

All areas of improvement form part of the established improvement programme for EOLC and progress against actions is monitored through EOLC steering group, with any escalations made through the corporate governance structure to Quality Governance Group (QGG) and the Quality and Safety Committee.

3.0 Conclusion

The October 2025 CQC inspection demonstrates the progress made. The findings also recognise that improvements are required to achieve consistently high levels of assurance across all services.

Overall, the findings indicate an organisation that is transitioning from a period of reactive improvement towards greater organisational maturity. This is evidenced by measurable rating improvements across all three inspected services, stronger leadership visibility, more mature governance arrangements, enhanced multidisciplinary working, and sustained evidence of compassionate, person-centred care. The most significant gains have been achieved within Medical Care and EOLC, both of which attained an overall rating of Good, while UEC demonstrated substantial improvement from its previous regulatory position, particularly within the Safe, Effective and Caring domains.

The inspection also demonstrates that many of the Trust's improvement programmes are yielding tangible benefits.

4.0 Recommendations

The Board of Directors is asked to:

- **Note** the findings and response to the CQC inspection
- **Approve** the Trust response and approach to continuous improvement aligned to existing action plans, processes and assurance mechanisms.

Appendix A. Comparative analysis of regulatory breaches by core service

Core Service	Regulation breached	Inspection findings	Actions and monitoring
UEC	Regulation 18: Staffing	Medical safeguarding compliance remained below Trust standards, consultant establishment remained below Royal College of Emergency Medicine recommendations, appraisal compliance remained low and the Paediatric Emergency Department was unable to consistently provide two children's nurses as required by national standards.	Targeted recovery plan implemented for mandatory training and appraisal compliance. Targeted recruitment plan for ED RCNs and HCSWs implemented. Review of ED medical workforce capacity to support senior and independent decision making for patients corresponding with variances in the weekly attendance profile. Plans are monitored at Divisional Governance.
UEC	Regulation 12: Safe Care and Treatment	Inconsistent compliance with risk assessments, sepsis management standards, NEWS2 completion, infection prevention and control measures and patient streaming processes between ED and UTC.	Established assurance audits across all safety metrics identified as below target. BI monitoring in place in real-time. Compliance against improvement trajectories is monitored at weekly ED DNS meeting, Divisional Governance, QGG and Quality and Safety Committee.
UEC	Regulation 15: Premises and Equipment	Environmental risks remained unresolved, including unsecured cleaning products and concerns regarding emergency resuscitation capacity and storage arrangements.	Established processes in place: • IPC audit of environment • Cleaning audits • Fire warden checks • MEG safety check lists • Matron spot checks • Requests for estates work Improvements are monitored at senior nurse oversight meetings, Divisional IPC meetings, Divisional Governance, Health and Safety Committee and IPC Assurance Committee.
UEC	Regulation 9: Person-Centred Care	Patients experienced excessive waits, prolonged decision-to-admit delays and delays in accessing definitive treatment.	Comprehensive Emergency Department Improvement Plan in place. Monitored at weekly ED meeting, monthly specialty meeting, Divisional Governance, Exec-Led UEC, Discharge and Admission Avoidance group and OMB.

Core Service	Regulation breached	Inspection findings	Actions and monitoring
UEC	Regulation 17: Good Governance	Repeated concerns regarding IPC, safeguarding and environmental safety had not been fully identified or escalated through governance processes before inspection. Significant risks were only added to risk registers following inspection activity	Full governance review and risk register reconciliation has been completed. Monitored at Divisional Governance.
Medical Care	Regulation 12: Safe Care and Treatment	Escalation areas were being used for inpatient care, SDEC areas were supporting bed occupancy rather than ambulatory pathways, and delays in discharge resulted in prolonged hospital stays.	Escalation capacity has been reduced. SDEC corridors have closed. SDEC frailty unit is no longer used as escalation area. Comprehensive patient flow improvement programme in place. Monitored at weekly ED meeting, monthly specialty meeting, Divisional Governance, Exec-Led UEC, Discharge and Admission Avoidance group and OMB.
Medical Care	Regulation 15: Premises and Equipment	Fire safety defects remained unresolved, including non-compliant fire doors and obstructed escape routes. Similar concerns had been raised historically	Comprehensive plan in place to further improve fire safety. Plan is monitored at Health and Safety Committee.
Medical Care	Regulation 18: Staffing	Workforce pressures persisted within stroke services, healthcare support worker staffing on the ward and mandatory training compliance a concern. No 24/7 stroke coordinator service.	Targeted recruitment plan for HCSWs implemented. Business case completed for stroke coordinator. Targeted recovery plan implemented for mandatory training Plans are monitored at Divisional Governance.
EOLC	Regulation 9: Person-Centred Care	Advanced Care Plans (ACP) were not routinely completed, preferred place of care and death were not consistently recorded, and patient wishes were not systematically monitored across the Trust.	Comprehensive plan in place to implement, train and sustain. Plan is monitored at End-of-Life Steering Group, QGG and Quality and Safety Committee.

Appendix B. Strategic improvements



PUBLIC – Board of Directors
29TH September 2026

Report	Agenda Item 11.	Inpatient Survey Results (2025 Survey)					
Purpose of the Report	Decision		Ratification		Assurance		Information X
Accountable Executive	Sue Pemberton			Director of Nursing and Quality / Deputy Chief Executive			
Author(s)	Fiona Altintas			Deputy Director of Nursing, Quality & Governance			
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research BAF 11 Transformation			X X	Supports triangulation against quality and safety BAF risks.		
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health						X X X X
CQC Domains	Safe Effective Caring Responsive Well led						X X X X X
Previous considerations	Inpatient Survey 2024						
Executive summary	The Adult Inpatient Survey results (2025) was published in August 2026. It is important to acknowledge that the Trust, like all other Trusts, receive the results of the inpatient survey nearly 11 months after the survey cohort of patients is decided. Questions included in the survey follow the journey of patients from admission to hospital, treatment and discharge. There are 12 categories in which 39 questions are asked. 427 service users from Countess of Chester Hospital NHS Foundation Trust responded to the National In-patient survey (c.f. 457 responses the previous year). The response rate for Countess of Chester Hospital NHS Foundation Trust was 37%, with a national average response rate of 38%. The national survey results demonstrate significant improvement in all 12 categories.						

	For overall experience the Trust has moved nationally from a ranking of 117th to 59th out of 131 Trusts with a score of 8.3. In addition, 80% of patients rated their care 7/10 or above, the Trust's strongest position in around seven years with a score of 8.3. Scores to highlight are the score for kindness and compassion which was rated 9.1/10 and respect and dignity which was 9.2/10. Picker (survey analysts) interrogation of the data yielded extremely positive scores, 99% of patients reflected that they were treated with kindness and compassion, respect and dignity, and their privacy was maintained. An extremely high level of trust and confidence in our nurses and doctors was also reflected in the scores. There are areas of continued focus which require further improvement particularly in 'Leaving Hospital'. These improvements will be driven through the Patient Experience Improvement Framework and the Discharge Excellence program. These results follow a number of other improvements including the CQC ratings in July 2026 which reported marked improvements across three services, with medical care rated good overall, end of life services rated good overall and urgent care improving from inadequate to requires improvement. Caring for patients was rated good in all areas. In addition, within the National Oversight framework, the Trust has moved from a position of 133 to 95 in the most recent publication this month. Together, these results show that the improvements across the organisation are impacting positively on the experience of our patients. The next CQC inpatient survey (2026) will be conducted with patients in our hospital In November 2026.
	The Board of Directors is asked to: • Note the contents of the paper and the significant improvement this year compared to previous year. • Note the implementation of the new platform for FFT collection. • Note the progress of the Patient Experience Improvement Framework.

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

Inpatient Survey Results (2025)

1. Introduction

The Adult Inpatient Survey for 2025 was published in August 2026 - [Adult inpatient survey 2025 - Care Quality Commission](#). This National survey looks at the experiences of people who stayed at least one night in hospital as an inpatient during November 2025, and who were over 16 years or over at the time of their stay.

It is important to note, that the Trust like all other Trusts, receive the results of the inpatient survey, nearly 11 months after the initial data collection.

Between January and April 2025, 1,250 people at each participating NHS trusts were invited to take part in the survey. Responses were received from 427 (37%) people at Countess of Chester Hospital NHS Foundation Trust. The average response rate for all Trusts nationally is 38%. A split by male and female responders demonstrated that 49% were male and 51% were females. 71% of responders were in the age bracket of 66 and above years.

Questions included in the survey follow the journey of patients from admission to hospital, treatment and discharge. There are 12 categories in which 39 questions are asked.

2. Purpose

The purpose of this paper is to provide the Board of Directors with a summary of the 2025 Inpatient Survey results for the Countess of Chester, identifying themes and subsequent actions and monitoring improvements and outline how we are utilising the Friends and Family Test (FFT) to support and drive continuous improvements.

3. National feedback from the survey

Nationally, results from the 2025 survey show statistically significant improvement across multiple areas of care for a second consecutive year. Most patients reported positive interactions with hospital staff and feeling involved in their own care, and the results also showed some improvements in staff availability and meeting patients' fundamental needs, such as help with eating meals. Long-term trend analysis also suggests people's experience of inpatient care is improving.

Discharge from hospital has shown some positive change, for example with patients being told who to contact if they were worried about their condition or treatment after they left hospital. However, discharge planning and post-discharge care is an area of challenge. For example, family or carers not being given the information needed to care for patients once they get home, and patients not getting enough support from health or social care services to help them recover or manage their condition.

Patients living with frailty and those admitted as an emergency consistently reported worse experiences of inpatient care. Patients with a disability, dementia or Alzheimer's, or a neurological condition reported worse experiences across most areas of care.

4. Countess of Chester Inpatient Survey Results

The survey results specifically for the Countess of Chester demonstrate significant improvement in all 12 categories. These can be seen in table 1 in detail.

In addition to this 80% of patients rated their care 7/10 or above, the Trust's strongest position in around seven years.

Scores to highlight are the score for Kindness and compassion for which we scored 9.1/10 and Respect and Dignity for which we scored 9.2/10.

Table 1

Section	2024 score	2025 score
Admission to hospital	6.4/10	7.3/10 
Hospital and wards	7.0/10	7.4/10 
Basic needs	7.7/10	8.1/10 
Doctors	8.5/10	8.8/10 
Nurses	8.2/10	8.5/10 
Care and treatment	8.0/10	8.4/10 
Individual needs		8.2/10 
Virtual wards	6.5/10	6.6/10 
Leaving hospital	6.3/10	6.7/10 
Kindness and compassion	8.9/10	9.1/10 
Respect and dignity	8.9/10	9.2/10 
Overall experience	7.8/10	8.3/10 

With regards to where this improvement ranks the Trust nationally, in overall experience the trust has made a significant improvement in the national ranking, moving from 117th to 59th out of 131 Trusts. Table 2 outlines the rises in each category nationally, however the top 4 improvements in ranking are in the following areas:

- Your Care and Treatment (up 69 places)
- Overall experience (up 58 places)
- Respect and Dignity (up 57 places)
- Admission to Hospital (up 51 places)

Table 3 demonstrates that the Trust is better than the national average in 6 categories, the same in 2 categories and marginally worse in 4 categories. These will form a pivotal role in our continued improvement plan.

Table 2

Section	2024 Rank	2025 Rank	Improvement on ranking
Section 1: Admission To Hospital	90	39	Up 51 places
Section 2: Hospital & Ward	105	76	Up 29 places
Section 3: Basic Needs	92	62	Up 30 places
Section 4: Doctors	112	67	Up 45 places
Section 5: Nurses	111	70	Up 41 places
Section 6: Your care and treatment	120	51	Up 69 places
Section 7: Individual needs	Not ranked	24	(not ranked in 2024)
Section 8: Virtual wards	83	74	Up 9 places
Section 9: Leaving hospital	130	102	Up 28 places
Section 10: Kindness and compassion	93	57	Up 36 places
Section 11: Respect and dignity	116	59	Up 57 places
Section 12: Overall experience	117	59	Up 58 places

Table 3

Section	2025 Score	Nat. Avg	Diff from avg	2025 Rank
Section 1: Admission To Hospital	7.3	7.1	0.2	39
Section 2: Hospital & Ward	7.4	7.6	-0.2	76
Section 3: Basic Needs	8.1	8.1	0.0	62
Section 4: Doctors	8.8	8.9	-0.1	67
Section 5: Nurses	8.5	8.5	0.0	70
Section 6: Your care and treatment	8.4	8.3	0.1	51
Section 7: Individual needs	8.2	7.8	0.4	24
Section 8: Virtual wards	6.6	7.1	-0.4	74
Section 9: Leaving hospital	6.7	7.0	-0.3	102
Section 10: Kindness and compassion	9.1	9.0	0.1	57
Section 11: Respect and dignity	9.2	9.1	0.1	59
Section 12: Overall experience	8.3	8.2	0.1	59

The top 5 areas where patients experience is best in the Countess of Chester are

- ✓ **Individual needs:** staff taking into account patients individual needs – religious needs
- ✓ **Individual needs:** staff taking into account patients individual needs – cultural needs
- ✓ **Food:** patients being able to get hospital food outside of set mealtimes
- ✓ **Information while on waiting list:** quality of information while on waiting list
- ✓ **Waiting List:** length of time on waiting list before hospital admission

Areas where patient experience could improve

- Leaving Hospital: staff discussing with patients whether patients may need further health/social care services after leaving- reduced score from 77% to 73%
- Information about virtual wards: patients getting information about risks and benefits of continuing treatment on virtual wards – increased score from 68% to 74%
- Taking medication: Patients being able to take medication they brought in with them when they need to – reduced score from 85% to 84%
- Leaving hospital: Staff telling patients who to contact if worried about condition/treatment after leaving hospital – increase from 67% to 69%
- Sleeping: Patients being prevented from sleeping at night due to noise from other patients – although improved score from previous year

To conclude, in the 5 categories where we could improve the most, we improved our score in 3 of these categories.

5. Picker Interrogation

Picker is an approved contractor who work with 61 organisations and supports the Trust in the interrogation of the survey results. The trust has shown favourable results in a variety of questions and patient responses, and the table below highlight the high rating and improving scores the trust has received.

- ✓ Mealtime help and food availability outside of mealtimes has improved year on year since 2020 and is at 83%
- ✓ 97 % of all responder's have confidence and trust in doctors and 97% of doctors have included the patient in conversation.
- ✓ 98% of responders have confidence and trust in nurses and 98% of patients responded that nurses included them in conversations
- ✓ 99% of patients said staff helped control pain and 99% said that staff helped when needed attention.
- ✓ 99% of patients said that they were given enough privacy when being examined or treated
- ✓ 99% of patients responded that they were treated with kindness and compassion
- ✓ 99% of patients said they were treated with respect and dignity overall.
- ✓ 81 % of patients rated their overall experience as 7/10 or more – best score since 2021.

6. Friends and Family Test

In addition to the national survey results, the Trust utilises the Friends and Family Test (FFT). This is an important real time feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback, on their experience. Listening

to the views of patients helps identify what is working well, what can be improved and how. The Trust receives a monthly report, which is shared with all wards and departments.

The FFT asks people about their overall experience of services they have used and offers a range of responses.

The Trust has recently moved to a new and improved platform for collecting friends and family feedback. Using ward and departmental specific QR codes, patients can access the FFT during their time on the ward and on discharge. All areas have their own iPad to facilitate FFT. Text messages are also sent. Image 1 demonstrates the significant improvement in response rates since the implantation of the new MEG FFT platform in June. We are now exceeding the national average of response rates.

The benefit of the new platform allows ward and departmental leads to view real-time the results for their areas.

Image 2 demonstrates the positive response rate, although we have seen a dip in August, the response rates are generally improving and certainly in the outpatient and inpatient setting are showing an improving trend. We have identified some areas where positives comments are reflected negatively in the scores and work is being undertaken to rectify this.

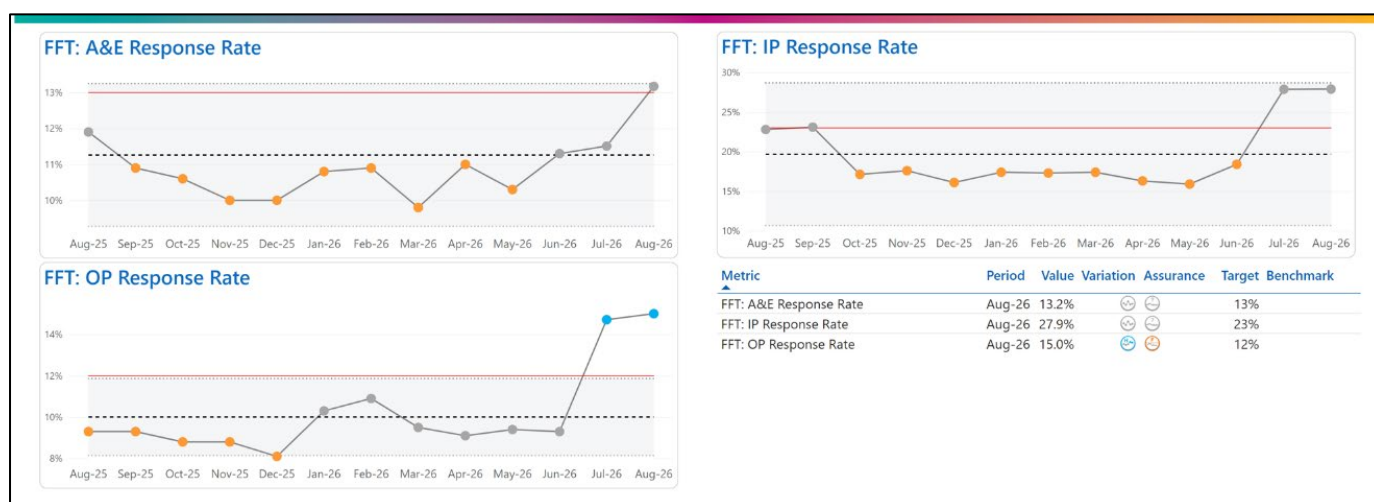


Figure 1 – Trust FFT Response Rates August 2026

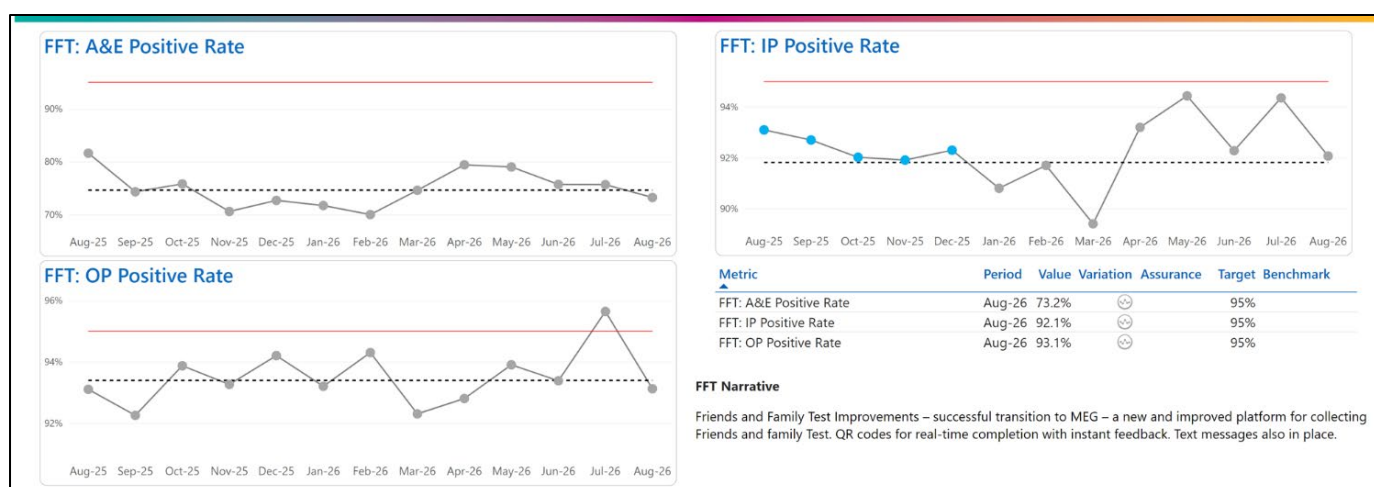


Figure 2 Trust FFT Positive Response Rates August 2026

7. Patient Experience Improvement Framework

Development of the Trust's Patient Experience Framework continues to gain momentum following the inaugural stakeholder workshop held on 16 June 2026, with the second extremely positive meeting taking place mid-September. The framework aims to establish a coordinated Trust-wide approach to understanding patient experience, bringing together feedback, complaints, concerns, enquiries, compliments, survey results, engagement activity and co-production into a single improvement methodology. The goal is also to widen our stakeholder involvement, Healthwatch have already attended the first two meetings.

Progress to Date

- ✓ The inaugural Patient Experience Framework workshop was held on 16 June 2026.
- ✓ The second meeting was extremely well attended with all divisions providing an update of the patient experiences initiatives and engagement events to dates.
- ✓ Feedback was also provided by external stakeholders.
- ✓ The event brought together colleagues from key services to establish priorities, identify existing strengths and agree the principles that will underpin the framework (including EDI).
- ✓ The programme aims to bring together patient feedback, complaints, concerns, enquiries, compliments, survey data and engagement activity into a single improvement-focused approach.
- ✓ Development of the framework will support a more coordinated understanding of patient experience and provide a clearer mechanism for identifying themes, learning and opportunities for service improvement.
- ✓ The framework is helping to shift patient experience from a collection of individual initiatives towards a coordinated improvement programme.

8. Conclusion

The Inpatient Survey results demonstrate a significant improvement from last year's results showing an improvement in all 12 categories. A significant improvement in National ranking from 117th to 59th out of 131 Trusts nationally in Overall Experience. Improvements demonstrated in all 12 categories both in scores and national ranking.

Picker interrogation of the data yielded extremely positive scores, in particular 99% of patients reflected that they were treated with kindness and compassion, respect and dignity and their privacy was maintained. An extremely high level of trust and confidence in our nurses and doctors was also reflected in the scores.

There are areas of continued focus, in the main being in the category of 'Leaving Hospital', where improvements will be driven through the Patient Experience Improvement Framework and the Discharging Excellence program.

In November 2026, the patients who are under our care will be those selected to take part in the National survey for 2026.

9. Recommendations

The Board of Directors is asked to:

- Note the contents of the paper and the significant improvement this year compared to previous year.
- Note the implementation of the new platform for FFT collection.
- Note the progress of the Patient Experience Improvement Framework.

Committee Chair's Report

Thursday 3rd September 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 (<i>matters that the Committee wishes to bring to the Board's attention</i>)	
- The Infection, Prevention & Control (IPC) update included escalation of the infection rates for Klebsiella and P.aeruginosa which are already above NHS England (NHSE) annual trajectories. There remains significant audit and improvement activity across IPC. An assessment of impact of the estate and infrastructure on IPC also identified risks, notwithstanding the mitigations and targeted investment and improvement programme. The Committee agreed that this paper should be presented to the Board of Directors. - The Emergency Department (ED) length of stay and Mental Health patients within ED continues to be a concern. - Maternity 10 point plan supported by the Committee but requires formal Board approval. Discussion required regarding oversight and review of further submissions, and whether this remains with the Board or formally delegated and how we schedule the timing aligned to NHSE expectations and deadlines.	
Assure (<i>matters in relation to which the Committee received assurance</i>)	
- Received the audit tracker and the full quality spot checks internal audit report. The Committee discussed the findings and the context to the controlled drug recommendation and importance of remaining colleagues on documentation. - Urgent Emergency Care (UEC) update demonstrating the position against UEC performance and safety indicators, with improvements recognised across a wide range of areas and a remaining focus on driving improvements in compliance with mental health rounding; NEWS and clinical assessment; intentional rounding; 15 minute triage standard; 12 hour length of stay. - UEC thematic review report provided and overview of the incidents for the period 1st July 2026 to 30th June 2026. Included pathway themes, consistency and decision making. Work will be undertaken with the teams to develop an action plan. - Review of Integrate Performance Report (IPR) with a summary of the key areas, including notification of 1 STEIS reportable incident; increase in Hospital Acquired Pressure Ulcers per 1000 bed days; and 1 fall with harm. - Quality Governance Group Chair Report with assurance across a range of areas. Alerts included Venous thromboembolism (VTE) compliance and the actions being taken to drive improvements; clinical audit progress against open audits with agreement on communicating with Divisions to prioritise completion of mandated and professional standards audits; IPC ongoing concerns and actions regarding environment and hand hygiene; Acute kidney injury (AKI) alerts in the community and planned Electronic Patient Record (EPR) system changes. - Quality, Safety and Experience strategy update setting out progress against the core, divisional and corporate quality, safety and experience priorities.	

- Maternity and Neonatal 10 point plan assessment with a request for Committee approval to support submission to NHSE on 25th September 2026 with further submission following formal Board approval on 29th September 2026. The paper included the full baseline assessment against all 26 requirements. 10 requirements identified as partial (amended to 7 following discussion) with the remaining agreed as compliant. The assessment included improvement actions for further triangulated reporting; workforce gaps and resilience; expansion of trauma informed training; and alignment with National dashboard developments as they take place. The Committee approved the assessment for submission noting that this would be submitted with clear narrative on Committee approval and Board approval will follow and a re-submission/ confirmation of Board assurance provided following the Board meeting on the 29th September.
- Perinatal services Q1 update providing assurance on compliance with Maternity Incentive Scheme (MIS); maternity and oversight surveillance system (MOSS) with no signals requiring escalation in the latest update; home birth service review; exit from joint oversight system following the demonstration of improvements; Maternity and Neonatal Voices Partnership; safety champions meetings; and perinatal equality and anti-discrimination programme. The Committee discussed delayed induction of labour, including understanding the data and the context of the ongoing improvement work (with further detail requested for the next meeting).
- Quality Impact Assessments (QIAS) providing assurance on completion and approval of QIAs in respect of Cost Improvement Programme (CIP) schemes over £25K. Request was made to consider how we report on the quality impact considerations from the wider transformation programmes as the shift to transformation progresses.
- Safety surveillance and learning (Q1) confirming continued culture of incident reporting; 9 incidents reported to STEIS; reported incident themes remain consistent; involvement in 17 Coroners inquests; learning and improvement. The Committee requested further focus on impact of the improvements made.
- IPC Q1 update and Chairs report, including infection rates, outbreaks, surveillance, improvement work, antimicrobial stewardship, training and assurance with the IPC board assurance framework requirements (5 areas remain with partial compliance and actions are progressing). The update included alerts regarding *Klebsiella* and *P.aeruginosa* infection rates which is reported as above the threshold set by NHSE; IV line care and documentation; and environmental and infrastructure standards. The Committee also received a detailed report on the IPC issues from the Trust's estate and infrastructure, clearly identifying the remaining risks notwithstanding the mitigations in place and the targeted estate investment and improvement programme.
- Ionising Radiation (Medical Exposure) Regulations (IRMER) update including 20 incidents reported between January and August 2026 all low and no harm. Active risks were moderate or low with action progressing to further mitigate.
- Medicines optimisation annual report providing assurance on managing and governing medicines, with positive progress including digital developments, medicines savings, increase in homecare provision, and delivery of the medicines optimisation strategy.
- Mortality surveillance Q1 report demonstrating mortality indices as expected, referrals, completion of mortality reviews and oversight and learning and how this is aligned with safety surveillance.

- Medical devices gap analysis and action plan progress, identified some delays in progressing the actions whilst the establishment of appropriate governance structures and identification of dedicated leads were confirmed. It is clear that further action is required with a proposed approach drafted and to be presented to the Executive Directors Group to drive this forward. The Committee requested a further update to the next meeting with clear progress and delivery.
- NICE compliance annual report providing an overview on the publication of NICE guidance and progress on implementation.
- Clinical Audit and Assurance Annual Report providing an overview of audit completion and outcomes. The Committee discussed the context of the audit with limited assurance and clarity of how this is being addressed, including assurance that is subsequently received from re-audits.
- Annual corporate consent audit report setting out the results from the annual audit, with a number of areas for improvement including consistency of documentation in EPR to provide further assurance. Developments within EPR are progressing to improve processes to support compliance. Committee discussed the importance of understanding triangulating the issues with other updates whilst the system improvements are made.
- Cancer Services Group Chair's report confirmed that the previously reported backlog had been completed but continued oversight is required to ensure reviews remain timely and that learning is consistently captured, which will be a standing item on the Group's agenda. The Committee agreed that this report can be de-escalated to Quality Governance Group (QGG) oversight.

Advise (items presented for the Board's information)

- Committee received a verbal update on Non Criteria to Reside patients. High numbers persist. As well as COCH not being the best place of care for these patients, there are particular challenges in managing behavioural issues of some long stay patients; the burden can be particularly felt by healthcare assistants.
- Discussed the review and development of the IPR to include specific quality and safety metrics, recognising this is being discussed and action taking place.
- Human Tissue Authority (HTA) inspection report received and working through factual accuracy process with a report and response to be submitted to the Board of Directors in September 2026.
- Establishment of Clinical Assurance and Effectiveness Group (CAEG), clinical assurance and effectiveness group to act as a mechanism for review and approval of proposals for new technologies to report into QGG.
- Cheshire and Merseyside UEC red lines toolkit and system guidance presented to the Committee.

Risks discussed and new risks identified

- Board Assurance Framework (BAF) and significant risk report extracts relevant to the Quality and Safety Committee terms of reference were presented. The BAF was revisited at the end of the meeting and agreed that no changes were required on the basis of the assurances and items discussed.

PUBLIC – Board of Directors
29th September 2026

Report	Agenda Item 13.	Perinatal Services Quarterly Update – Quarter 1 2026/27					
Purpose of the Report	Decision		Ratification		Assurance	X	Information
Accountable Executive	Sue Pemberton			Director of Nursing & 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 BAF 11 Transformation			X X X	BAF 1 – Failure to maintain quality may negatively impact patient and family experience BAF 2 – Gaps in safety and harm prevention can compromise patient outcomes. BAF 3 – Failure to meet operational planning standards or address patient backlogs may lead to poorer outcomes and financial risk for the Trust.		
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health						X X X
CQC Domains	Safe Effective Caring Responsive Well led						X X X X X
Previous considerations	Quality & Safety Committee 3 rd September 2026						
Executive summary	This report provides assurance to the Board regarding the quality, safety and performance of maternity and neonatal services for Quarter 1 2026/27. The detailed position and supporting evidence were scrutinised by the Quality & Safety Committee on 3 September 2026. This report therefore provides the Board with an exception based summary of the principal areas of assurance, risk and ongoing improvement. Maternity and neonatal services continue to demonstrate a stable safety profile. During the reporting period there were no maternal deaths, no neonatal deaths in babies born at or beyond 24 weeks' gestation, no						

	Maternity and Newborn Safety Investigations and no Patient Safety Incident Investigations. Significant external assurance was received following the Trust's formal exit from Enhanced Oversight in July 2026. The LMNS assurance process identified sustained improvement in governance, leadership, safety culture, risk management and Board engagement. The Trust continues to progress the requirements of the Maternity Incentive Scheme Year 8. Full compliance was achieved with the applicable Safety Action C requirements for Quarter 1. MOSS is operational and no signals requiring escalation have been identified. The principal areas requiring continued oversight are: • induction of labour delays • maternity and neonatal workforce sustainability • reliability of Birthrate Plus Live Acuity Tool completion • maternity triage compliance Induction of labour remains the most significant operational exception. Performance deteriorated from 40.5 delayed inductions per 1,000 deliveries in Quarter 1 to 82.4 per 1,000 in Quarter 2. No incidents resulting in identified harm have been directly attributed to these delays, but sustainable improvement has not yet been demonstrated and assurance therefore remains partial. An improvement plan is in place with continued oversight through established governance arrangements. The Trust has completed its baseline assessment against all 26 requirements of the NHS England Maternity and Neonatal 10 Point Plan, which has been reviewed by the Quality and Safety Committee in advance of Board approval and submission in September 2026. The Board is asked to take assurance regarding the overall safety, quality and governance of maternity and neonatal services, whilst noting the areas where further improvement and evidence of sustained progress are required.
Recommendations	The Board of Directors is asked to take assurance regarding the overall safety, quality and governance of maternity and neonatal services, noting that the detailed position has been scrutinised by the Quality & Safety Committee. The Board is asked to note the areas of partial assurance relating to induction of labour performance, workforce sustainability and Birthrate Plus Live Acuity Tool completion, and the improvement and mitigation arrangements in place.

Corporate Impact Assessment	
Statutory/regulatory requirements	Supports oversight of national maternity safety requirements, MIS Year 8, Saving Babies' Lives Care Bundle Version 3, Ockenden recommendations, and relevant professional workforce standards.

Risk	Principal risks relate to induction of labour delays, workforce sustainability, reduced Birthrate Plus Live Acuity Tool completion, maternity triage compliance and delivery of emerging national requirements. Mitigations and improvement plans are monitored through established governance arrangements.
Equality & Diversity	The report includes oversight of maternity inequalities, data quality and service user experience. Current triangulation has not identified a consistent local inequality signal, although small subgroup numbers and incomplete deprivation coding limit assurance.
Communication	Outcomes and actions are communicated through maternity and neonatal governance, the Perinatal Assurance and Improvement Board, Safety Champions and Trust Board reporting arrangements.

Perinatal Services Quarterly Update – Quarter 1 2026/27

1. Introduction

Maternity and neonatal quality and safety remain a Trust priority, aligned with national maternity and neonatal safety requirements, the Ockenden recommendations and the national Maternity and Neonatal 10 Point Plan. This report provides assurance on the quality, safety and performance of maternity and neonatal services, summarising key outcomes, governance, incidents, learning and compliance with the Maternity Incentive Scheme (MIS) Year 8 standards. It supports oversight through provision of ward-to-board intelligence and highlights current and emerging risks requiring action or assurance. The principal reporting period is Quarter 1, 1 April to 30 June 2026. Where relevant, significant assurance activities and developments arising after the quarter have been included to provide the board with the most current position

2. Background

National maternity and neonatal services continue to be subject to enhanced oversight following the Ockenden Review, the Amos Review and subsequent national maternity and neonatal improvement programmes. The NHS Resolution Maternity Incentive Scheme (MIS) has been refreshed for 2026/27 and now comprises six core safety actions focused on workforce, governance, safety surveillance, learning from investigations, culture and clinical standards.

The Trust continues to implement the NHS England Maternity and Neonatal 10 Point Plan through established governance arrangements. A separate paper provides detailed oversight of progress against the plan.

Maternity (Perinatal) Incentive Scheme (MIS)

The Trust continues to make progress towards compliance with all six Maternity Incentive Scheme (MIS) Year 8 Safety Actions. Compliance is monitored through the Perinatal Assurance and Improvement Board, supported by strengthened governance arrangements, enhanced clinical oversight and quarterly assurance reporting.

Key Board assurance is:

- Safety Action A workforce and capacity requirements are currently being met, although workforce sustainability risks remain.
- Safety Action C achieved 100% compliance for Quarter 1, providing Full Assurance.
- No qualifying perinatal events required notification to MBRRACE UK, NHS Resolution Early Notification or MNSI during the quarter.
- Governance arrangements remain in place for multidisciplinary review, family involvement and triangulation of incidents, concerns and claims.

Dashboard

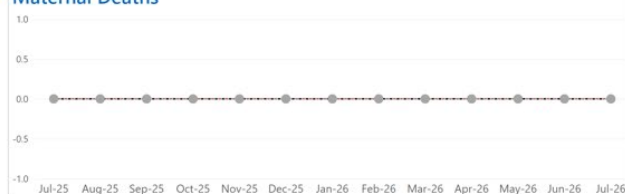
Maternity performance remained stable. There were no maternal deaths, one stillbirth, and no neonatal deaths above viability.

COCH IPR: Maternity - Mortality

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



Maternal Deaths



Stillbirths



Neonatal Deaths



Rolling 12 Month Stillbirths per 1000 births



Metric	Period	Value	Variation	Assurance	Target	Benchmark
Maternal Deaths	Jul-26	0	🟢	🟢	0	
Neonatal Deaths	Jul-26	0	🟢	🟢	0	
Rolling 12 Month Stillbirths per 1000 births	Jul-26	1	🟢	🟢		
Stillbirths	Jul-26	1	🟢	🟢	0	
Stillbirths rate per 1000 births	Jul-26	5.46	🟡	🟡	4	

Perinatal Mortality Rate

The national stillbirth rate is 3.22 per 1,000 births and the neonatal mortality rate is 1.63 per 1,000 births (MBRRACE-UK, 2023).

The Trust's rolling 12-month stillbirth rate remains low at 1.0 per 1,000 births. The maternity and neonatal safety position remained stable during the reporting period.

- No maternal deaths.
- One stillbirth during the quarter.
- No neonatal deaths in babies born at or beyond 24 weeks' gestation.
- Rolling 12 month stillbirth rate of 1.0 per 1,000 births.
- No MNSI investigations.
- No PSIs.
- Twelve concerns and no formal complaints were received during Quarter 1. No new or escalating safety concerns were identified through review of these concerns.

Workforce and capacity

The May 2026 Birthrate Plus review identified a recommended midwifery establishment of 119.30 WTE against a funded establishment of 113.85 WTE, a gap of 5.45 WTE. A phased workforce plan will be developed through existing financial planning arrangements.

Birthrate Plus Live Acuity Tool completion reduced to 67.96% from 77.72% in the previous reporting period. This affects the reliability of real time staffing oversight and remains an improvement priority.

There were 107 midwifery red flag events between January and June 2026 compared with 69 in the preceding six month period. Escalation processes were applied and no associated patient safety impact is identified in the report, but the increase represents an important workforce sustainability indicator.

The neonatal unit currently meets BAPM standards for its current workload. Workforce modelling identifies a requirement for 33.39 WTE nurses compared with a funded establishment of 27.53 WTE. The gap continues to be managed through skill mix, roster management and targeted recruitment.

Maternity Outcomes Signal System (MOSS)

MOSS is operational within the Trust and no signals requiring escalation or further investigation have been identified.

The September 2026 MOSS critical safety check drill provided assurance regarding maternity governance, safety oversight and escalation. It identified no previously unidentified safety concerns. An opportunity was identified to strengthen the rapid escalation pathway and standard operating procedure should a future MOSS signal occur.

Separately, following the LMNS assurance visit on 24 June 2026, the ICB Quality and Performance Committee approved the Trust's exit from Enhanced Oversight on 9 July 2026. The review found evidence of sustained improvement across maternity and neonatal services.

Maternity and Neonatal Inequalities Dashboard

Review of the July 2026 Maternity and Neonatal Equalities Dashboard (Appendix 2) identified no consistent local inequality signal requiring escalation through current triangulation. However, small subgroup numbers limit the strength of assurance, and the absence of a visible signal should not be interpreted as evidence that inequality risk is absent. Data quality remains good overall, with further work underway to strengthen deprivation coding. Ongoing monitoring and triangulation of outcomes will continue through established maternity governance arrangements, with any emerging inequalities escalated as appropriate.

Maternity Incentive Scheme (MIS) Year 8 Safety Action C: Learning from Reviews and Investigations for Quarter 1, 1 April to 30 June 2026.

Key messages

- 100% compliance achieved, providing Full Assurance against the national standard.
- There were no qualifying perinatal events during the reporting period requiring notification to MBRRACE-UK, NHS Resolution Early Notification Scheme, or Maternity and Newborn Safety Investigations (MNSI). Compliance is therefore assured.
- Robust governance arrangements remain in place, including established processes for:

- External multidisciplinary review of cases.
- Seeking and incorporating parents' views.
- Providing information to families regarding investigations and reviews.
Offering follow-up meetings with relevant clinicians.
- Quarterly triangulation of incidents, complaints and claims to identify learning and improvement opportunities.

Learning and triangulation

Although no qualifying events occurred during Quarter 1 and there were no PSIs or Serious Incidents (SIs) reportable during this period, the Quarter 4 2025/26 triangulation report identified learning themes for continued oversight. These themes are reviewed through established maternity governance structures, with associated actions monitored through divisional quality processes. Learning is triangulated with incident data, patient experience and wider safety intelligence to assess impact, identify emerging trends and provide ongoing assurance.

- Postpartum haemorrhage risk assessment.
- Delayed induction of labour associated with staffing and acuity pressures.
- Midwifery staffing.
- Communication with women and families.
- Delays in appointments and treatment.
- No new clinical negligence claims were reported during the quarter.

Assurance

The report concludes that the Trust has met all applicable requirements of MIS Safety Action C and provides Full Assurance to the Perinatal Assurance and Improvement Board. No mitigation actions or recommendations are required at this time.

Induction of Labour Delays: Board Oversight and Performance Monitoring

The board is receiving this information to provide oversight and assurance regarding performance within the induction of labour (IOL) pathway, including the impact on women's safety, experience and operational flow.

Induction of labour delays increased during Quarter 1 and have remained a significant focus for the service. National Oversight Framework (NOF) reporting demonstrated a deterioration from 40.5 delayed inductions per 1,000 deliveries in Quarter 1 to 82.4 per 1,000 deliveries in Quarter 2, placing the Trust above both regional and national performance benchmarks.

Internal monitoring indicates that delays have continued during July and August 2026 and Quarter 3 performance is anticipated to remain above national benchmarks.

Detailed review of pathway performance has identified staffing pressures, capacity constraints and delays associated with artificial rupture of membranes (ARM) as the principal contributory factors. Analysis demonstrates that 21.4% of women undergoing induction experienced at least one delay during the reporting period, a rate broadly comparable with national experience.

No incidents resulting in identified patient harm have been directly attributed to induction of labour delays during the reporting period. Women experiencing delays continue to receive ongoing clinical review, risk assessment and escalation in accordance with established safety processes.

A formal Induction of Labour Improvement Plan has now been implemented. The programme includes strengthened operational oversight, review of pathway capacity and flow, enhanced monitoring of delays, and targeted actions to address identified causes of delay. Progress is being monitored through divisional governance arrangements and the Perinatal Assurance and Improvement Board, with monthly review of performance, incidents, concerns and women's experience.

Current assurance remains partial. Whilst mitigating controls remain in place and no direct harm has been identified, performance continues to be below the standard expected by the Trust. Improvement actions are underway, however sustainable improvement has not yet been demonstrated. Further assurance will be provided through established governance arrangements as implementation progresses and evidence of sustained improvement becomes available.

Saving Babies' Lives Care Bundle (SBLv3)

Overall SBL compliance remains strong at 99%. The only area below target is antenatal corticosteroid administration prior to preterm birth (29% versus LMNS target 53%). Case review identified no missed opportunities for clinically appropriate administration. Performance will continue to be monitored.

Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training

Workforce training compliance across maternity and neonatal services remains strong and continues to provide assurance regarding the competency of the multidisciplinary workforce. Compliance with key maternity safety training standards, including Saving Babies' Lives, fetal monitoring, neonatal life support and multi-professional maternity emergencies training, exceeds 90% across most staff groups. Areas of lower compliance relate primarily to mandatory and statutory training within some medical staff groups, for which recovery plans are in place. Overall, the position provides assurance that staff are appropriately trained to deliver safe maternity and neonatal care, with training compliance monitored through established governance arrangements.

Home Birth Service Review

A review of the Home Birth Service was undertaken in response to a regional NHS England request. The review provides assurance that the Trust continues to deliver a safe and established home birth service, supported by a skilled and appropriately trained workforce, robust risk assessment processes and effective equipment governance arrangements. The review identified a number of strengths, including strong training compliance, positive home birth outcomes and low incident rates. Whilst no immediate safety concerns were identified, opportunities to strengthen governance arrangements were highlighted to support alignment with emerging national and regional expectations. An improvement plan has been developed and will be monitored through the Perinatal Assurance and Improvement Board.

Experience, culture and inequalities

Service user feedback continues to be triangulated with complaints, safety intelligence and MNVP insight. Twelve concerns and no formal complaints were received during Quarter 1, with themes relating to communication, clinical care, delays and continuity of care. No new or escalating safety concerns were identified.

Review of the Maternity and Neonatal Equalities Dashboard identified no consistent local inequality signal requiring escalation. However, small subgroup numbers and limitations in deprivation coding reduce the strength of assurance and continued monitoring is therefore required.

The Trust continues work on perinatal culture and equity, including alignment of existing work with the national Perinatal Equity and Anti Discrimination Programme.

A Maternity and Neonatal Safety Champions Walkaround was undertaken in August 2026 across the Neonatal Unit and Labour Ward. No immediate safety concerns were identified. The visit provided positive assurance regarding safety culture, multidisciplinary working and the learning environment, with positive feedback also received from a family regarding their experience of care

3. Recommendations

The Board of Directors is asked to take assurance regarding the overall safety, quality and governance of maternity and neonatal services, noting that the detailed position has been scrutinised by the Quality & Safety Committee. The Board is asked to note the areas of partial assurance relating to induction of labour performance, workforce sustainability and Birthrate Plus Live Acuity Tool completion, and the improvement and mitigation arrangements in place.

Appendix 1: 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.

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.

Appendix 2: Maternity and Neonatal Inequalities Dashboard – Board Extract

The July 2026 Maternity and Neonatal Equalities Dashboard provides updated assurance on activity, data quality, demographics, access and selected maternity outcomes. The dashboard is intended to support transparency and identification of inequalities rather than act as a performance ranking tool.

Key assurance

The Trust is not identified as an outlier within the dashboard extracts reviewed. Access to maternity care remains positive, with 68.5% of booking appointments undertaken within the first ten weeks of pregnancy compared with 64.8% for England. Ethnicity recording is strong at 98.0% for bookings and 96.1% for births. Deprivation coding is lower, at 85.4% for bookings and 84.2% for births, and remains an area for continued data quality oversight.

The Trust's preterm birth rate was 69.4 per 1,000 compared with 77.2 per 1,000 for England. Postpartum haemorrhage of 1,500ml or more was 34.0 per 1,000 compared with 32.7 per 1,000 nationally and will continue to be monitored through established governance and case-review processes.

North West service-user experience data demonstrates variation in whether women felt concerns raised during labour and birth were taken seriously. Results ranged from 77.9% to 84.6% across deprivation deciles and from 79.1% to 93.5% by ethnicity. Regional data is used as contextual intelligence and is triangulated with local service-user feedback and MNVP insight.

Key risk and limitations

The Trust serves a population that is less ethnically diverse than England overall and subgroup numbers are small. This limits the statistical power to identify reliable inequality gradients and creates a risk of under-detection or false reassurance. Absence of a visible inequality signal should therefore not be interpreted as absence of risk.

Assurance is consequently based on triangulation of quantitative dashboard information with MNVP lived experience, complaints and concerns, PMRT and MNSI learning, safeguarding intelligence and case-review themes. Current triangulation has not identified a consistent local inequality signal requiring escalation.

Next steps

The Equalities Dashboard will continue to be reviewed through maternity and neonatal governance, with a specific focus on improving ethnicity and deprivation data completeness. Any emerging inequality signal will trigger targeted review using pathway, clinical outcome and qualitative intelligence. An annual summary will be provided to Safety Champions and Board to demonstrate continued oversight.

PUBLIC – Board of Directors
29th September 2026

Report	Agenda Item 15.	Winter Planning 2026/27: Board Assurance Template					
Purpose of the Report	Decision	X	Ratification		Assurance		Information
Accountable Executive	Cathy Chadwick			Chief Operating Officer			
Author(s)	Shaun Brown			Deputy Chief Operating Officer			
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research BAF 11 Transformation			X X X X X	Linked to several areas of the BAF, with BAF 3 being the most significant		
Strategic goals	Patient and Family Experience						X
	People and Culture						X
	Purposeful Leadership						
	Adding Value						
	Partnerships						
CQC Domains	Population Health						
	Safe						X
	Effective						X
	Caring						X
	Responsive						X
Previous considerations	Well led						X
	Executive Directors Group – 9 th September 2026						
	The Trust's Winter Plan aims to ensure safe, effective care and operational resilience during the winter period, in line with NHS and ICB requirements. Focused areas include staff and inpatient flu vaccination, maximising bed and staffing capacity, improving patient flow, robust infection control, and maintaining urgent, elective, and cancer care standards. The Trust has developed its 2026/27 Winter Plan in response to NHS England requirements issued on 17 July. The plan was developed to test assurance against the Board Assurance Statement (BAS) template detailed below. Following approval of the Winter Plan at EDG (09 September), the BAS requires Board approval. The Winter Plan provided requisite evidence to provide assurance against all of the assurance statements within the BAS with exception of the two statements-2.1 and 2.2. Both statements relate to the capacity and adequacy of the local system's discharge pathways. Unfortunately, given						

	the Trust's NCTR (non criteria to reside) % being consistently significantly above the target position of 15%, the Winter Plan was unable to evidence a plan that would return this back to target prior to anticipated Winter pressures commencing.
Recommendations	The Board of Directors is asked to approve the BAS prior to submission to NHSE on 30 th September 2026.

Corporate Impact Assessment	
Statutory/regulatory requirements	Access targets and provider licence compliance
Risk	Effects quality and safety and operational risks.
Equality & Diversity	Not applicable
Communication	Not confidential

Winter Planning 26/27

Board Assurance Statement (BAS)



1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust Boards has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please include the Trust / Provider name at the top of the tab.

This section gives Trust the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist

This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026**.



Winter Planning 26/27

Section A: Board Assurance Statement (BAS)

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Provider/Trust Name (drop down):

If Other, write Provider/Trust Name:

Contact details (email, phone number):

Date:

Countess Of Chester Hospital Foundation Trust

01/09/2026

Please complete these sections

Assurance statement			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance and executive leadership					
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.	Yes	The plan is presented as the basis for EDG and Board approval; formal Board approval is still required	Obtain formal Board approval before the BAS submission deadline of 30 September.
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	QEIA approved by EDG	
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes	Development and delivery of the plan involved CWP. Feedback from Local authority and Welsh partners on Winter plans have informed elements of the Trust's Winter Plan	
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Cathy Chadwick attended the NHS England regional stress test on 18 September	
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes	Cathy Chadwick is the named Executive Winter Lead; Sue Pemberton is accountable for the Autumn/Winter Vaccination Programme .	
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes	Executive-led workstreams report through operational, finance and quality governance to Board, supported by daily executive oversight and OPEL escalation	

Winter Planning 26/27

Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Section B: 26/27 Winter Plan checklist			Please complete these sections		
Section B: 26/27 Winter Plan checklist			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: - the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; - that both walk-in and bookable appointments are available; - that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and - the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes	Occupational Health plans roving/drop-in delivery at both hospital sites, bookable appointments, RAVS recording and updated ESR coding.	
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes	Targeted vaccination, respiratory-virus prevention, Occupational Health screening, communications and priority activity in respiratory, emergency and intensive-care areas are described	
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes	A detailed inpatient flu vaccination pathway covers long-stay patients and care-home discharges, with RAVS reporting,	Confirmation received from NHSE that COVID-19 vaccinations no longer in scope for Acute Trusts
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes	CIPHA searches and MDT identification are used with community services and PCNs to risk-stratify high-risk cohorts and implement preventative action	
Occupancy and discharge					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	No	Discharge pathways, NCTR oversight and community capacity have been reviewed with community providers and system partners, including seven-day and holiday-period arrangements.	NCTR consistently above the agreed 15% target. For example August NCTR average was 28% CWCC LA have removed the P1 social care hours block (previously 150 hours per week). There continues to be a low number of P1 discharges supported by CWAC reablement per week (circa 5 patients) leaving a gap in demand of 20 patients per week who are unable to be discharged due the lack of availability of care. P2 winter capacity is set to reduce by 4 beds compared to that available in 25/26 following 4 * beds at Pinetum nursing home being decommissioned by CWCC LA. Flintshire have put on hold plans to commission West Cheshire Community collaborative Rapid Response team to provide P1 capacity; an alternative plan to support their high P1 caseload at COCH has not yet been articulated. P3 NCTR has deteriorated in 26/27 with high numbers of patients waiting a long-term placement. There are consistently between 40-60 patients who are NCTR and a/w P3 placement. Half of these wait for between 22-50 days for placement
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: - coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. - executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. - targeted operational actions to reduce long discharge delays. - Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	No	The Trust has self-assessed against the Model Discharge Pathway standards. Compliance can be evidenced against all standards with exception of Local Authority P1, P2 and P3 capacity. Home First, D2A in place for health discharges, seven-day discharge, NCTR/LLOS oversight and escalation are established. However, social P1 capacity is materially below profiled demand and P2 capacity at Pinetum is reduced.	NCTR consistently above the agreed 15% target. For example August NCTR average was 28%. Agree a deliverable social P1/reablement plan with the local authority and mitigate the 4 bed P2 reduction.
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes	A pre-Christmas week-long MADE event will review pathways 0-3 and long-stay patients, followed by a further event on 7 January.	

	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	Yes	SDEC and Frailty operate seven days, 08:00-23:00, with RAT, Hospital at Home, Virtual Ward, therapy expansion and new ACP/complex-care models supporting admission avoidance.	
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes	Frailty pathways have been reviewed against Model Acute standards and include SDEC Frailty, Hospital at Home, Virtual Ward, seven-day therapy and planned short-stay/ACP models.	
Capacity					
3	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes	EDG approval to recruit substantively for 50% of escalation bed base requirements. Daily roster check and challenge and staffing oversight in place	There are significant nurse bank gaps- the agreed plan to staff the escalation beds through a combination of substantive and bank will provide some mitigation against this.
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes	Medical rotas provide weekday ward rounds, established out-of-hours specialty cover, weekend discharge/day-2 teams and three additional acute consultants planned before winter	
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Ringfenced elective capacity (ESSU and Jubilee Day Surgery Centre) will be protected. Operational plans have been developed with explicit consideration of impact on Winter on elective, cancer and diagnostic performance.	
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes	Board-approved operational trajectories consider winter impact; the plan covers 4-hour performance, sustained 12-hour improvement and RTT mutual-aid arrangements, with IPR and Board oversight.	
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes	Urgent community demand is clinically prioritised; additional UCR funding supports five extra patients daily, with Hospital at Home, Community Care Teams and expanded GP OOH capacity.	
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	Yes	Corridor-care elimination is a patient-safety priority, all GIRFT emergency-care recommendations are implemented, and daily thresholds/escalation are governed through executive briefings, bed meetings, OPEL, IPR and risk reporting.	
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes	Ambulance handover plans were reviewed and assessed as deliverable prior to operational planning submission; Q1 performance remained within trajectory and June averaged 24 minutes	
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	Yes	System escalation meetings, SCC coordination, daily partner calls, community capacity escalation and shared OPTICA/NCTR oversight support timely transfer and flow.	
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	Yes	The Trust has self-assessed against Model ED and reviewed Model Discharge requirements, with detailed assurance evidence in appendices A and C.	
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes	IPC confirms infrastructure, estates engagement, governance, isolation oversight, environmental risk assessment and real-time MDT cohorting controls for safe reconfiguration.	
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	The DIPC, Deputy DIPC, Head of Nursing for IPC and consultant microbiologists are engaged in winter planning, mitigations and actions.	
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes	An RPE coordinator oversees risk-prioritised FFP3 fit testing recorded in ESR; PPE usage and procurement escalation are monitored. Overall compliance is 88%.	Continue targeted fit testing to close the remaining 12% compliance gap before peak respiratory demand.
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes	Real-time MDT cohorting, bay-by-bay escalation, isolation-capacity risk assessment and established IPC governance are ready for activation according to pathogen and occupancy conditions.	
Leadership and operational grip					
	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes	Executive and general-manager rotas are fully rostered 24/7, with overnight consultant advice, a 24/7 clinical site coordinator and daily review of urgent community capacity.	

6	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes	The OPEL plan was updated in May 2026 with role-specific actions, OPEL escalation beds/spaces, Full Capacity Protocol and Critical Incident action cards, supported by daily operational oversight.	
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes	The C&M ICB SCC provides daily 7/7 non-elective mutual aid and the Elective Recovery Team has an agreed RTT mutual-aid process.	
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes	Business continuity plans are reviewed annually and have been tested through real incidents and exercises covering IT, flooding and supply disruption.	
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes	The Adverse Weather Plan was fully reviewed in 2025 and implemented in 2026; an MOU with 4x4 Response North-West supports critical-staff transport during snow or flooding .	
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes	Industrial-action arrangements are regularly reviewed and a dedicated planning team is stood up for each period of action .	
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes	Staff support is available through the internal Wellbeing service, Employee Assistance Programme, manager support and winter wellbeing toolkits, with People Governance assurance.	
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	Yes	CWP response: Daily review of staffing for urgent mental health services to ensure resilience and delivery of services. Improvement focus on crisis line wait times has demonstrated reduction in call wait times by 20% with target for further improvements being established. Access to urgent mental health services is maintained via NHS 111 and local crisis teams.	None
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	Yes	CWP response: All patients have a clear safety and crisis plan in place to identify appropriate support for periods of relapse. Readmission reports and dashboards have been developed within PowerBI and are monitored via CWP Performance Assurance Framework and core governance structures	None
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.	Yes	CWP response: CWP has 24/7 Liaison Psychiatry depts and established pathways. CWP has developed a surge team response that also can support at times of escalation. CWP has now developed an internal S136 team to support with presentations at the 4 Emergency Depts that we support. Staffing cover has escalation routes via daily SitRep meetings	weekly implementation meetings to raise and address any issues with delivery for timely resolution. Continuation of the hospital based POS - this remains unchanged and will continue to accept patients on a 136 with a physical health need. There is capacity here (current demand) if the new route encounters any unexpected delivery issues.

Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

Trust / Provider Name: Countess of Chesyer NHS Foundation Trust

Provider CEO name: Jane Tomkinson

Date reviewed: 17/09/2026

Provider Chair name: Neil Large

Date reviewed: 15/09/2026

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)

Cathy Chadwick, Chief Operating Officer. cathy.chadwick1@nhs.net

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.

10.09.26- reviewed and approved by SRO

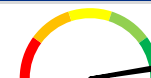
Please confirm date reviewed

10/09/2026

BAS Self-Assessment Dashboard

Trust

Overall Assessment Rating: 5 - Full assurance



		Rating
Section B	Prevention	5 - Full assurance
	Flow, occupancy and discharge	3 - Moderate assurance
	Capacity and community	5 - Full assurance
	UEC Flow	5 - Full assurance
	Infection Prevention and Control (IPC)	5 - Full assurance
	Leadership and operational grip	5 - Full assurance
	Specific actions for Mental Health Trusts	5 - Full assurance

Committee Chair's Report

23rd July 2026

Committee	Operational Management Board
Chair	Chief Executive, Ms J Tomkinson

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

Alert (matters that the Committee wishes to bring to the Board's attention)
No areas to Alert recognising the Board receive performance information and assurance on performance and risk.
Assure (matters in relation to which the Committee received assurance)
- Update on Digital and Data programme including timeframes for system development and implementation, current position on Lyrebird testing, cyber security priorities, data and analytics work, and key risks. - Progress update against VTE action plan with a number of key actions complete. Further work continues against the action plan including developing a reporting structure for incidents, digital system improvement action plan, communications plan, nurse recruitment and improved BI reporting. These actions are key to improving compliance and consistency of care. Divisional updates Planned care overview of quality, workforce, operational and financial performance. Ophthalmology follow up risks with significant activity being undertaken to recover the position; sickness absence with actions in place to improve the position; plastics service resilience; general surgery on-call with alternative options being discussed; level of concerns and complaints, timely resolution and communications with patients; finance position is an underspend at M3 which includes overachievement in activity. TICC overview of quality, workforce, operational and financial performance. Increase in activity and patient contacts; unmet need position (Occupational Therapy and Physio); 100% bed occupancy on virtual wards; increased referrals for urgent care community response; capacity pressures in community response activity; paper planned on Urgent Care Single Point of Access for Cheshire/Warrington; financial performance slightly better than plan; positive performance against quality and safety metrics; use of wound care App to support wounds and pressure ulcer care; sickness absence levels and actions for long term sickness; Women and Children's overview of quality, workforce, operational and financial performance. Incidents and learning; analysis of complaints themes and leaning; people metrics with challenges on sickness absence and appraisal compliance; activity and productivity; financial performance slightly better than plan; and wider sharing of learning from external reviews and reports (including listening to patients and families; communications with patients; use of data; culture and compassionate leadership; stronger clinical governance and accountability;

strengthened documentation; team communication; and use of best practice including GIRFT recommendations).

- **Diagnostics and Clinical Support Services** overview of quality, workforce, operational and financial performance. Incidents reporting, concern and complaints; update on phlebotomy actions; risks including new risk regarding non medial referrers; performance including DM01; microbiology performance; pharmacy KPIs with some improvements noted notwithstanding more to do to achieve compliance; financial performance slightly above plan but risk re CIP (significant percentage unidentified) and forecast outturn (with recovery plan requested); pathology hub developments (business case anticipated for September Board meeting).
- **Urgent Care** overview of quality, workforce, operational and financial performance. Quality and safety metrics; learning from complaints and concerns; ambulance performance and ED long waits (context of increased demand on UEC and priority leadership actions); financial position challenge year to date and CIP progress (significant percentage unidentified in year); People (including update on resident doctor 10 point plan and review taking place following recent of GMC survey results) and focus on improving performance in outlying areas.
- Updates on Trust wide operational performance; finance and CIP (M3 in line with plan but with release of non recurrent benefits covering gaps in CIP delivery); people metrics; quality and safety (including work being undertaken to clarify categorisation of enquire and concerns and a process to align response and monitoring).
- Discharge, UEC and Admission Avoidance Programme workstream summary updates.
- Transformation, productivity and CIP update on programmes, progress and risk.

Advise (items presented for the Board's information)

- Presentation on outpatient transformation, priorities and workstreams at Divisional and Trust level including clinical utilisation and use of the patient engagement portal. National GIRFT key priorities and deliverables are being incorporated into the transformation programme.
- CEO report provided an overview of national, regional and local updates, including action being taken by the Trust. The paper included achievements including NHS Oversight Framework, being stepped down from the Maternity Joint Oversight and Support, and 100% compliance on accreditation audit of sterile services.
- Presentation on the role of the acute pain services, activity data, demand and capacity, priorities, challenges and future direction.
- Presentation on new NOF with focus on new metrics. Work ongoing with Digital team and operational leads to review guidance and position.
- Papers shared in launch of NHS Staff standards; launch of NHS leadership and management framework; and implementation plan for new appraisal system (WorkPal).
- Approved business case for substantive Echo physiologist to support DM01 and RTT (with DM01 funding approved during planning round).
- Approved membership amendments to OMB TOR for recommendation to the Board.

Risks discussed and new risks identified
• The risk report set out the risks escalated from the Divisional Reports where action and further assurance are required. These were triangulated with the Divisional performance and risk reports. The Medical Devices Group Chairs report included a continued alert regarding compliance with the medical devices outcome registry, with work progressing to establish and deliver the actions needed. Progress against the wider medical devices action plan was also alerted with significant work to do and some decisions to be made on leads, governance and holding to account for progress. Divisional attendance and support requested to ensure sustained focus and agreement of actions and how these will be delivered. The Health and Safety Committee alerts were fire alarm systems recognising this is a multi-year capital replacement project with key aspects planned to be completed in 2026/27; security staffing levels with an update that actions had been taken and recruitment progressing; and Medical gas training and a gap in standard operating procedures with an improvement plan being developed. Verbal update on completion of ligature risk assessments across the Trust and action plans being delivered to reduce risk.

PUBLIC – Board of Directors
29th September 2026

Report	Agenda Item 16b.	Terms of Reference Update – Operational Management Board (OMB)						
Purpose of the Report	Decision		Ratification	X	Assurance		Information	
Accountable Executive	Karan Wheatcroft			Director of Governance & 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 BAF 11 Transformation			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	The Terms of References have been reviewed and approved at OMB on 23 rd June 2026.							
Executive summary	The Board has an overarching responsibility to review the adequacy and effectiveness of its governance systems and responsibilities it discharges to its sub-committees. The following changes have been proposed to the OMB Terms of Reference: • Amendments to job titles • Updates to the committee membership to include the Director of Transformation and Productivity The full Terms of Reference are appended to the report for review.							
Recommendations	The Board of Directors is asked to ratify the Terms of References following the recommendation to approve from OMB.							

Corporate Impact Assessment	
Statutory/regulatory requirements	Part of the Trust's governance structure.

Risk	As part of wider risk and governance framework.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics.
Communication	The terms of reference is to be circulated as part of the meeting pack.

OPERATIONAL MANAGEMENT BOARD TERMS OF REFERENCE

1. Remit

The Operational Management Board is established by the Board of Directors of Countess of Chester Hospital NHS Foundation Trust and has responsibility for the oversight of implementation of the Trust's operational strategies and objectives. It provides assurance to the Board of Directors that effective performance management is being discharged through the Operational Management Board, ensuring delivery of the Trust's plans and operational targets.

The Operational Management Board is a vital part of the Trust's governance arrangements and is the principal forum at which the leadership team come together to fulfil their shared governance responsibilities.

2. Authority

The Operational Management Board has executive decision-making powers as defined in the Scheme of Reservation and Delegation (SORD) which is approved by the Board of Directors.

Trust Standing Orders and Standing Financial Instructions apply.

3. Objectives and Duties

The Operational Management Board oversees the implementation of the Trust's operational and strategic objectives and is where divisions are held to account for their performance. The Operational Management Board will drive delivery of the annual plan and make informed decisions (within approved delegated limits) in relation to business investment/disinvestment and the development of the estate.

The Operational Management Board will:

- i) Ensure the operational implementation and delivery of strategies and objectives as directed by the Board of Directors, including oversight and implementation of the Trust's:
 - Annual plan and underpinning operational plans (including financial, capacity and workforce plans)
 - Estates plan and capital programme
 - Digital and data programme
 - Strategic objectives
- ii) Monitor the operational performance of the Trust (service, financial, workforce and quality & safety), at a Trust and Divisional level including improvement plans as required, providing assurance to the Board of Directors.

- iii) Review the wider system developments and collaborations in respect of positioning, influence and impact for the Trust.
- iv) Share and cascade Organisational Learning including learning from deaths and incidents and demonstrate action and embedding.
- v) Review the completeness and accuracy of the Risk Register and provide appropriate challenge and resolution to the sufficiency of mitigating action plans.
- vi) Approve relevant business cases, service changes and investments as per SORD.
- vii) Review and approve relevant Trust-wide policies and procedures.
- viii) Review the impact of new and emerging guidance from regulators and external agencies and prepare the Trust's response.

4. Integration

Ensure that equality and diversity and due consideration to the Human Rights Act are regarded in all aspects of the Operational Management Board's work. This will include review of any equity analyses that are commissioned against the Trust's clinical services portfolio.

In addition, the Operational Management Board will have regard for the NHS constitution in delivering its objectives.

The Operational Management Board will support the integration of clinical, organisational and financial governance across the Trust.

5. Membership

The Membership of the Operational Management Board consists of:

- Chief Executive (Chair)
- Chief Finance Officer
- Director of Nursing & Quality/ Deputy CEO
- Medical Director
- Chief Operating Officer
- Chief Digital and Data Officer
- Chief People Officer
- Director of Governance and Risk
- Director of Strategy and Partnerships
- Director of Transformation and Productivity
- Director of Pharmacy and Medicines Management
- Director of Medical Education
- Director of Research
- Deputy Medical Director
- Deputy Director of Nursing, Quality and Governance
- Deputy Director of Nursing and Quality
- Associate Medical Director – Planned Care
- Divisional Director of Nursing - Planned Care

Divisional Director of Operations – Planned Care
 Associate Medical Director – Urgent Care
 Divisional Director of Nursing - Urgent Care
 Divisional Director of Operations – Urgent Care
 Associate Medical Director – Women's and Children's
 Director of Midwifery
 Divisional Director of Operations – Women's and Children's
 Associate Medical Director – Diagnostics and Clinical Support
 Divisional Director of Operations – Diagnostics and Clinical Support
 Associate Medical Director – Therapies and Integrated Community Services
 Associate Director of Therapies - Therapies and Integrated Community Services
 Divisional Director of Operations – Therapies and Integrated Community Services
 Divisional Director of Nursing - Therapies and Integrated Community Services
 Director of Performance and Operational Improvement
 Deputy Chief Operating Officer
 Associate Director of Estates and Facilities

Each member and attendee is required to nominate a deputy to attend in his/her absence as agreed with the Chair.

6. Quorum and Frequency

To be quorate, the meeting requires the attendance of the Chair or Vice Chair; plus an additional 9 members of the Committee to include at least one member from each of the Divisional Leadership Teams. However, should the meeting not be quorate, the Chair reserves the right to continue with the meeting with responsibility for the implementation of any decisions made, subject to ratification at the next quorate meeting.

Attendance may be in person or via video conferencing.

The Operational Management Board will meet formally at least 7 times each year. In addition, a full day strategic development session with all clinical leads will be held at least 3 times each year. This will allow dedicated time for strategic work and/ or Operational Management Board development.

Where there is a need for formal or urgent business, a formal business meeting may be convened during any of the strategic full day sessions, at the discretion of the Chair.

The work of the Operational Management Board will be supported by 'deep dive' Divisional reviews between each of the Divisional Leadership teams and members of the Executive Team in accordance with the Trust's performance governance arrangements. The frequency and focus of these meetings will be determined by the Chair of the Operational Management Board (the CEO) in accordance with organisational priorities along with ad hoc items brought to the weekly Executive Directors Group meeting. The Chief Executive reserves the right to suspend or change the timing/ frequency of Divisional reviews to fit with organisational priorities. The performance governance process enables timely escalation and response to any area of adverse performance.

7. Reporting

The Operational Management Board will provide minutes and Chair's reports to the Board of Directors to provide assurance that it is effectively discharging its responsibilities. In addition, the Board of Directors routinely receives Strategic and Operational dashboards,

high risks and Board Assurance Framework (BAF) updates directly to ensure that it is sighted on all aspects of operational delivery.

The Operational Management Board will determine the format, frequency and content of the information it requires from each reporting sub committee e.g. minutes, action logs and/or exception reports.

8. Conduct of Meetings

The Chair of the Operational Management Board will ensure that the appropriate processes are followed:

- Minutes, action log and reports of the Operational Management Board to the Board of Directors are accurate, comprehensive and timely.
- The agenda and supporting papers are sent out to members 4 working days prior to the meeting, unless authorised by the Chair for exceptional circumstances.
- The agenda, in terms of items and their delivery will be prepared using a risk-based approach to prioritisation. Divisions are expected to be proactive in identifying agenda items that they wish to be considered.
- Authors of papers presented must use the required template. Attention should particularly be given to the following:
 - Limit the size of papers to a minimum set of information.
 - Have clarity on the “must do’s” with a focus on decisions not discussion. Communicate what is expected to be achieved from the agenda item and what input is expected from those attending.
 - Make it explicit on the agenda the specific information or preparation work that members need to have ready.
 - Be clear on where a paper has been before, where it is going and what value the Operational Management Board is expected to add. If the paper duplicates what has been considered elsewhere be clear on what is to be separately achieved by it being considered by the Operational Management Board.
- Presenters of papers can expect all members to have read the papers and should keep to an executive summary that outlines the purpose of their paper/report and key issues. Verbal updates and presentations should be kept to a minimum.
- For the avoidance of doubt, Trust employees who attend the Operational Management Board do so not only to represent or advocate their division or service area but to act in the interests of the Trust as a whole and as part of a Trust-wide governance structure.
- All Operational Management Board members and those in regular attendance should actively participate in discussions pertaining to the agenda, ensuring that solutions and action plans have Multidisciplinary perspectives and consideration of Trust-wide impact.
- Behaviours at meetings should reflect the Trust’s values. In particular, all members should treat each other with respect and be “present” in the room e.g. no checking of emails.
- The Chair will regularly review the effectiveness of meetings and make any recommendations regarding changes to these Terms of Reference to the Board of Directors as and when required. In addition, at each meeting there will be an evaluation focusing on what went well and what might be improved for the future
- Meetings may be held face to face, via MS Teams or a combination of the two, at the discretion of the Chair. Any participant joining by videoconferencing will be deemed

present and count towards the quoracy.

- MS Teams etiquette must be observed in respect of participation via video conferencing and meetings may be recorded for the purpose of support for minute taking.

Approved by Trust Board: 29th September 2026

Reviewed by the Operational Management Board: 23rd July 2026

Next Review: July 2027

Version number: Version 4

Committee Chair's Report

Wednesday 20 August 2026 / 12.00–13.00 / Microsoft Teams

Committee	Finance & Performance Committee (Extraordinary Meeting)
Chair	Mr M Oldham, Non-Executive Director

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

Alert <i>(matters that the Committee wishes to bring to the Board's attention)</i>	
- The Trust reported a Month 4 deficit of £5.4m, broadly in line with the planned £5.0m deficit; however, delivery required £2.8m of year-to-date benefits to offset undelivered savings, industrial action, income loss and workforce pressures. - CIP delivery remained materially behind plan: £581k was delivered in Month 4 against a £2.2m target, creating a monthly shortfall of £1.63m and a year-to-date shortfall of approximately £1.8m. - The risk-adjusted forecast assumed approximately £9.1m CIP delivery, a £16.3m under-delivery against requirement and a year-end deficit of £30.1m before further recovery action. Even after identified mitigations, a residual £2.7m gap remained against the planned position. - Six recurring barriers to CIP delivery were identified: inconsistent ownership, limited medical engagement, capacity constraints, capability and data-literacy gaps, ineffective professional handovers, and risk aversion or reluctance to transact savings.	
Assure <i>(matters in relation to which the Committee received assurance)</i>	
- The annual plan remained break-even, inclusive of £21.9m Deficit Support Funding, and the Month 4 reported position remained broadly in line with plan. - Cash remained healthy at £22.5m, equivalent to approximately nineteen days' operating expenditure; capital expenditure was ahead of profile due to earlier project completion, with no material year-end capital concerns forecast. - Recurrent schemes of approximately £25m had been identified against the £25.4m target, and specialty benchmarking packs had been completed and issued to support further productivity opportunities. - Divisions had been required to produce financial recovery and CIP delivery plans within ten days. Executive Directors were applying stronger challenge, requiring weekly actions and measurable outputs, with intervention where unnecessary delays continued. - The revised forecast used recognised NHS methodology and prudent risk-adjusted assumptions. Future reporting will track the revised trajectory, recovery actions, mitigations and best- mid- and worst-case scenarios.	

Advise <i>(items presented for the Board's information)</i>
• Emergency Department attendances were approximately 8.6% higher and around 7% above plan; non-elective activity was approximately 5–6% higher than the same period last year. Sustained demand and increased patients with no criteria to reside were offsetting anticipated financial benefits from improved flow. • Digital-enabled schemes, including Ambient Voice Technology and Luna Rover, had been delayed, reducing confidence that the planned benefits would be realised in-year. • Remedial action was underway to improve Better Payment Practice Code performance, with a new general ledger system expected in October 2026, although cumulative performance was unlikely to recover fully during the year. • The winter plan was nearing completion and will provide a further opportunity to test workforce, escalation-capacity and expenditure assumptions within the financial forecast.
Risks discussed and new risks identified
• Under-delivery and slippage of CIP schemes, together with delays in transacting realised savings. • Potential withholding or recovery of Deficit Support Funding by NHS England if confidence in the Trust's financial trajectory and savings delivery is not sustained. • Winter demand, escalation-capacity requirements, increased non-elective activity and growth in patients with no criteria to reside. • Workforce pressures, including Band 2 to Band 3 regrading and uncertainty regarding possible national Band 5 to Band 6 nursing changes. • Repayment by December 2026 of emergency cash support received earlier in the year. • A continuing residual financial gap of £2.7m after identified mitigations, requiring close monitoring and delivery of robust Divisional recovery plans.

Committee Chair's Report

11th August 2026

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

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

Alert (matters that the Committee wishes to bring to the Board's attention)
• Mandatory training compliance - Overall mandatory training compliance remains on target; however, compliance is declining and remains below target for Information Governance, Resuscitation Level 1 and Infection Prevention and Control Level 2. Targeted executive-level focus and intervention supported by targeted work with managers to improve oversight, accountability and local follow-up are in place to address performance. • Workforce annual plan 2026/27 - The Committee noted an increasing variance from plan, with workforce numbers 133 WTE above the planned trajectory. Further work is under way to understand the drivers of the variance and to triangulate the workforce position with financial performance and the timing and impact of planned workforce changes. Variable pay expenditure has reduced since March 2026; however, delivery against the workforce plan remains a material risk requiring sustained executive focus and oversight.
Assure (matters in relation to which the Committee received assurance)
• Audit actions - Recommendations from the e-rostering and bank internal audit are complete, with evidence to be submitted to MIAA for review and closure. • Partnership Forum - Assurance was received on progress with the Band 2/3 re-banding programme and policy development. The Committee noted continuing nurse staffing pressures associated with escalation, vacancies and patient acuity. It also noted the implications of changes to immigration rules for sponsorship; the previously agreed Trust approach will remain in place pending further national guidance. • People and Culture Sub-Committee - No alerts were raised. Assurance was received on wellbeing and occupational health, communications and engagement, divisional staff survey action plans, the Celebration of Achievement Awards and development of the workforce culture dashboard. The Committee requested that future reports provide clearer evidence of progress, impact and any delivery challenges. • Freedom to Speak Up - The January to June 2026 report provided assurance on activity, themes and outcomes, training compliance, the Champions network and wider education. The Committee welcomed engagement with staff networks and increasing diversity among Champions. It also noted the transition to new National Guardian's Office reporting arrangements and development of a dashboard to support wider triangulation of workforce intelligence. • Education, Learning and OD Sub-Committee - Assurance was received on Trust-specific training, workforce information, nursing excellence and practice development, and education performance. The National Education and Training Survey showed increased participation and a 3% improvement in the overall learner experience score, demonstrating progress, although the Trust remains in the lower national quartile. The Committee noted the targeted actions under way to improve

the learner experience and agreed that mandatory training compliance should be escalated as an alert.

- **Workforce Sub-Committee** - Alerts were noted on HCSW vacancies, workforce plan and CIP delivery, and sustained high demand for occupational health case management, with potential further pressure from changes to people policies. Assurance was received on the range of improvement activity under way across the nurse establishment review, recruitment, bank and agency use, employee relations and workforce transformation. The Committee noted the significant support being provided to managers to strengthen delivery and maintain pace.
- **Joint Local Negotiating Committee** - The Committee noted concerns from the Guardian of Safe Working regarding the financial impact of exception reporting, which has been escalated nationally, and locum rates, rota gaps and associated patient safety risks, which continue to be monitored. Assurance was received on the approved medical staff annual leave policy, resident doctors' forum feedback and completion of consultant pay progression.
- **Fair deal for nursing – job evaluation** - The delivery plan remains on track and has been submitted to NHS England. Governance, quarterly reporting requirements and key risks were reviewed; a Board assurance statement and update are planned for September 2026.
- **Resident Doctor 10-point plan and safe working** - Progress continues, with work schedules and annual leave remaining amber because requirements are not yet met consistently. Two areas remain dependent on national arrangements concerning rotational training and employer transition. The quarterly safe working report showed a continued reduction in exceptions.
- **Workforce metrics** - Exceptions included increased sickness absence, areas of mandatory training below target, a slight increase in employee relations activity and reduced access to apprenticeship levy funding. The Committee received assurance on the targeted improvement work under way, including intensive support from the People team to strengthen managers' capability, confidence and accountability in addressing attendance, employee relations and compliance issues at local level. This is supported by continued triangulation of workforce and incident-reporting themes to focus action where it is most needed.
- **Annual and statutory reporting** - The 2025/26 appraisal, revalidation and medical governance submission was recommended for Board approval, with GMC referrals updated separately to the Board. The employee relations annual report confirmed continued high case volumes and increased complexity, alongside improved timeliness. The Committee received assurance on the ongoing work to strengthen managers' capability and confidence in addressing issues earlier, supported by targeted advice and development from the People team.
- **Safer staffing** - The Committee received the biannual safer nurse staffing and safer midwifery staffing reports for July to December 2025, noting that both had already been reported to the Board.

Advise (items presented for the Board's information)

- **Education, Development and Training Centre** - The Committee noted capacity constraints and immediate mitigations, including relocating some neurology staff, moving resuscitation training and relocating the student common room to the café. Longer-term education and estates planning is required, with a further update requested for October 2026.
- **Chief People Officer update** - The Committee noted national and local developments, including NHS publications, the launch of People Pulse, implementation of appraisal and medical e-rostering systems, the rostering AI pilot

and the North West Race Equity Assembly Conference. These developments support the wider programme of workforce improvement, leadership development and modernisation under way across the Trust.

- **Governance** - The Committee reviewed and approved the terms of reference for its subsidiary reporting groups.
- **NHS Leadership and Management Framework** - The Committee received an overview of the new national framework and expectations. Initial implementation plans will build on the Trust's existing programme of manager development and support, strengthening consistent leadership and management practice across the organisation.
- **NHS Staff Standards** - The Committee noted the launch of the standards and their inclusion in the NHS Oversight Framework. The initial baseline position was reviewed and existing improvement activity, including work to strengthen management capability, staff experience and organisational culture, will be consolidated into a single implementation plan supported by communications and engagement.

Risks discussed and new risks identified

- The Committee reviewed BAF 4 (People) and relevant significant risks, confirming alignment with the Committee's work. Members discussed the target risk score and timeframe for reduction, recognising that the cumulative impact of planned actions will be assessed principally through the staff survey. It was agreed that other outcome measures, including the forthcoming inpatient survey results, should also inform assurance. No change to the current risk score was proposed.

PUBLIC – Board of Directors
29th September 2026

Report	Agenda Item 19.	2025-6 Annual Submission: Appraisal, Revalidation and Medical Governance					
Purpose of the Report	Decision	X	Ratification		Assurance		Information
Accountable Executive	Medical Director and Responsible Officer			Dr Nigel Scawn			
Author(s)	Medical Appraisal Lead Appraisal and Revalidation Manager			Dr Anne Tro Mrs Lesley Spruce			
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 BAF 11 Transformation			X	BAF 2 Failure to maintain safety and prevent harm would result in poorer patient care and outcomes.		
				X	BAF8 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	People Committee – 11 th August 2026						
Executive summary	The purpose of this report is to provide assurance in the execution of the roles and responsibilities of the Responsible Officer with regard to Medical Appraisal, Revalidation and oversight of medical governance activity. The report demonstrates sound governance processes in the management and oversight of Medical Appraisals with good regulatory oversight. There are robust mechanisms in place to support the Responsible Officer in supporting Revalidation recommendations. Fair and equitable decision making is undertaken through consistent processes that were strengthened in 2024 with the addition of a Non-Executive Director to the Responsible Officer Advisory Group.						

	343 appraisals have been completed (84 %) with 74 recommendations made, 60 of which were positive. There were no referrals made for non-engagement. Regular liaison meetings are held with the GMC and NHS Resolution (Practitioner Performance Advise) in support of the Responsible Officer Role.
Recommendations	The Board of Directors is requested to review and approve the annual submission ahead of the submission of the Statement of Compliance date in October 2026.

Corporate Impact Assessment	
Statutory/regulatory requirements	Meets the Trust compliance with Foundation Trust status Fulfil GMC Regulations as a Delegated body
Risk	BAF 2 - Failure to maintain safety and prevent harm would result in poorer patient care and outcomes and BAF8 - 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	Not confidential

2025-2026 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement

This completed document is required
to be submitted electronically to NHS
England North West at
england.nw.hlro@nhs.net
by **30 October 2026**

As this is a national deadline, failure
to submit by this date will result in a missed
submission being recorded. We are unable
to grant any extensions.

2025-2026 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Countess of Chester Hospital NHS FT
What type of services does your organisation provide?	Secondary Care

	Name	Email
Responsible Officer	Dr Nigel Scawn	nigel.scawn@nhs.net
Medical Director	as above	
Medical Appraisal Lead	Dr Anne Troy	ann.troy@nhs.net
Appraisal and Revalidation Manager	Lesley Spruce	lesley.spruce@nhs.net
Additional Useful Contacts	Dr Ian Benton	I.benton@nhs.net

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

NO

If yes, who is this with?

Organisation:
Please describe arrangements for Responsible Officer to report to the Board:
Date of last Responsible Officer Report to the Board:
Action from last year:

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative

Section 2 – Metrics

Section 3 - Summary and conclusion

Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of:

Countess of Chester Hospital NHS Foundation Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	To continue
Comments:	The RO is the Executive Medical Director
Action for next year:	To continue

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	To continue
Comments:	The Trust has a ROAG (Responsible Officer Advisory Group) which meets monthly. This group comprises of the RO (MD), the Deputy MD, Medical Appraisal & Revalidation Lead, Appraisal & Revalidation Manager, a Non-Executive Director and Head of HR.
Action for next year:	To continue

1A(iii) An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	None
Comments:	The Appraisal & Revalidation Manager maintains a record of all doctors employed by the Trust. This is updated as and when a new doctor joins the Trust. If a doctor has not made their own 'connection' to the Trust, the ARM will make the connection on their behalf. When doctors leave the Trust their connection to the Trust is removed by the ARM via the GMC Connect Website.
Action for next year:	To continue

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	To review our Appraisal Policy in 2024/2025 to ensure it is up to date and effective.
Comments:	Appraisal Policy was reviewed and updated 12/06/2025
Action for next year	Next review date is June 2028 unless needed earlier.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Yes
Action from last year:	To strengthen the peer review process.

Comments:	A Peer Support Group has been set up with the Medical Appraisal & Revalidations Teams from three neighbouring Trusts (Wirral, Mid-Cheshire and East Cheshire). Our third meeting took place in March 2026. The next meeting is scheduled to take place in September 2026.
Action for next year:	Continue regular meetings

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	-
Comments:	All doctors for whom COCH is their Designated Body and main employer are supported in their appraisal & revalidation should that fall due whilst working at COCH. New starters are emailed a video which discusses the appraisal & revalidation processes and how they can access further help. We also hold Appraisal Awareness Sessions twice per year, run by the Appraisal Lead, a Senior Appraiser and the ARM. In this session they are introduced to the Trust's appraisal and revalidation processes and signposted to any help and guidance that they may need. They are also given an account on the L2P electronic appraisal platform when they commence employment at the Trust.
Action for next year	To continue

1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	None

Comments:	As part of the appraisal process, doctors provide details about and discuss their scope of practice at COCH and in any other organisations in which they work. A scope of practice form needs to be included in their appraisal evidence from any other organisations, which incorporates information on any claims, incidents or adverse events they have been involved in. Appraisers are aware that this needs to be present.
Action for next year:	-

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	n/a
Action from last year:	n/a
Comments:	n/a
Action for next year:	n/a

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	None
Comments:	Our Appraisal Policy was updated and circulated to all doctors in June 2025.
Action for next year:	-

1B(iv) Our organisation has the necessary number of trained appraisers¹ to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes
Action from last year:	None

¹ While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Comments:	With the appointment of a new Appraisal Lead, the Appraiser Training has been updated and streamlined. A training session was held in April 2026, with another planned for the end of the year. We continue to ensure that we have an adequate number of trained appraisers.
Action for next year:	To continue to provide bi-annual Appraiser Training and to update the training as and when required.

1B(v) Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

Y/N	Yes
Action from last year:	None
Comments:	We hold regular Appraiser Support Group (ASG) Meetings to update and support our trained appraisers. At these meetings we update our appraisers on any changes or developments that we receive from NHS England Revalidation Team meetings and provide a forum for open discussion on appraisal matters or challenges arising. The ARM and Medical Lead for Appraisal & Revalidation are also easily available for appraisal advice. We also have a quality assurance process that reviews 20% of appraisers annually.
Action for next year:	Continue with Appraiser Support Group (ASG) and appraiser support.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	None.
Comments:	The Appraisal & Revalidation Manager quality assures submitted appraisals and if incomplete or of a substandard quality, will discuss these with the Medical Appraisal Lead. These appraisals are returned to the appraiser/appraisee

	with feedback on what improvements are needed to reach the required standard. Appraisals reaching the standard are then submitted to the appropriate Associate Medical Directors (AMDs) for review. The ASPAT tool is used to quality assure the Appraisal Summary and PDP of doctors in the organisation. We will retrospectively review 20% of the appraisers summaries each year, so over a 5-year cycle, all the appraisers will have been audited and quality assured once.
Action for next year:	The findings will be reported to the ROAG 6 monthly.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	To continue
Comments:	All revalidation recommendations are considered by the Responsible Officer Advisory Group (ROAG) on a monthly basis. Evidence is circulated two weeks in advance for review. The ROAG review appraisal and 360 MSF (Multi Source Feedback) evidence for doctors who are due for revalidation and the RO then makes his recommendation to the GMC.
Action for next year:	To continue.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	None.

Comments:	Doctors are informed by the ARM once the RO has submitted a recommendation for them. If the recommendation is one of deferral or non-engagement this will have been fully discussed with the doctor prior to the recommendation being submitted.
Action for next year:	-

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	None
Comments:	Any concerns raised about a doctor would be discussed with them at the first available opportunity, including removing them from the clinical environment if considered necessary to ensure patient safety. Each clinical division within the organisation holds a monthly governance meeting, where feedback would be given about doctors if any concerns had arisen and what plans were in place going forward. The doctor would also have a duty to inform other organisations in which they work if they are excluded from clinical practice. The Appraisal & Revalidation Manager (ARM) provides reports on claims, complaints and incidents which are uploaded into appraisal documentation in advance of their appraisal, so that they have time to reflect and comment upon any claims, complaints and incidents that are recorded. The MD (RO) has regular meetings with the GMC Liaison Advisor and the NHS Resolutions advisor which allows discussion regarding any doctors with concerns.
Action for next year:	-

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
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Action from last year:	None
Comments:	All doctors employed by the Trust including Lead Employer Trainee doctors are subject to the Trusts Disciplinary and Capability procedure (see later) and the MHPS document. All conduct and performance issues are discussed and logged with NHS Resolutions (Practitioners Performance Advisory) and their advice is shared with the doctor in difficulty. Any serious conduct and performance concerns regarding senior medical staff are reported to the Trust Board through the MD's report.
Action for next year:	-

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	None
Comments:	Doctors are emailed any claims, complaints or incident reports one month in advance of their appraisal date. The doctor is expected to then reflect and make comment on these and they are available for the appraiser to view prior to the appraisal. They also receive their Mandatory Training Report in this way.
Action for next year:	To continue to upload Clinical Governance Reports into doctor's appraisals along with Mandatory Training Reports.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	Reviewing this is still outstanding and an extension has been granted by the People Committee until September 2026

Comments:	The organisation has a policy on Sharepoint entitled: "Disciplinary and Capability Procedure for Medical and Dental Staff Maintaining High Professional Standards". This was written in 2017 by the Medical Director at the time and last modified in 2020. The policy will be reviewed and updated if necessary. The RO holds regular informal updates with both the GMC Employment Liaison Advisor and the Practitioners Performance Advisor.
Action for next year:	-

D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	None
Comments:	There are regular informal updates with both the GMC Liaison Advisor and the Practitioners Performance Advisor. Disciplinary matters concerning doctors is a standing Agenda item for the medical Director at every Trust Board Meeting and discussed at Divisional Governance Meetings (see earlier). If a doctor is excluded from practice this is reported immediately to the Chief Executive and the Board and reported every 4 weeks until the exclusion is lifted, and the doctor is back in work.
Action for next year:	-

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
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Action from last year:	None
Comments:	We use the Transfer of Information Form (TOI) to request information from a doctors previous Trust. The information on this is cross-checked with other evidence including their DBS check, GMC information and their references. We also complete TOI requests from other Trusts when a doctor has left our employment. The RO is made aware of any concerns that we may have surrounding any TOI forms received in from another Trust.
Action for next year:	-

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#)).

Y/N	Yes
Action from last year:	None
Comments:	All MHPS/Disciplinary cases are 'overseen' by a non-Executive Director. The RO is also advised by the Trust's ROAG which has been strengthened by the addition of a non-Executive Director and Head of HR - HR Operations. Equality and Diversity Training is mandatory for all staff.
Action for next year:	-

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	-

Comments:	The RO, ARM and Medical Appraisal & Revalidation Lead attend regional RO meetings each year where updates are highlighted and discussed. In between these times, the RO would bring information on any developments to the monthly ROAG meeting.
Action for next year:	-

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

Action from last year:	None
Comments:	All health care practitioners are reviewed annually as part of their own professional appraisal process, by peers in their profession.
Action for next year:	

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	Not Applicable
Comments:	All recruitment includes relevant employment checks with verification and approval of relevant qualifications by a suitable clinical colleague
Action for next year:	To continue

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	
Comments:	The Trusts Responsible Officer provides a connection between individuals professional standards to the Trust Board, monitoring both professional performance and adherence to Trust values and culture. Medical revalidation requires documented reflections on individuals contribution to quality improvements and seeks multi source feedback to drive excellence in clinical care. The Trust continues to embed just and learning principles in MHPS processes
Action for next year:	To continue

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	-
Comments:	The Trust continues to embed just and learning principles within professional standards policy and processes. The trust values of Safe, Kind and Effective promote compassion and inclusivity across the organisation at all levels. Fairness, respect, diversity and inclusivity are promoted via a Trust zero acceptance campaign, through delivery of an integrated EDI action plan for workforce, and are monitored via people governance structures. Established staff networks enhance staff voice, providing check and challenge in relation to organisational policies and processes and enabling two way feedback and communication to staff with protected characteristics.

Action for next year:	Continued delivery of the Trusts EDI Action plan for workforce, driven by Trust metrics and feedback from staff.
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1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	-
Comments:	The Trust has a Freedom to Speak up guardian, Executive FTSU Responsible Officer and a network of FTSU champions. Raising of concerns is regularly promoted and championed by the Chief Executive and Executive colleagues. MHPS policy makes explicit reference to whistleblowing and clearly documents processes in place to support individuals. The Trust holds regular learning and sharing forums as part of an organisational learning culture.
Action for next year:	Ongoing promotion of routes available to raise concerns and further development of feedback loops to all staff as part of ongoing commitment to organisational learning culture.

1F(iv) Mechanisms exist that support feedback about the organisation's professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	Ongoing arrangements in place
Comments:	The Trust has a Responsible Officer Advisory Group with senior medical leaders, NED, HR representation. This group closely reviews complaints, concerns and shortfalls in standards. The group will agree further actions including external referral to PPA for advice on decision making. MHPS is also closely referred to including the use of informal resolution and utilising appraisal process for meaningful reflections

Action for next year:	To continue
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1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

Y/N	yes
Action from last year:	Ongoing forum in place
Comments:	The Responsible Officer Advisory group (ROAG) reviews all employee relations cases on a monthly basis including those which are subject to external PPA review. The review also includes ED&I considerations. The group recently undertook an exercise to assess validation deferrals against country of medical qualification. The Trust is also compliant with WRES/WDES submissions.
Action for next year:	To continue a focussed review on cases and ensure further MHPS training is planned for senior medical leadership.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	None
Comments:	The RO, ARM and Medical Lead for Appraisal & Revalidation attend twice yearly regional RO meetings, and we will continue to engage with our local hospitals WUTH and Mid Cheshire Hospitals NHS Foundation Trust
Action for next year:	-

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	406
Total number of appraisals completed	343
Total number of appraisals approved missed	44
Total number of unapproved missed	19
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	74
Total number of late recommendations	0
Total number of positive recommendations	60
Total number of deferrals made	14
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	8
Total number of trained case managers	8
Total number of concerns received by the Responsible Officer ²	5
Total number of concerns processes completed	5
Longest duration of concerns process of those open on 31 March (working days)	154
Median duration of concerns processes closed (working days) ³	147
Total number of doctors excluded/suspended during the period	3
Total number of doctors referred to GMC	2

² Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

³ Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	
Total number of new doctors joining the organisation	68
Total number of new employment checks completed before commencement of employment	52 (100% of external recruits)
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld ⁴	0

⁴ Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
A new Medical Appraisal Lead was appointed in December 2025. Peer Support Meetings are now ongoing with three local Trusts.
Actions still outstanding
Annual Audit of country of primary medical qualification and protected characteristics for doctors discussed at ROAG for the previous 12 months for people who have been deferred- partly completed
Current issues
-
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
Refer above.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists))]

Official name of the designated body:	Countess of Chester NHS Foundation Trust
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Name:	Jane Tomkinson
Role:	Chief Executive
Signed:	
Date:	

Name of the person completing this form:	Dr Nigel Scawn
Email address:	nigel.scawn@nhs.net