NHS
Countess of Chester Hospital
NHS Foundation Trust

**Public meeting of the Board of Directors Agenda**
**(published items)**
Tuesday 24th November 2026, 09.00 – 12.50
Women & Children's Building Seminar Room

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| **Chair** | Mr N Large, Trust Chair |
| **Apologies** | |
| **In attendance** | Ms L Haslam, Participation Coordinator, Ms M Whelan, Education & Training Manager and Ms L Wilson, Ms G Powell, Ms H Thomas and Ms K Adams-Guppy, Volunteers (Item 3.). Ms E Maxwell, Head of Nursing Urgent Care and Ms C Ellis, Ward Manager (Item 4.) |

| Time | Agenda No. | Agenda item | Lead | Page No. | Decision Required |
|---|---|---|---|---|---|
| 09.00 | 1. | Welcome, apologies and Chair's opening remarks (verbal) | Trust Chair | | For noting |
| 09.03 | 2. | Declarations of Conflicts of Interest with agenda items (verbal) | Trust Chair | | For noting |
| 09.05 | 3. | Service Showcase (to be presented on the day) | | | |
| 09.30 | 4. | Patient Story (to be presented on the day) | | | |
| 09.40 | 5. | Minutes of the previous meeting held on 29th September 2026 (attached) | Trust Chair | 5 - 23 | For approval |
| 09.45 | 6. | To consider any matters arising and action and decision log (attached) | Trust Chair | 24 - 3 | For noting |
| 09.50 | 7. | Chief Executive Officer's Report (attached) | Chief Executive Officer | 31 - 35 | For noting |
| 10.00 | 8. | Trust Chair's Update (verbal) | Trust Chair | | For noting |
| 10.05 | 9. | a) Board Assurance Framework (Quarter 2) Update (attached)<br><br>b) Significant Risks Report (November 2026) (attached) | Director of Governance and Risk<br><br>Director of Governance and Risk | 36 - 59<br><br>60 - 69 | For decision<br><br>For noting |
| **Quality of Care** | | | | | |
| 10.15 | 10*. | GMC National Trainee Survey Results (attached) | Medical Director | 70 - 117 | For noting |
| 10.18 | 11. | Freedom to Speak Up Report (FTSU) (April 2026 – September 2026) (attached) | Chief Operating Officer | 118 - 126 | For assurance & noting |
| 10.25 | 12. | Quality & Safety Committee Chair's Report – 5th November 2026 (attached) | Chair Quality & Safety Committee | 127 - 129 | For assurance |
| 10.35 | 13. | Quarter 2 Maternity and Neonatal Trust Board Safety Report (attached) | Director of Midwifery | 130 - 158 | For assurance |

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| **Comfort Break – 10.45 – 10.55** | | | | | |
| 10.55 | 14. | Quarter 2 2026-2027 Mortality Surveillance Report (learning from deaths) (attached) | Medical Director | 159 - 168 | For assurance |
| **Operational Performance** | | | | | |
| 11.00 | 15. | Integrated Performance Report (IPR) (to follow)<br><br>Operational Performance<br><br>Quality<br><br>Safety<br><br>People<br><br>Finance | <br><br>Chief Operating Officer<br><br>Director of Nursing & Quality<br><br>Medical Director<br><br>Chief People Officer<br><br>Chief Finance Officer | | For assurance |
| 11.20 | 16. | Non-elective Pressure & Impact on Finance and Performance (attached & presentation on the day) | Director of Transformation & Productivity | 169 - 188 | For noting |
| 11.30 | 17. | Operational Management Board Chair's Report – 24th September 2026 and 22nd October 2026 (attached) | Chief Executive Officer | 189 - 194 | For assurance |
| 11.35 | 18. | NHS Oversight Framework (NOF) (attached) | Chief Data & Digital Officer | 195 - 202 | For noting |
| **Finance, Use of Resource and Performance** | | | | | |
| 11.40 | 19. | Finance & Performance Committee Chair's Report – 9th November 2026 (attached) | Finance & Performance Committee Chair | 203 - 204 | For assurance |
| 11.50 | 20. | Audit Committee Chair's Report – 6th October 2026 (attached) | Audit Committee Chair | 205 - 206 | For assurance |
| **Strategic Change** | | | | | |
| 12.00 | 21. | Emergency Preparedness Response & Resilience (EPRR) Annual Report (attached) | Director of Governance & Risk | 207 - 223 | For assurance |
| 12.05 | 22. | Anchor Institution Annual Report 2025/26 (attached) | Director of Strategic Partnerships | 224 - 241 | For assurance |
| 12.10 | 23. | Health Inequalities Annual report 2025/26 (attached) | Director of Strategic Partnerships | 242 - 284 | For decision & assurance |


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| 12.15 | 24. | Digital and Data Strategy Development Update (attached) | Chief Digital & Data Officer | 285 - 298 | For decision |
| 12.20 | 25. | People Strategy 2025–2028: Year 1 Delivery Review and Year 2 Priorities (attached) | Chief People Officer | 299 - 308 | For assurance |
| **Leadership, Improvement Capability, Organisation Development and People** | | | | | |
| 12.25 | 26. | People Committee Chair's Report – 16th November 2026 (attached) | People Committee Chair | 309 - 311 | For assurance |
| 12.35 | 27. | a) Equality, Diversity & Inclusion (ED&I) Report (including 2026 WRES, WDES and Gender Pay Gap) (attached)<br><br>b) Becoming an Anti-Racist Organisation (including response to the Lord Mann Review) (attached) | Cheshire People Officer<br><br>Chief People Officer | 312 - 316<br><br>317 - 328 | For decision & noting<br><br>For decision |
| 12.45 | 28*. | Council of Governors Report – November 2026 (attached) | Director of Governance & Risk | 329 - 331 | For noting |
| **Items for noting** | | | | | |
| 12.45 | 29.* | Items for noting and receipt (attached):<br>***Sent under separate cover*:**<br>**Minutes of Committee Meetings:**<br>a) Approved minutes of the Quality & Safety Committee – 3rd September 2026.<br>b) Approved minutes of the People Committee – 11th August 2026.<br>c) Approved minutes of the Finance & Performance Committee – 22nd September 2026.<br>d) Approved minutes of the Audit Committee – 23rd June 2026 and 14th July 2026.<br>e) Approved minutes from the Operational Management Board – 23rd July 2026 and 24th September 2026.<br>**Other items:**<br>f) Board of Directors Workplan 2026/27. | Trust Chair | | For noting |
| **Other items** | | | | | |
| 12.47 | 30. | Any Other Business (verbal) | Trust Chair | | For noting |
| 12.48 | 31. | Questions from Governors and members of the Public relating to items on the meeting agenda - ***Questions to be submitted in writing in advance of the meeting to:*** coch.membershipenquiriescoch@nhs.net ***by Thursday 19th November 2026*** | Trust Chair | | For noting |


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| | | **Future Dates:**<br>26th January 2027<br>16th March 2027 | | | |
| 12.50 | 32. | Closing remarks (verbal) | Trust Chair | | For noting |

Next Meeting: Tuesday 26th January 2027 at 9.00, Women & Children's Building Seminar Room

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



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# MINUTES OF THE PUBLIC BOARD OF DIRECTORS

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

| Members | 19/05/26 | 21/07/26 | 29/09/26 | | | |
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| 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 | ☑ | ☑ | N/A | | | |
| Non-Executive Director, Mrs S Corcoran | ☑ | ☒ | ☑ | | | |
| Non-Executive Director, Mrs H Gunawickrema | N/A | 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 | ☑ | ☑ | ☑ | | | |

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| Chief People Officer, Ms V Wilson | ☑ | ☑ | ☑ | | | |
| Director of Transformation & Productivity, Mr D Nash | ☑ | ☒ | ☑ | | | |
| **In attendance** | **19/05/26** | **21/07/26** | **29/09/26** | | | |
| Head of Corporate Governance, Mrs N Cleuvenot | ☑ | ☑ | N/A | | | |
| Director of Midwifery, Ms N Macdonald | ☑ (Item 11) | N/A | ☑ (Item 13) | | | |
| Director of Clinical Research, Mr P Bamford | ☑ (Item 18) | N/A | N/A | | | |
| Deputy Director of Nursing & Quality, Ms M Kynaston | ☑ (Item 3) | ☑ (Item 11b) | N/A | | | |
| Practice Development Nurse, Ms K Jones | ☑ (Item 3) | N/A | N/A | | | |
| Directorate Manager Planned Care, Mr K Smith | N/A | ☑ (Item 3) | N/A | | | |
| Consultant Urology, Dr S Das | N/A | ☑ (Item 3) | N/A | | | |
| Ward Manager - Ward 42, Ms L Hunter | N/A | ☑ (Item 4) | N/A | | | |
| Associate Director of Pharmacy - Medicines Optimisation, Ms H Stokes | N/A | ☑ (Item 15) | N/A | | | |
| Divisional Director Urgent Care, Mr T Jackson | N/A | ☑ (Item 18) | N/A | | | |
| Associate Director of Estates and Facilities, Mr A Hope | N/A | ☑ (Items 22 & 23) | N/A | | | |
| Head of Midwifery, C Davis | N/A | ☑ (Item 11a) | N/A | | | |
| Deputy Medical Director, Mr I Benton | N/A | ☑ | N/A | | | |
| Deputy Chief Operating Officer, Mr S Brown | N/A | N/A | ☑ | | | |
| Director of Digital, Mr D Reilly | N/A | N/A | ☑ | | | |

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| Associate Medical Director, Dr S Brigham | N/A | N/A | ☑ (Item 13) | | | |
| Executive Office Manager, Mrs R Butterworth | N/A | N/A | ☑ | | | |
| Associate Director of Nursing, Ms J Cooper | N/A | N/A | ☑ (Item 3) | | | |

Observers in attendance:

- Maria Knowles - Xyla

| Agenda No. | Agenda item | Action |
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| 1. | **Welcome, apologies and Chair's opening remarks**<br>The Chair welcomed Board members and attendees to the meeting.<br>Apologies were received from Non-Executive Director, Ms A Simpson, Chief Operating Officer, Miss C Chadwick, and Chief Digital and Data Officer, Mr J Bradley.<br>Trust Chair, Mr N Large, opened the meeting acknowledging the challenges that the Trust had faced and invited Chief Executive Officer, Ms J Tomkinson to read a statement to the Board in relation to the publication of the Thirlwall Inquiry Report. Ms J Tomkinson reflected on the impact of the Inquiry's findings and stated that the Trust's thoughts remained with the families affected by the crimes of Lucy Letby. The Trust are reviewing the recommendations, noting that some extended beyond the organisation. | |
| 2. | **Declarations of Conflicts of Interest with agenda items**<br>There were no declarations of interest to note.<br>Trust Chair, Mr N Large (NL) apologised for the papers that had been circulated late and the explanations would be included in the updates., In view of a full agenda NL asked those presenting items to take their papers as read. | |
| 3. | **Service Showcase**<br>Associate Director of Nursing, Ms J Cooper (JC), presented the Safeguarding Annual Report, drawing the Board's attention to referral activity, capacity assessments, Deprivation of Liberty Safeguards (DoLS) applications and evidence that learning was being cascaded across the partnership.<br>In response to a question from Non-Executive Director, Professor A Hassell about the service's ability to manage increased activity, Ms J Cooper advised that processes were becoming more effective, with greater focus on appropriate referral thresholds. It was recognised that staff could sometimes refer to safeguarding because of uncertainty. A model similar to that introduced in in JC's previous Trust was being considered to support | |

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| | proportionate decision-making while ensuring staff felt confident and safe in applying the thresholds.<br><br>Non-Executive Director, Mrs S Corcoran (SC), welcomed the report and the supporting evidence, particularly the training data, and queried whether one reference should read March 2026 rather than March 2025. JC confirmed that this was an error and that the report should be corrected.<br><br>The Board discussed the reduction in Level 3 safeguarding mandatory training compliance. JC reported that data was reviewed monthly and targeted action was taken in areas with outstanding training. Compliance currently stood at 87%, representing a significant improvement from approximately 50% two years previously. JC advised that further sessions could be arranged, adding that delivery was resource-intensive because the training was interactive and required renewal every three years.<br><br>Trust Chair, Mr N Large (NL) asked whether mandatory training could be staggered or brought forward. Chief People Officer, Ms V Wilson (VW) informed the Board that this formed part of a wider consideration of mandatory training arrangements.<br><br>In response to a question from Non-Executive Director, Mr M Oldham (MO) regarding the DoLS data regarding the applications and assessments, JC clarified that assessments were undertaken by the local authority and that outstanding cases reflected assessments not yet completed by the authority. The Board also noted forthcoming changes to the DoLS framework and the focus on individuals who were not consenting.<br>JC also highlighted Prevent activity and the associated training undertaken following the Southport incident. The Board noted the role of the Safeguarding Assurance Committee in overseeing this work. JC reported that the paediatric liaison nurse role was helping to identify gaps and provide an additional safety net for children and young people.<br><br>The Board considered the learning from a domestic homicide review involving an individual who had attended the Emergency Department and disclosed domestic abuse but had not received appropriate follow-up. J C advised that a mandatory question had subsequently been introduced at triage, resulting in the identification of more people who could be offered safeguarding support.<br><br>The Board received an update on safeguarding assurance in relation to the Thirlwall Inquiry and it was confirmed that further Board training would be included at the next meeting. It was noted that Level 3 training was in place for staff; however, a number of operational staff had not yet undertaken this training, and further provision would be developed, and a training package would also be developed for staff participating in the on-call rota. JC confirmed that a formal process for managing allegations was embedded and that quarterly assurance reports were considered by the Safeguarding Assurance Committee.<br><br>The Board noted the Sudden Unexpected Death in Infancy and Childhood (SUDIC) process. JC advised that preparations were under way for an | |

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| | anticipated Care Quality Commission inspection of children's services involving Cheshire West and Chester Council.<br><br>Chief Executive Officer, Ms J Tomkinson thanked Ms J Cooper for the report and emphasised the importance of establishing a clear and formal arrangement for out-of-hours safeguarding cover and escalation.<br><br>NL commended the quality of the report and acknowledged the commitment and progress demonstrated by the safeguarding team.<br><br>The Board **noted** the Safeguarding Annual Report and Service Showcase.<br>***JC exited the meeting.*** | |
| 4. | **Patient Story**<br><br>Director of Nursing & Quality/Deputy Chief Executive, Mrs S Pemberton (SP) read a patient story from an individual who identified themselves as an NHS service manager and who had attended the Emergency Department with kidney stones. The patient commended the care, compassion and responsiveness demonstrated throughout their treatment, including the support provided when their preferred care plan changed from discharge to admission. Having recently moved to the area, this was the patient's first attendance at the Countess of Chester Hospital Emergency Department.<br><br>Particular praise was given to the portering staff, who provided reassurance and conversation to help distract the patient from their pain; the ward team, including a named staff member, who continued to check on the patient; the radiology team for the CT scan experience; and the overnight staff and prescribing nurse, whose care made the patient feel personally supported. The patient also felt well informed about the diagnosis and considered the discharge process to have been managed efficiently. A subsequent scan at the Ellesmere Port Hospital was also praised.<br><br>The patient expressed their appreciation and reported being impressed by the overall standard of care. The Board noted a piece of feedback from the patient regarding waiting 90 minutes in the Emergency Department before receiving pain relief.<br><br>The Board **noted** the patient story. | |
| 5. | **Minutes of the previous meeting held on 21st July 2026**<br><br>The minutes of the previous meeting held on 21st July 2026 were **approved** as a true and accurate record of the meeting subject to the following amendment: under the people section of the IPR Item on Page 65 of the pack, Miss V Wilson did not say "lower compliance was largely associated with staff who did not routinely access computers as part of their role" | |
| 6. | **To consider any matters arising and action and decision log**<br><br>Action 1- IPR feedback would now be shared directly to the Chief Digital & Data Officer as part of ongoing improvement and therefore the action can be closed. | |

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| | Action 2 – Medical Director, Dr N Scawn advised that the existing action could close, as implementation was progressing across the organisation. E-rostering was already being used in urgent care and was planned more widely, providing clearer information on expected hours, leave and staffing gaps.<br><br>Action 3 – Action closed.<br><br>Action 4 – Further work required to arrange the outstanding Board development session and agree the revised date/content.<br><br>Action 5 – Specific feedback was to be captured during Integrated Performance Report and incorporated before the action was closed.<br><br>Action 6 – A status report on urgent care required further discussion with the Trust Chair, including triangulation with the related work before determining how it should be used. The action would remain open.<br><br>Action 7 – Agreed as closed, although the volume and clarity of Board papers would continue to be monitored. | |
| 7. | **Chief Executive Officer's Report**<br><br>The Board received the Chief Executive's Report, which was taken as read.<br><br>The Chief Executive, Ms J Tomkinson (JT) highlighted positive performance in the patient survey results and noted that the findings provided oversight of progress in relation to accountability, culture and governance within the Trust.<br><br>JT referenced paragraph 4 in the report around the Cheshire and Merseyside Provider Collaborative Leadership Board meeting and gave a brief update on the Blueprint and the work being undertaken through the collaborative leadership arrangements, to refresh the existing blueprint and that in light of anticipated fundamental changes, there would be a pause to consider the appropriate organisational response.<br><br>JT shared correspondence received from the local Member of Parliament, Samantha Dixon congratulating the Trust on the improvements following the latest Care Quality Commission (CQC) inspection.<br><br>JT then gave the Board additional information to the report, including:<br><br>The Trust's Executive team had been invited to attend a national session in London focused on eliminating corridor care.As the session was on the same day as the Board of Directors, the executive team did not attend but members from the senior leadership team attended on the Trust's behalf.<br><br>Forthcoming engagements, included a relationship meeting with the CQC on 30th September 2026, which would provide an opportunity to meet new colleagues from the CQC and continue constructive engagement. Additionally, there was a planned visit to the Trust from the new regional Chief Operating Officer on 13th October 2026. Ms Tomkinson advised that Board that she has invited him and was very keen for him to come and showcase the positive work within the Trust.<br><br>JT highlighted the Macmillan open day on 30th September 2026, which would showcase the support available to patients and families, and urged | |

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| | Board members to call in if they were able, to provide an opportunity to meet the Macmillan team.<br><br>JT also informed the Board that following endorsement by the Remuneration Committee, Mr M Gibbs had been appointed to the role of Director of Strategy and Partnerships, and was expected to join the Trust in early December.. The Board **noted** the CEO report and the additional information. | |
| 8. | **Chair's Update**<br><br>The Trust Chair, Mr N Large (NL), gave an update to the Board noting the following points<br><br>NL, reported that he had attended a call with NHS chairs, which reinforced the responsibilities arising from the Ockenden findings.<br><br>NL had visited the Haematology Unit, reporting that the development had created additional clinical space for the service and would provide additional capacity during winter pressures. The Chair welcomed the development, noted the positive response from staff and thanked the Estates Team for its contribution.<br><br>During a walkabout of the theatres with Non-Executive Director, Mr P Jones, NL noted that he had observed the challenges faced by teams and the collaborative approach taken by colleagues to maintain services and make effective use of the available facilities.<br><br>NL advised he had attended the Membership Committee and informed the Board tthat the legislation regarding the future role of Governors at the end of March had not changed. NL raised that there were opportunities in the Trust for Governors interested to make a valuable contribution to patient engagement, and further consideration would be given to how they could be involved in developing this work.<br><br>NL advised the Board that Lead Governor, Mr J Jones would be stepping down after nine years. NL thanked to Mr J Jones for his longstanding support and contribution during his tenure, The Board noted its appreciation for his longstanding support, commitment and contribution. The Board **noted** the Chair's Update | |
| 9. | **a) Board Assurance Framework (BAF) and Risk Appetite Statement 2026/27**<br><br>**Dr Trueger, Staff Governor, joined the meeting via the Team's link and was welcomed by the Board.**<br><br>Director of Governance & Risk, Mrs K Wheatcroft (KW) noted that the BAF paper was a standing item on the Board. The Quarterly review is due for the November Board so would not be considered in detail at this meeting. KW drew attention to the information on the cover paper and informed the Board that the Thirlwall Inquiry report and baseline assessment would also form part of the quarterly BAF review.<br><br>The Trust Chair, Mr N Large commented that the information in the BAF gave him confidence of improvement and stabilisation within the Trust. There was a discussion around the risk appetite and the need to look at the external assurances received to assess whether risks had reduced, and the Board's role in challenging these scores | |

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| | Chief Executive Officer, Ms J Tomkinson added that the triangulation with the Thirlwall Inquiry report was important and timely as one of the recommendations was how organisations use their risk management systems at divisional levels through to the Board and including the BAF.<br><br>The Board **noted** the BAF.<br><br>**b) Significant Risks Report (July 2026)**<br><br>Director of Governance & Risk, Mrs K Wheatcroft (KW) presented the Significant Risks Report, advising that it provided oversight of the Trust's highest operational risks, with ten risks currently scored at 15 or above.KW noted that the report supported triangulation between divisional risk registers, executive oversight, Board committees and associated assurance reporting. KW also noted the ongoing work to strengthen risk management processes, risk ownership and reporting arrangements across the Trust.<br><br>KW advised that further work was required to improve the timeliness with which matters were added to the risk register. This continued to be monitored through the Risk Management Committee**.**<br><br>In response to a question from Non-Executive Director, Mr P Jones on delivery against plan and executive ownership, it was confirmed that executive leads were in place for all significant risks. The hybrid theatre was discussed as a significant investment; however, delivery was not expected by end of Quarter 2 of 2026/27 as initially anticipated in the report.<br><br>In relation to risk 2964 concerning patients with no criteria to reside, Deputy Chief Operating Officer, Mr S Brown, highlighted the limited assurance available from local authority partners regarding mitigation and that this risk could remain a significant risk beyond the period for which the risk stated it would remain at this level.<br><br>The Trust Chair, Mr N Large asked whether there were any new risks of which the Board should be aware. It was explained that some risks appeared longstanding because they had remained as risks but the scores changed during this time and therefore had moved through the reporting process. Assurance was provided that new significant risks would be clearly identified, with the key at the top of the report indicating those newly added.<br><br>Director of Digital, Mr D Reilly drew the Board's attention to the cyber risk and the ongoing mitigations, adding that it was difficult to specify a closure date while the risk and the impact of mitigating actions continued to evolve. Chief Executive Officer, Ms J Tomkinson, asked whether national work could support implementation. It was agreed that an update on the cyber operating model would be provided at a future Finance and Performance Committee meeting and that the Trust would make use of relevant national resources as they became available. The Board also noted that a plan for artificial intelligence risk was included within the Data Security and Protection Toolkit, which should provide further assurance.<br><br>Non-Executive Director, Mr P Williams emphasised that the Board needed to be realistic about what successful mitigation would look like, particularly where risks were influenced by external factors. | |

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| | Non-Executive Director, Mrs S Corcoran advised that the Board needed to determine which risks it was prepared to accept and agree a clear process for reducing or closing risks once the relevant issues had been resolved.<br><br>The Board **noted** the Significant Risks Report and the ongoing work to strengthen risk management across the Trust. | |
| 10. | **Care Quality Commission (CQC) Report and Action Plan (Medical Care, Urgent & Emergency Care, and End of Life services)**<br><br>The Director of Nursing and Quality/Deputy Chief Executive, Mrs S Pemberton, advised that the Board had already been briefed on the CQC report and therefore the report findings would not be covered in detail but it was important to note the significant changes in ratings and advised that further work was to continue.<br><br>Mrs S Pemberton advised the Board that page four of the report set out the changes, including the Urgent and Emergency Care service achieving a rating of 'Good' for caring. An update was also provided on the new inspection team and the pilot approach to inspections. Any identified risks would be escalated through the appropriate governance routes.<br><br>Non-Executive Director, Professor A Hassell asked whether an asterisk or similar marker could be used within the other reports received through the committees to draw attention to specific areas of concern identified by the Care Quality Commission.<br><br>Director of Governance & Risk, Mrs K Wheatcroft supported the proposal recognising that the areas for action are already embedded in existing reports, and noting that it would provide helpful visibility for the Board and demonstrate the progress made in establishing the necessary arrangements and assurance.<br><br>Non-Executive Director, Mrs S Corcoran supported this view, emphasising that the purpose of the reporting and assurance arrangements was to support improvements in patient care.<br><br>Trust Chair, Mr N Large thanked Mrs Pemberton and added that it was great to see the improvement, and the positive impact this would also have on staff providing recognition of the hard work which has taken place.<br><br>The Board **noted** the Care Quality Commission (CQC) Report and Action Plan (Medical Care, Urgent & Emergency Care, and End of Life services). | |
| 11. | **Inpatient Survey Results (2025 Survey)**<br><br>The Director of Nursing and Quality/Deputy Chief Executive, Mrs S Pemberton (SP) presented the Inpatient Survey Results and emphasised the importance of the survey as a direct source of patient feedback., She highlighted the improvements from last year, in particular in overall care, which was scored at eight point three, where the Trust had previously sat in the seven range, as well as the high scores in both kindness and compassion.<br><br>SP advised that a new Patient Experience Meeting had been established, with a particular focus on strengthening divisional engagement with patients and families and making effective use of Friends and Family Test feedback. | |

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| | SP highlighted areas requiring further attention including the experiences of patients living with frailty who attended the Emergency Department, together with neurology and dementia care. Work was under way to improve how these patients were identified and supported within the Emergency Department. This included reviewing dementia care processes with support from external clinicians**.**<br><br>SP advised that the next survey would take place throughout November 2026 with the results being shared towards the end of 2027, which is why it is important to have continuous improvement and not just a response to results.<br><br>Chief Executive Officer, Ms J Tomkinson welcomed the results, noting that they reflected sustained cultural improvement and leadership from ward to Board. Ms J Tomkinson thanked teams for their contribution to the turnaround and noted that the Trust had risen to 59th in the comparative ranking.<br><br>Non-Executive Director, Professor A Hassell confirmed that the Quality and Safety Committee had oversight of the matters raised, with the exception of virtual wards, which would be considered at a future meeting.<br><br>**Action:** It was agreed that the Divisional Director for Therapies and Integrated Care, Ms A Swanton, would be invited to a future meeting to provide a presentation to the Board on virtual wards**.**<br><br>Non-Executive Director, Mrs S Corcoran asked how the results and improvements were communicated to staff. SP advised that feedback was shared through Team Briefs and staff forums, with a year-end summary planned to demonstrate what had been achieved**.**<br><br>The Board noted the importance of communicating the improvements proactively, recognising that external media coverage did not always reflect the positive progress being made.<br><br>The Board:<br><br>• **Noted** the contents of the paper and the significant improvement this year compared to previous year.<br>• **Noted** the implementation of the new platform for FFT collection.<br>• **Noted** the progress of the Patient Experience Improvement Framework | **CC** |
| 12. | **Quality & Safety Committee Chair's Report – 3rd September 2026**<br><br>Non-Executive Director, Professor A Hassell (AH) drew the Board's attention to a number of areas in the report requiring continued oversight.<br><br>AH noted the ongoing infection prevention and control challenges across a number of areas. The importance of the separate report on the estate and infrastructure, particularly the older parts of the estate, and the implications for infection prevention and control was emphasised, and it was requested that this be presented as a regular reporting item on the Committee agenda.<br><br>The Integrated Performance Report highlighted emergency department length of stay, with the number of mental health patients remaining in the department continuing to be a concern. The Director of Nursing and Quality/Deputy Chief Executive, Mrs S Pemberton (SP) advised that a meeting with Cheshire and Wirral Partnership NHS Foundation Trust had | |

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| | been arranged to discuss the matter. It was advised that at this point the Committee could not provide assurance to the Board on this matter.<br><br>AH noted that the Committee had reviewed the maternity ten-point plan, which would be covered later in the Private Board agenda and would therefore be discussed in more detail.<br><br>The annual consent audit results remained below the expected standard, with documentation identified as the principal area of challenge. While there was evidence that patients were being consented, not all required elements of the consent process were demonstrably recorded. The expectation was that developments within the Electronic Patient Record system could improve the visibility and completeness of compliance by supporting better documentation.<br><br>The Board **noted** the Quality and Safety Committee Chair's report | |
| 13. | **Perinatal Services Quarterly Update – Quarter 1 2026/27** **(This item was covered after Item 14. Integrated Performance Report)**<br><br>The update was presented by Director of Midwifery, Ms Natasha Macdonald (NM) and Associate Medical Director, Dr Sara Brigham (SB). The report provided assurance regarding the quality, safety and performance of maternity and neonatal services and highlighted current and emerging risks.<br><br>The Chair, Mr N Large, asked for clarification on the measures in relation to neonatal deaths following the conversation on the Integrated performance Report item around the reported neonatal deaths at 19 weeks. The Board were advised that the neonatal measure within the IPR dashboard would be separated to distinguish between births occurring before and after 24 weeks' gestation. The perinatal mortality rate for the Trust remains low and below the national rates for stillbirth and neonatal deaths<br><br>The Board was advised on the position in relation to staffing and maternity safety surveillance. No organisational signals had been identified through the Maternity Outcomes Signal System (MOSS). A critical safety drill had been undertaken and, while no new escalations had arisen, an opportunity had been identified to review the available data further.<br><br>NM told the Board that the Trust continued its progress towards compliance with all six Maternity Incentive Scheme (MIS) Year 8 Safety Actions.<br><br>• Safety Action A: workforce and capacity requirements are currently being met, although workforce sustainability risks remain.<br>• Safety Action C: achieved 100% compliance for Quarter 1, providing Full Assurance.<br>• No qualifying perinatal events required notification to MBRRACE UK, NHS Resolution Early Notification or MNSI during the quarter.<br>• Governance arrangements remain in place for multidisciplinary review, family involvement and triangulation of incidents, concerns and claims.<br><br>NM informed the Board that there were no qualifying reportable events in Quarter 1, but that the Quarter 4 triangulation report from the previous year (2024/25) had identified learning themes which are reviewed through the maternity governance meetings. | |

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| | Delays in induction of labour were discussed, with further performance detail to be provided in the Quarter 2 report. The delays were attributed to acuity and staffing pressures, and the Board noted the opening of the induction bay.<br><br>NM advised the Board that an external review of the home birth service had been complimentary about the current position and had identified no immediate safety concerns. National standards were awaited in January. It was noted that community midwives might require further training, which could necessitate additional whole-time equivalent backfill. A formal letter confirming exit from the oversight programme was also expected.<br><br>In response to a question from Chief People Officer, Miss V Wilson, regarding how staff received feedback on red flags, it was confirmed that these were shared at unit meetings, together with details of the actions taken to mitigate them**.**<br><br>NL sought further assurance regarding induction performance. It was confirmed that no incidents or harm had been reported as a consequence of delayed inductions. The escalation process was outlined, including the establishment of Gold Command where delays arose. Members noted that movement of patients across the region occurred frequently as part of the wider management arrangements.<br><br>NL acknowledged the work undertaken by the team.<br><br>Non-Executive Director, Mrs S Corcoran **welcomed** the increase in the birth rate numbers in the Trust while recognising the associated additional pressures on staff.<br><br>The Board **Noted** the 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**.**<br><br>The Board **Noted** 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.<br><br>**SB and NM left the meeting.** | |
| 14. | **Integrated Performance Report (IPR)**<br><br>**Operational Performance**<br><br>Deputy Chief Operating Officer, Mr S Brown (SB), gave an overview of the Operational Performance highlighting the following points.<br><br>Emergency department performance had fallen below plan in August, reflecting a high level of attendance. The proportion of patients classified as not meeting the criteria to reside was 28% in August, while ambulance handover performance remained within plan.<br><br>Elective referral-to-treatment performance against the 18-week standard was delivered in line with plan. The 52-week position also remained on plan and there had been no 65-week breaches. The waiting list had, however, increased since the start of the year and was approximately 2,000 pathways | |

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| | above plan. Further investigation was under way to understand the composition of the increase and identify mitigating actions.<br><br>Cancer performance remained on plan for the Faster Diagnosis Standard for the fifth consecutive month, and the 52-day referral-to-treatment measure was on target. Performance against the 31-day decision-to-treatment standard was 85%, compared with the 96% target.<br><br>Diagnostic performance against the DM01 standard had dipped slightly, principally because of reduced non-obstetric ultrasound capacity. This was expected to affect the overall DM01 position. A watching brief was being maintained, and an action plan was in place.<br><br>Non-Executive Director, Mr P Williams, asked how referral-to-treatment performance was triangulated with growth in the waiting list and whether the two were linked. SB confirmed that there was a direct relationship, although the position was supported by performance for patients waiting less than 18 weeks, with additional validation being undertaken to identify pathways approaching or exceeding 18 weeks, with improvement expected.<br><br>In response to a question from Non-Executive Director, Mr P Jones, regarding the DM01 performance, SB confirmed that the deterioration in DM01 performance was primarily a capacity issue and that no further underlying cause had been identified. The Board also considered the increase in emergency department attendances, including walk-in and ambulance arrivals, attendance from Wales and the number of younger patients presenting, which could indicate challenges in accessing community services. Attendance for dressing-related issues was also noted. Further work would identify relevant conditions and patterns associated with particular GP practices and consider the role of intermediate-tier services.<br><br>Non-Executive Director, Mr M Oldham, asked whether any actions had arisen from the urgent and emergency care work led by Professor Tim Briggs. SB reported early signs of improvement, including increased consultant input and a reduction in the admission rate. Work was continuing in the Urgent Treatment Centre, including reviewing and tightening the criteria for type 3 activity while balancing any consequential risk to type 1 performance and establishing the underlying causes of the current position.<br><br>Trust Chair, Mr N Large (NL), commented that the Urgent Treatment Centre remained one of the most significant challenges and had a material impact on performance. The work under way to understand and address this position was expected to underpin further improvement and would be reported to the Board.<br><br>**Quality**<br><br>The Director of Nursing and Quality/Deputy Chief Executive, Mrs S Pemberton (SP) gave an overview of the Quality Performance highlighting the following points.<br><br>Further improvement was required in the prevention and management of pressure ulcers, including ensuring that patients were placed on appropriate mattresses promptly and strengthening involvement from the tissue viability team. The staffing grid provided a snapshot of ward staffing at midnight. Mitigating actions and bank staffing requests were reviewed, and assurance | |

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| | was provided that staffing levels were monitored continuously through the Safe Care application.<br><br>The Board noted work relating to long-stay patients, including the management of violence and aggression and support for patients with complex needs and dementia**.**<br><br>Chief Executive Officer, Ms J Tomkinson (JT), commented that the maternity overview did not yet provide the Board with sufficient insight into the position underpinning the reported figures. Digital Director, Mr D Reilly (DR) agreed to review how the information and supporting narrative could be strengthened.<br><br>**Action:** Mr D Reilly to review how review how the information and supporting narrative could be strengthened, relation to maternity data in the IPR.<br><br>The Board discussed two neonatal deaths involving babies born at 19 weeks' gestation, before the recognised threshold of viability at 24 weeks. It was explained that the cases were recorded as neonatal deaths because signs of life had been observed following birth. The cases did not indicate a concern regarding the care provided.<br><br>JT emphasised that the Board report should make clear that the babies had been born before the threshold of viability and should include the supporting data previously presented to the Quality and Safety Committee. SP agreed to review the narrative to ensure that the report reflected this context. It was confirmed that an explanatory note had been added.<br><br>Non-Executive Director, Professor A Hassell sought clarification regarding the Clostridioides difficile position within the National Oversight Framework. SP advised that a new requirement relating to sampling appeared to conflict with established clinical practice. Concerns raised by microbiology colleagues would be escalated to Mr J Banwell, Head of Pathology. Performance for C. difficile was one case better than target, however Klebsiella remained the principal area of concern.<br><br>Medical Director, Dr N Scawn provided an update on safety indicators including venous thromboembolism (VTE) compliance advising the requirement for heparin administration was based on completion within a 14-hour window. The process had therefore been amended from a fixed 6pm point to reflect the full compliance window.<br><br>Electronic discharge performance remained static. The electronic patient record working group had not yet reached agreement on the approach. The team had engaged with two other trusts, and work remained in progress to improve the proportion of electronic discharges.<br><br>Mortality remained within the expected range. The Board acknowledged the work undertaken to improve sepsis performance and thanked Dr Esther Cooper, the previous sepsis lead for her work around sepsis performance. It was noted that a new sepsis lead had been appointed, Dr Tom Wlodarczy.<br><br>**People**<br><br>The Board received the workforce update from Chief People Officer, Miss V Wilson (VW), who informed the Board that the workforce indicators provided | **DR** |

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| | a varied picture. VW advised that turnover remained below target, and while it could be seen a stability it could also indicate fewer opportunities for further improvement across the wider system.<br><br>The approach to holding vacancies among healthcare assistants, administrative and clerical staff was being managed carefully, with consideration given to the timing and operational impact of decisions.<br><br>VW noted that sickness absence had reduced in-month to 5.42%, with the Trust continuing to compare favourably with peers. However, this followed several months of increased absence, consistent with regional and national trends. Stress and anxiety remained the principal reason for sickness absence. The Trust continued to focus on both the effective management and prevention of sickness absence, supported by its staff wellbeing offer. VW also noted the impact of sustained operational pressures on the workforce, including mandatory training and appraisal compliance, with targeted interventions in place**.**<br><br>The agency staffing position was reported positively with expenditure at less than half the level experienced at the end of previous years and remaining below the Trust's target as a proportion of the overall pay bill.<br><br>Chief Executive Officer, Ms J Tomkinson (JT), sought assurance regarding the relationship between whole-time equivalent staffing levels and delivery of the cost improvement programme, including the number of staff recruited to support escalation areas. It was reported that this equated to approximately 105 whole-time equivalents.<br><br>The Board discussed the increase in workforce establishment in the context of cost improvement programme requirements and the need to maintain safe operational capacity**.**<br><br>**Finance**<br><br>Director of Finance, Mrs K Edge (KE), reported that the financial plan was being delivered both in-month and year to date, including deficit support funding which was received for Quarters One and Two. The principal concern remained a £3.4 million shortfall in delivery of the cost improvement programme, for which mitigating action was required. KE advised the Board of the work which was being done with Divisions to mitigate the shortfalls and as a result of that the Trust was forecasting to finish on plan.<br><br>**Action:** Following concerns raised by Trust Chair, Mr N Large, on the new National Oversight Framework (NOF) terms, it was agreed that a future Board session would consider the implications and definitions associated with the new NOF.<br><br>The Board **Noted** the contents of the IPR and the assurance provided within this report, including the areas requiring improvement and the mitigating actions described. | **JB** |
| 15. | **Winter Planning 2026/27: Board Assurance Template**<br><br>Deputy Chief Operating Officer, Mr S Brown (SB), presented the winter plan to the Board advising that Chief Operating Officer, Ms C Chadwick was the named Executive Lead, providing clear executive accountability for delivery of the plan. A regional stress test of winter plans had been undertaken. | |

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| | The plan included additional bed capacity and consideration of the associated finance, workforce and estate requirements. The proposed response had been refined in light of learning from previous winters, including the impact of critical care pressures on the organisation's ability to escalate capacity.<br><br>Estates enabling work was under way on Ward 60 to support an increase in the winter bed base. Nursing requirements for the additional areas had been considered, and a breakdown of proposed additional therapy staffing had been shared.<br><br>Clear checkpoints had been established for areas assessed as red. A MADE event and a specific Christmas and New Year exercise were planned. Members noted the strength of executive and clinical oversight and the updated operational escalation plan.<br><br>Non-Executive Director, Mr P Williams, sought clarification as to whether the self-assessment indicators were generated automatically or relied on management judgement, particularly in relation to occupancy and discharge. SB advised that completion of the assessment involved management review of the areas of concern, with the rationale for any lack of assurance clearly articulated against the indicators in the checklist.<br><br>Non-Executive Director, Mr P Jones asked whether feedback had been received from the local authority, including in relation to length of stay**.** It was requested that this position be more clearly articulated. The date of the next meeting had not yet been confirmed.<br><br>Non-Executive Director, Mr M Oldham, asked whether a bed model was available to demonstrate the capacity required and identify any gaps. SB advised that there was ordinarily a gap of approximately sixty beds, although performance during the previous winter had been positive. Modelling work led by Director of Transformation & Productivity, Mr D Nash indicated increased attendances and a higher number of patients who did not meet the criteria to reside**.**<br><br>Additional escalation capacity was available through opening other areas, although this would only be used if required.<br><br>SB reported that the longstanding arrangement with Flintshire had been withdrawn because of funding constraints. Work was under way to develop an integrated discharge response. The potential provision of social workers at the hospital front door had been discussed; however, Flintshire had advised that this would require resources to be redirected from other areas.<br><br>Trust Chair, Mr N Large, checked understanding that funding remained the principal constraint and that additional escalation capacity could be implemented if the necessary resources were available**.**<br><br>The Director of Nursing and Quality/Deputy Chief Executive, Mrs S Pemberton highlighted the staffing risks associated with escalation, including the movement of staff between areas. The organisation was already providing staffing for escalation capacity within the Same Day Emergency Centre (SDEC).<br><br>Director of Strategy and Partnerships, Mr J Develing, referred to the role of the Health and Wellbeing Board and provided an update regarding its new powers. In relation to the Better Care Fund, it was noted that the local | |

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| | authority had set a target of no more than six hundred and fourteen admissions to long-term care. Progress against this target would be reported to the Urgent Care Group.<br><br>The Board noted that, while the Trust was required to submit its winter plan to commissioners, equivalent detail regarding the commissioner's winter plan had not been received.<br><br>Chief Executive Officer, Ms J Tomkinson, confirmed to the Board that this concern had been raised formally.<br><br>The Board discussed the role of the Integrated Care Board and the responsibilities of system partners in coordinating winter planning and delivery**.**<br><br>NL acknowledged the work undertaken by SB and the wider team in developing the winter plan. Adding that the recommendations identified those areas where assurance had not yet been established.<br><br>Mr M Oldham opened a discussion on the bed model, which NL advised would be considered further outside of this meeting.<br><br>SB confirmed that the draft plan had been submitted to the regional team for review and feedback on the draft had advised the Non Criteria to Reside (NCTR) position be clearly highlighted.<br><br>The Board **approved** the Board Assurance Statement for submission to NHSE on 30th September 2026 recognising that the winter plan had been considered in isolation from a number of wider system factors for which responses from system partners remained outstanding. | |
| 16. | **Operational Management Board**<br><br>**a) Operational Management Board Chair's Report – 23rd July 2026 Operational Performance**<br><br>The Board received the Operational Management Board (OMB) Chair's Report. The Chief Executive Officer, Ms J Tomkinson noted that there were no overall concerns to raise.<br><br>The Board **Noted** the OMB Chair's report<br><br>**b)Terms of Reference Update – Operational Management Board**<br><br>Director of Governance & Risk, Mrs K Wheatcroft, advised the Board that the proposed minor amendments to the Operational Management Board Terms of Reference had been made in response to feedback from the OMB and required Board approval.<br><br>The Board **approved** the OMB Terms of Reference document. | |
| 17. | **Finance & Performance Committee Chair's Report – 20th August 2026**<br><br>The Board received the Finance & Performance Committee Chair's Report from 20th August 2026.<br><br>Non-Executive Director, Mr M Oldham, also provided an overview of the Finance and Performance Committee meeting, held on 22nd September 2026, including the reasons for the financial shortfall.<br><br>The Board discussed six recurring barriers to delivery of the cost improvement programme and the action being taken to address them. | |

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| | Director of Finance, Mrs K Edge, drew the Board's attention to the cash risk, detailed in the Chair's report from the extraordinary meeting in August as included in the pack, advising that although the current cash position remained strong, deficit support and distress cash funding were repayable in December. Discussions were under way regarding repayment arrangements, and a request for further distress funding would be submitted.<br><br>Trust Chair, Mr N Large, asked why additional support was required if the financial plan remained deliverable. Mrs K Edge explained that, although the plan forecast a break-even position, delivery was weighted towards the latter part of the year.<br><br>The Board **approved** delegation of authority to the Finance and Performance Committee to approve the request for distress cash funding in Q3.<br><br>The Board **noted** the Finance & Performance Committee Chair's report 20th August 2026 and the additional feedback from the 22nd September 2026 meeting. | |
| 18. | **People Committee Chair's Report – 11th August 2026**<br><br>The report was taken as read.Chief People Officer, Miss V Wilson highlighted to the board that the Fair Deal for Nursing job evaluation delivery plan was on track and had been submitted to NHS England.<br><br>Miss V Wilson also advised that the NHS leadership and management framework would build on the Trust's existing programme of manager development, and it was agreed that this would be brought back to a future Board meeting following its considerdation by the People Committee.<br><br>The Board **noted** the People Committee Chair's Report. | |
| 19. | **2025/266 Annual Submission: Appraisal, Revalidation and Medical Governance**<br><br>Medical Director, Dr N Scawn, presented the paper, noting that it had also been considered by the People Committee and was submitted to the Board for approval. It was reported that 343 doctors had been appraised during the year, representing 84%, and that 74 revalidation recommendations had been made. Of these, 60 were positive recommendations for revalidation and 14 related to recommended delays/ extensions, primarily where individuals had outstanding appraisal, mandatory training or other requirements. It was confirmed that no referrals for non-engagement had been necessary during the year.<br><br>The Board **approved** the 2025/266 Annual Submission: Appraisal, Revalidation and Medical Governance ahead of the submission of the Statement of Compliance date in October 2026. | |
| 20 | **Items for noting and receipt (attached):**<br><br>**Minutes of Committee Meetings:**<br><br>The following items were received for noting with no discussion requested. | |

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| | **a)** Approved minutes of the Quality & Safety Committee – 2nd July 2026.<br><br>b) Approved minutes of the People Committee – 9th June 2026.<br><br>c) Approved minutes of the Finance & Performance Committee – 24th June 2026 and 20th August 2026.<br><br>d) Approved minutes from the Operational Management Board – 28th May 2026.<br><br>e) Research & Innovation Committee Chair's Report 7th September 2026 and 16th July 2026 Minutes (attached)<br><br>Other items:<br><br>f) Board of Directors Workplan 2026/27. | |
| 21. | **Any Other Business**<br><br>There was no other business to note | |
| 22. | **Questions from Governors and members of the Public relating to items on the meeting agenda**<br><br>The Board welcomed comments from Maria Knowles, who had observed the meeting. Maria Knowles introduced herself and provided a brief overview of her organisation and its experience. She reflected positively on the meeting. The Trust Chair, Mr N Large, thanked Maria Knowles for her observations and contribution.<br><br>**Future Dates:**<br><br>24th November 2026<br><br>26th January 2027<br><br>16th March 2027 | |
| 23. | **Closing remarks**<br><br>The Trust Chair, Mr N Large, thanked Board members and colleagues for their contributions to the meeting and asked if colleagues had any reflections or questions they wished to come back on, if they were happy with the decisions taken and the papers and the agenda and if they would like to see anything different at the next meeting.before bringing the meeting to a close. | |

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

Countess of Chester Hospital NHS Foundation Trust

**Public Board of Directors**
**Action Log & Decision Log**
Updated November 2026

**Action Log:**

| Action No. | Meeting Date | Allocated to | Action Details | Action Update/ Outcome | Due Date | Status |
|---|---|---|---|---|---|---|
| 1 | 29th July 2025 | Chief Digital and Data Officer | Mr J Bradley, will develop 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.<br>**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.<br>**Update 20th January 2026** – Trajectories continue to be added for key metrics, with the Emergency Department (ED) trajectories added for the December IPR.<br>**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.<br>**Update 31st March 2026** – Progress noted. The Chair requested that assurance committees contribute to forward trajectories where relevant.<br>**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 | **Closed** |

| Action No. | Meeting Date | Allocated to | Action Details | Action Update/ Outcome | Due Date | Status |
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| | | | | trajectories and integrated NOF changes, will be ready for presentation at the July Board meeting.<br>**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.<br>**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.<br>**Update 29th September 2026** – any feedback for the IPR should now be fed back to Mr J Bradley so that the action can be closed | | |
| 2. | 27th January 2026 | Medical Director/Chief People Officer | Ms V Wilson and Dr N Scawn to explore 0.8 trainee contracts through Medical Staffing. | **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.<br>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 | **Closed** |

| Action No. | Meeting Date | Allocated to | Action Details | Action Update/ Outcome | Due Date | Status |
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| | | | | **Update 29th September 2026** – Dr N Scawn advised that the existing action could close, as implementation was progressing across the organisation, e-rostering was already being used in urgent care and was planned more widely, providing clearer information on expected hours, leave and staffing gaps. | | |
| 4. | 21st 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.<br>**Update 7th October 2026** – Mr J Develing confirmed that the vision will be taken through the Board Development Session for strategic discussion. | Sept-26 | **Open** |
| 5. | 21st July 2026 | Chief Digital and Data Officer | Mr J Bradley, 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.<br>**Update 29th September 2026** – to remain open pending feedback from IPR report | Sept-26 | **Open** |

| Action No. | Meeting Date | Allocated to | Action Details | Action Update/ Outcome | Due Date | Status |
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| 6. | 21st July 2026 | Director of Strategy and Partnerships | The Chair requested that Mr J Develing add local GP access data alongside Emergency Department attendance data to better demonstrate the relationship between demand and wider system performance. | **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 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. **Update 7th October 2026** – Mr J Develing confirmed the Chair and himself have met to develop a narrative that best describes activity and demand across the whole urgent care pathway. To inform this further they are to define a series of datapoints by which we can determine activity variations across the new neighbourhood footprints. | Sept-26 | **Open** |
| 8. | 29th September 2026 | Chief Operating Officer | Divisional Director for Therapies and Integrated Care Ms A Swanton to be invited to a future meeting to provide a presentation to the Board on virtual wards | **Update 9th November 2026** – Ms A Swanton is to be invited to the January 2027 Board of Directors for the Service Showcase. | ~~Nov – 26~~ Jan – 27 | **Open** |
| 9. | 29th September 2026 | Chief Digital and Data Officer | Mr J Bradley to arrange for a future Board Development session to consider the implications and definitions associated with the new NOF | **Update 16th November 2026 –** paper for Board of Directors November 2026 | Nov-26 | **Closed** |

| Action No. | Meeting Date | Allocated to | Action Details | Action Update/ Outcome | Due Date | Status |
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| 10 | 29th September 2026 | Director of Digital | Mr D Reilly to review how the information and supporting narrative could be strengthened in relation to maternity data in the IPR. | **Update 17th November 2026** – A review of the IPR key indicators including maternity is currently being conducted with the Executive owners. This will inform areas for strengthening metrics and narrative. Revisions will be made for the 27/28 reporting period. | Nov-26 | **Open** |

**Decision Log:**

| No. | Meeting Date | Decision |
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| 1. | 31st March 2026 | The Board **approved** the updates to the 2025/26 Board Assurance Framework |
| 2. | 31st March 2026 | The Board **approved** the proposed answers for submission of the Self-Assessment and Designated Body Controlled Drugs Accountable Officer (CDAO) Improvement Framework for 2026. |
| 3. | 31st March 2026 | The Board **approved** the Trusts Workforce EDI Annual Report 2025/26 for publication |
| 4. | 31st March 2026 | The Board **approved** the Standing Financial Instructions. |
| 5. | 31st March 2026 | The Board **agreed** the Trust priorities identified in section 5 NHS Staff Survey Results and Actions (subject to review and approval at the next People Committee) |
| 6. | 31st March 2026 | The Board **approved** the Trust's current compliance against the Provider Licence, with a final review to take place as at 31st March and any implications from this to be included in the Trust's Annual Governance Statement and Annual Report. |
| 7. | 31st March 2026 | The Board **approved** the Trust's current compliance position. (code of governance) |
| 8. | 19th May 2026 | The Board of Directors is asked to **approve** the reported position against the NHSE enforcement undertakings as at 31st March 2026. |
| 9. | 19th May 2026 | The Board:<br>• **approved** the Board Assurance Framework risks for 2026/27<br>• **approved** the Strategic Objectives for 2026/27 |
| 10. | 19th May 2026 | The Board **approved** the Risk Management Policy following recommendation for approval from the Risk Management Committee. |
| 11. | 19th May 2026 | The Board **approved** the application of the Trust Seal in retrospect. |
| 12. | 21st July 2026 | The Board:<br>• **Approved** the 2026/27 Board Assurance Framework, including the addition of the new Transformation Risk (BAF11);<br>• **Approved** the updated Risk Appetite Statement; and |
| 13. | 21st July 2026 | The Board **approved** the proposed establishment changes. (bi-annual safer nurse staffing report) |

| No. | Meeting Date | Decision |
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| 14. | 21st July 2026 | The Board **approved** the updated terms of references for all the assurance committees. |
| 15. | 29th September 2026 | The Board **approved** the BAS prior to submission to NHSE on 30th September 2026. recognising that the winter plan had been considered in isolation from a number of wider system factors for which responses remained outstanding. |
| 16. | 29th September 2026 | The Board **approved** the OMB Terms of Reference document. |
| 17. | 29th September 2026 | The Board **approved** delegation of authority to the Finance and Performance Committee to approve the funding request |
| 18. | 29th September 2026 | The Board **approved** the 2025-6 Annual Submission: Appraisal, Revalidation and Medical Governance for ahead of the submission of the Statement of Compliance date in October 2026 |

**PUBLIC – Board of Directors**
**24th November 2026**

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| **Report** | **Agenda Item 7.** | **Chief Executive Officer's Report** | | | | | | |
| **Purpose of the Report** | Decision | | Ratification | | Assurance | | Information | **X** |
| **Accountable Executive** | Jane Tomkinson OBE | | | Chief Executive Officer | | | | |
| **Author(s)** | Karan Wheatcroft | | | Director of Governance and Risk | | | | |
| **Board Assurance Framework** | BAF 1 Quality<br>BAF 2 Safety<br>BAF 3 Operational<br>BAF 4 People<br>BAF 5 Finance<br>BAF 6 Capital<br>BAF 7 Digital<br>BAF 8 Governance<br>BAF 9 Partnerships<br>BAF 10 Research<br>BAF 11 Transformation | | | **X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X** | Relevant across all BAF areas. | | | |
| **Strategic goals** | Patient and Family Experience<br>People and Culture<br>Purposeful Leadership<br>Adding Value<br>Partnerships<br>Population Health | | | | | | | **X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X** |
| **CQC Domains** | Safe<br>Effective<br>Caring<br>Responsive<br>Well led | | | | | | | **X**<br>**X**<br>**X**<br>**X**<br>**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. National updates

Driven by a mandate to cut ICB running costs by roughly 50% and reduce staff numbers by about a third (around 8,000 posts), the number of ICBs has decreased from an initial 42 ICBs 25 ICBs or clusters/merged entities. As Cheshire and Merseyside is one of the larger ICBs there has been no change in geographical footprint although the managerial head count has been applied.

ICBs are transitioning from detailed operational micro-management into leaner, strategic commissioning bodies.

Integrated Care Partnerships (ICPs) are being removed, replaced by streamlined joint forward plans, neighbourhood health plans, and 5-year population health improvement plans.

## 2. Regional updates

As ICBs slim down, service integration is being aligned at a **'place' level** (typically aligned with local authority or borough boundaries covering populations.

The government has committed to aligning ICB footprints with strategic combined authorities and mayoral boundaries. In some devolution models, traditional local authority board representations are shifting to direct involvement from regional mayors, bridging local government, social care, housing, and the voluntary sector.

In Cheshire a devolution agreement has been approved, and, at the time of this report, we await to understand the full impact of this arrangement.

Health and Wellbeing Boards will also wish to take account of their changing role and the impact of devolution.

## 3. Neighbourhoods and Community Care

Collaborative groups are emerging in support of neighbourhood care with the alignment of GP practices, community services and third sector organisations into clusters or neighbourhoods. Such services are designed to offer preventative, multi-agency care open extended hours. It is likely that such arrangements will mature and new contractual arrangement put in place to support single neighbourhood and multi neighbourhood contracts.

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

October 2026

The CMPC Leadership Board met on 2nd October 2026, and discussed:

- **ICB Development and System Priorities**
  The Board received an update on the Cheshire and Merseyside ICB and discussed provider engagement, transformation capacity, neighbourhood development, governance and decision-making arrangements, and opportunities to align priorities, including prevention and population health.

- **Workforce Controls and Bank Rates**
  The Board reviewed arrangements for escalated bank rates and agreed the importance of a consistent system approach. Work will be taken forward through Directors of Nursing.

- **Procurement Service**
  The Board considered progress on the Procurement Service case.

- **Corporate Benchmarking**
  The latest benchmarking analysis demonstrated continued improvement in corporate cost performance relative to national benchmarks. Further work will focus on identifying variation and opportunities for collaboration, productivity improvement and digital optimisation across the system.

- **Financial Position**
  The Month five financial position showed modest improvement; with significant further progress required to achieve year-end plans. Members agreed the importance of understanding underlying financial risks and delivery confidence ahead of the next planning round.

- **Emerging National and Regulatory Issues**
  The Board discussed the implications of the Thirlwall recommendations, Birth Rate Plus requirements, guidance relating to unauthorised access to patient records, and the developing regional performance framework. Members noted the potential operational and financial implications and the need for a coordinated system response, where appropriate.

## 5. Performance Accountability Framework (KW)

NHS England wrote to the Trust on the 26th October 2026, confirming that the regional Support Group had assessed the Countess of Chester Hospital NHS Foundation Trust at Level 2 of the North West Performance Accountability Framework. The letter concludes that the assessment reflects the “judgement that the Trust is managing its responsibilities effectively overall, but that a number of specific risks, priorities or performance challenges would benefit from targeted regional oversight and support”.

Oversight will continue through existing arrangements and the Trust will continue to work with NHS England North West and our wider system partners.

## 6. Workforce Oversight Meeting

The Workforce oversight meeting (WOM) with NHS England North West took place on 2 November 2026. Led by NHS England North West's Regional Chief People Officer, the WOM provides regional oversight of the Trust's workforce position and plans, focusing on key risks, progress against priorities and areas requiring regional support. Discussions covered winter workforce preparedness, temporary staffing, sickness absence, job evaluation, medium-term workforce planning and education priorities, including the capacity required to support additional training places.

## 7. Tiering (UEC)

The Trust met with Regional NHS England colleagues on the 3rd November 2026 to review the Trust's current Urgent and Emergency Care (UEC) performance, increasing demand pressures, and progress against recovery actions discussed at previous Tiering meetings.

The meeting covered an update on the Trust's recovery programme, with good executive engagement and clear evidence of continued focus on improving UEC performance. The meeting identified further work to strengthen the quantification of hospital controlled discharge delays, progress the seven-day frailty service, and understand and respond to increasing demand pressures.

Recognising the quality of the information presented it was agreed that Regional tiering meetings should move to a two-monthly frequency.

## 8. MP Engagement

On the 23rd October 2026 we met with a number of our local MPs as part of our ongoing engagement arrangements. We discussed the Trust's improvement journey, including the national oversight framework, CQC, and performance metrics. We also shared the continued challenges we face and the work we are doing with partners.

## 9. Board-level succession planning – launch of ELEVATE Career and Talent Hub

NHS England North West launched the ELEVATE Career and Talent Hub on 22 October 2026, replacing spreadsheet-based Board-level succession planning returns with a digital platform. The Hub will support clearer identification of succession risks and development needs, strengthening leadership continuity locally and across the region. The Trust will use the Hub to inform its approach to Board-level succession planning and targeted leadership development, with an initial submission due by 4 December.

## 10. Consultant industrial action

On 26 October 2026, the British Medical Association announced consultant industrial action in England from 7am on 25 November to 7am on 27 November 2026. The dispute relates to pay

and working conditions, including workload, working hours and protected time for teaching and service improvement. On the 11th November the BMA subsequently announced a decision to pause strike action. The Trust will continue to monitor and respond to future updates.

## 11. Anti-racism

The Trust plans to submit its application for Bronze accreditation under the North West Race Equity Assembly Anti-Racism Framework in November, with feedback expected in December. Preparing the submission has reinforced the need for broader Board and organisational ownership, recognising that commitments and activity alone are not evidence of improved staff experience. The focus is on sustained leadership accountability and practical action to address racism and inequity.

## 12. 2026 NHS Staff Survey

The 2026 NHS Staff Survey closes on 27 November. The Trust is encouraging broad participation, with targeted engagement and practical support for colleagues to complete the survey alongside operational demands. The findings will inform improvement priorities for 2027 and provide evidence of progress against the NHS Staff Standards. Both the staff engagement score and the Staff Standards score contribute to the people domain of the NHS Oversight Framework (NOF), reinforcing the importance of staff experience within the Trust's overall performance assessment. The focus remains on listening, acting on feedback and demonstrating what has changed in response.

## 13. Board Leadership

In December 2026 the Trust will welcome Mike Gibbs to the Board of Directors following his appointment as the Director of Strategy and Partnerships. Mike brings extensive experience to the role.

Jon Develing will retire from his role at the end of December 2026, where he has brought significant leadership to the development and delivery of the Trust Strategy, along with working with clinical leads to establish clinical strategies, and progress against all elements of the Trust's role as an Anchor Institution. We wish Jon well for the future.

**PUBLIC – Board of Directors**
**24th November 2026**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Report** | **Agenda Item 9a.** | **Board Assurance Framework (Quarter 2) Update** | | | | | | |
| **Purpose of the Report** | Decision | **X** | Ratification | | Assurance | | Information | |
| **Accountable Executive** | Karan Wheatcroft | | | Director of Governance & Risk | | | | |
| **Author(s)** | Karan Wheatcroft | | | Director of Governance & Risk | | | | |
| **Board Assurance Framework** | BAF 1 Quality<br>BAF 2 Safety<br>BAF 3 Operational<br>BAF 4 People<br>BAF 5 Finance<br>BAF 6 Capital<br>BAF 7 Digital<br>BAF 8 Governance<br>BAF 9 Partnerships<br>BAF 10 Research<br>BAF 11 Transformation | | | **X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X** | Linked to all BAF areas. | | | |
| **Strategic goals** | Patient and Family Experience<br>People and Culture<br>Purposeful Leadership<br>Adding Value<br>Partnerships<br>Population Health | | | | | | | **X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X** |
| **CQC Domains** | Safe<br>Effective<br>Caring<br>Responsive<br>Well led | | | | | | | **X**<br>**X**<br>**X**<br>**X**<br>**X** |
| **Previous considerations** | Not applicable | | | | | | | |
| **Executive summary** | The 2026/27 BAF risks were considered alongside the risk appetite statement during the Board development session in May 2026. The BAF 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.<br><br>The Board of Directors receives the BAF each meeting with a full update completed on a quarterly basis. The purpose of this paper is to provide an update at Q2.<br><br>The BAF risks and residual risk scores remain the same:<br>• BAF1 - quality of care (16)<br>• BAF2 - safety and harm (16)<br>• BAF3 - operational planning standards (16)<br>• BAF4 - workforce (15) | | | | | | | |

- BAF5 - financial plan (16)
- BAF6 - capital programme (15)
- BAF7 - digital transformation and infrastructure resilience (15)
- BAF8 - corporate governance (8)
- BAF9 - system working (12)
- BAF10 - research and innovation (12)
- BAF11 – transformation (16)

7 of the 11 risks on the BAF remain above risk appetite level. Actions are progressing, but given the strategic nature of these risks it is recognised that it will take time to fully implement and embed the improvements needed, along with ensuring clear evidence of assurance that the risks are being mitigated. Additional narrative has been provided regarding the driver for the risk and trajectory of delivery.

The report demonstrates the progress being made against key actions aligned to BAF risks and strategic objectives including:

- Continued focus on consistency of application of quality standards and expectations.
- The Trust continues to meet elective, cancer and diagnostic waiting targets within the medium term plan (MTP).
- There is a full UEC improvement programme in progress and the Trust continues to work with the wider systems and local authorities to enable an improved number of complex discharges. New system leadership group established with three clear priority programmes.
- A structured programme of patient and family engagement events in place.
- People Strategy progress including compassionate leadership programme with the Royal College of Nursing Foundation, EDI integrated action plan, and Anti-racism bronze accreditation application.
- Delivery of the financial plan, with continued grip and control, and clear focus on progressing the maturity of CIP schemes and the transformation programme. Improved governance with the Transformation Programme Board established and operating, and programme management software in place.
- Leadership and engagement at system level, supporting collaboration and partnerships.
- Divisional accountability, governance and risk management improvement with continued updates to the Audit Committee and an internal audit review planned for completion in Q4.
- Digital and Data Strategy developed along with a year 1 delivery plan.
- Health inequalities annual report completed and Anchor institute workstreams embedded.

| | |
|---|---|
| | • Research strategy delivery including opportunities to grow commercial income, collaborative working with the primary care Clinical Research Delivery Centre (CRDC) and joint research workstreams with the University of Chester. External review undertaken and actions being developed to progress arrangements.<br>• Thirlwall Inquiry report recommendations and wider learning response through a multidisciplinary group, taking account of National and regional guidance as this develops.<br>The BAF and the Board's use of the BAF continue to mature, alongside an improving awareness and approach to risk management across the organisation. |
| **Recommendations** | The Board of Directors is asked to:<br>(i) review and **approve** the 2026/27 Board Assurance Framework Q2 update<br>(ii) **note** the update on progress in delivering the 2026/27 strategic objectives as aligned to the BAF |

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

# Board Assurance Framework (BAF) 2026/27
# (Q2) update

## 1. BACKGROUND

The Board Assurance Framework (BAF) outlines the key risks to achievement of the Trust's strategic goals. The BAF is a key tool used by the Board to ensure a focus on strategic risk, including controls, assurances and actions to manage and mitigate the risks.

The 2026/27 BAF risks were considered alongside the risk appetite statement during the Board development session in May 2026. The BAF 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.

The Board of Directors receives the BAF each meeting with a full update completed on a quarterly basis. The purpose of this paper is to provide a Q2 update.

## 2. BAF RISKS ALIGNED TO STRATEGIC GOALS

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

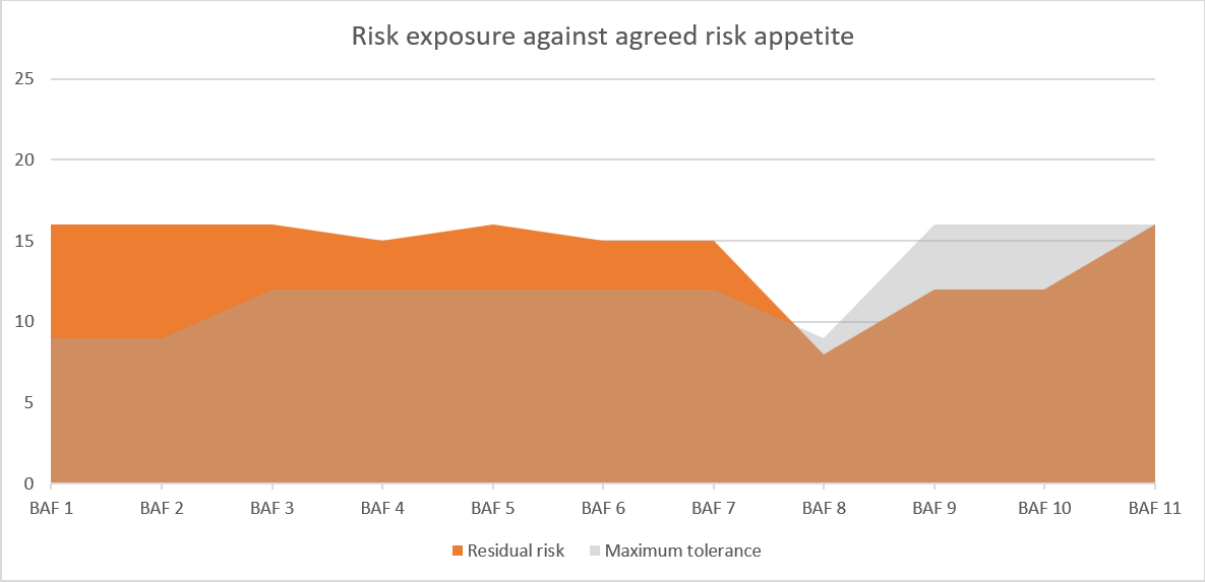
| Principal Risk | Strategic Goals | | | | | |
|---|---|---|---|---|---|---|
| | Patient and family experience | People and Culture | Leadership | Adding Value | Partnership | Populations |
| BAF1. Failure to maintain **quality of care** would result in poorer patient & family experience | | | | | | |
| BAF2. Failure to **maintain safety and prevent harm** would result in poorer patient care and outcomes | | | | | | |
| BAF3. Inability to deliver **operational planning standards**, inability to address the backlog of patients waiting could result in poorer patient outcomes, and result in financial consequences to the Trust. | | | | | | |
| BAF4. Challenges in ensuring a high quality, engaged, diverse and inclusive **workforce and culture** would affect our ability to deliver patient care | | | | | | |
| BAF5. Failure to deliver **financial plan** and underlying financial position could impact long term | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| financial sustainability for the Trust and system partners | | | | | | |
| BAF6. Inability to achieve the **capital programme** within a challenging and uncertain operating environment and deliver an Estates Strategy that supports the provision of our services | | | | | | |
| BAF7. Failure to deliver transformative **digital and data** solutions and performant, secure and resilient infrastructure could impact on patient and staff experience and organisational productivity | | | | | | |
| BAF8. Failure to ensure effective **corporate governance** could impact our ability to comply with legislation and regulation. | | | | | | |
| BAF9. **System working** and provider landscape changes may present challenges in ensuring COCH is positioned as a strong system partner, with priorities aligned to system partners across Cheshire & Merseyside. | | | | | | |
| BAF10. Inability to deliver the **Research and Innovation** agenda to exploit future opportunities | | | | | | |
| BAF11. Inability to deliver **transformation and productivity** programme would impact our ability to deliver our Medium-Term Plan | | | | | | |
| **Risk exposure** | | | | | | |

## 3. CURRENT RISK SCORE AGAINST TARGET SCORE

The following graph shows the current residual risk score against the target risk score. The graph enables a quick comparison of target versus actual residual risk. Actions to further mitigate and manage these risks are included within the BAF along with progress updates.

7 of the 11 risks on the BAF remain above risk appetite level. Actions are progressing, but given the strategic nature of these risk it is recognised that it will take time to fully implement and embed the improvements needed, along with ensuring clear evidence of assurance that the risks are being mitigated. Additional narrative has been provided regarding the trajectory for reduction alongside a narrative on current position. This will continue to be developed in 2026/27.




**Key** (including movement in residual risk scores since previous report)

BAF1 - quality of care ⟺
BAF2 - safety and harm ⟺
BAF3 - operational planning standards ⟺
BAF4 - workforce ⟺
BAF5 - financial plan ⟺
BAF6 - capital programme ⟺
BAF7 - digital transformation and infrastructure resilience ⟺
BAF8 - corporate governance ⟺
BAF9 - system working ⟺
BAF10 - research and innovation ⟺
BAF11 – transformation and productivity ⟺

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

## 4. PROGRESS AGAINST STRATEGIC OBJECTIVES

Strategic objectives have been refreshed for 2026/27. Progress against strategic objectives has been aligned to the BAF. Key updates include:

- Continued focus on consistency of application of quality standards and expectations.
- The Trust continues to meet elective, cancer and diagnostic waiting targets within the medium term plan (MTP).
- There is a full UEC improvement programme in progress and the Trust continues to work with the wider systems and local authorities to enable an improved number of complex discharges. New system leadership group established with three clear priority programmes.
- A structured programme of patient and family engagement events in place.
- People Strategy progress including compassionate leadership programme with the Royal College of Nursing Foundation, EDI integrated action plan, and Anti-racism bronze accreditation application.

- Delivery of the financial plan, with continued grip and control, and clear focus on progressing the maturity of CIP schemes and the transformation programme. Improved governance with the Transformation Programme Board established and operating, and programme management software in place.
- Leadership and engagement at system level, supporting collaboration and partnerships.
- Divisional accountability, governance and risk management improvement with continued updates to the Audit Committee and an internal audit review planned for completion in Q4.
- Digital and Data Strategy developed along with a year 1 delivery plan.
- Health inequalities annual report completed and Anchor institute workstreams embedded.
- Research strategy delivery including opportunities to grow commercial income, collaborative working with the primary care Clinical Research Delivery Centre (CRDC) and joint research workstreams with the University of Chester. External review undertaken and actions being developed to progress arrangements.
- Thirlwall Inquiry report recommendations and wider learning response through a multidisciplinary group, taking account of National and regional guidance as this develops.

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

## 5. RECOMMENDATIONS:

The Board of Directors is asked to:

**(i)** review and **approve** the 2026/27 Board Assurance Framework Q2 update

**(ii)** **note** the update on progress in delivering the 2026/27 strategic objectives as aligned to the BAF

**Appendix A – Summary of strategic risks above risk appetite**

7 of the 11 risks on the BAF remain above risk appetite level. Actions are progressing, however given the strategic nature of these risks it is recognised that it will take time to fully implement and embed the improvements needed, along with ensuring clear evidence of assurance that the risks are being mitigated. Additional narrative has been provided regarding the current position and trajectory for reduction.

| Principal Risk | Current Risk Score | Target Risk Score | Assurance Level | Key Actions Progressing | Current Assessment/ Driver to reduce risk |
|---|---|---|---|---|---|
| BAF1. Failure to maintain **quality of care** would result in poorer patient & family experience | **16** ⟺ | **9** | Partial | • Continued focus on consistency of application of standards<br>• UEC CQC action plan<br>• Embedding the patient and family engagement programme | • Improvement evidenced but need to see sustained improvement maintained with improved patient and staff feedback, and regulatory assurance to demonstrates this)<br>• CQC inspection recognised improvements across the services.<br>• Ward and department accreditation continues to focus on standards.<br>• Risk assessments for MUST, falls, and Braden remain a focus for improvement, particularly in ED.<br>• Patient and family engagement events and feedback arrangements strengthened. |
| BAF2. Failure to **maintain safety and prevent harm** would result in poorer patient care and outcomes | **16** ⟺ | **9** | Partial | • Improvement in compliance and safety outcomes<br>• Mental health and violence and aggression group actions<br>• Sepsis improvement work<br>• Delivery of Clinical Strategy with further session planned (Feb 2027)<br>• Review of Fragile services through CMPC | • 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.<br>• Sepsis screening compliance has improved, but performance for timeliness of antibiotics remains a focus for improvement.<br>• Further improved RTT impacts positively on reducing risk of harm.<br>• Focus remains on reducing violence and aggression experienced by staff. |
| BAF3. Inability to deliver **operational planning standards**, as set out in | **16** | **12** | Partial | • Flow improvement plan including admission avoidance, UEC and discharge | • Driven by UEC performance; reduction when consistent improvements in 12-hour waits and on delivering planned position for |

| Principal Risk | Current Risk Score | Target Risk Score | Assurance Level | Key Actions Progressing | Current Assessment/ Driver to reduce risk |
|---|---|---|---|---|---|
| the medium term plan could result in poorer patient outcomes, and result in financial and regulatory consequences to the Trust. | ⟺ | | | • Non RTT validation (including use of AI)<br>• Ophthalmology follow up recovery plan continues to progress to reduce risk | 4-hour targets.<br>• The Trust submitted a medium-term plan with non-compliant UEC performance trajectories in years 1 and 2.<br>• Access to UEC services remains challenged due to continued growth in ED attendances and lack of progress with the reduction of patients that no longer have the criteria to reside.<br>• Current performance shows a continued increase in ED attendances impacting 4 hour and 12 hour performance which remain below target. Improvement plans continue to be driven forward and productivity position shared to provide additional context to the position. |
| BAF4. Challenges in ensuring a high quality, engaged, diverse and inclusive **workforce and culture** would affect our ability to deliver patient care | **15** ⟺ | **12** | Partial | • Delivery of Medium-term Workforce plan and reporting<br>• People strategy delivery (including wellbeing, EDI, leadership and workforce development) | • Reduction when staff feedback supports positive culture shift, not expected at the earliest until end March 2027)<br>• People priorities remain a focus aligned to staff survey feedback. Culture and leadership delivery phase progressing with Royal College of Nursing Foundation compassionate leadership, EDI integrated action plan, and Anti-racism framework. |
| BAF5. Failure to deliver **financial plan** and underlying financial position could impact long term financial sustainability for the Trust and system partners | **16** ⟺ | **12** | Partial | • Delivery of the Medium-Term Plan<br>• Maturity of CIP schemes through to transaction<br>• Engagement with NHSE on cash support (as required) | • 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<br>• Finance position is on plan with non-recurrent benefits to support under delivery of CIP and impact of industrial action. There remains a risk in maturity of CIP schemes and delivery.<br>• Deficit cash support confirmed Q1-3. |

| Principal Risk | Current Risk Score | Target Risk Score | Assurance Level | Key Actions Progressing | Current Assessment/ Driver to reduce risk |
|---|---|---|---|---|---|
| BAF6. Inability to achieve the **capital programme** within a challenging and uncertain operating environment and deliver an Estates Strategy could impact the provision of safe services | **15** ⟺ | **12** | Partial | • Engagement in NHS England estates forums<br>• Exploring opportunities and bids for system capital<br>• Estates strategy development<br>• Old Women and Children's building deconstruction | • 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.<br>• Capital management Group continues to review and approve spend based on risk assessment and priortisation. This will require a multi-year investment alongside securing new capital monies (e.g. CDC Blacon).<br>• Estates strategy development in progress following Board session.<br>• Old Women and Children's building deconstruction significantly complete. |
| BAF7. Failure to deliver transformative **digital and data** solutions and performant, secure and resilient infrastructure could impact on patient and staff experience and organisational productivity | **15** ⟺ | **12** | Partial | • Digital and data strategy and delivery plan<br>• Data Security and Protection Toolkit (DSPT) and Cyber Assurance Framework (CAF)<br>• Infrastructure health<br>• Cyber security protection plan<br>• EPR optimisation and Ambient Voice Technology deployment<br>• Data quality framework<br>• National competency framework workstreams<br>• Training opportunities | • Inherent cyber risk makes it difficult to reduce this risk score.<br>• Procurement of additional solutions to strengthen cyber resilience, and programme of work progressing.<br>• DSPT submission confirming standards met.<br>• Information Asset Owner training being reviewed and rolled out. |

## Appendix B – Progress against Strategic Objectives

The progress against strategic objectives is set out in the tables below.

| Strategic Objectives | Lead | Progress |
|---|---|---|
| **SG1 Patients and Family** | | |
| Ensure consistent application of quality and safety standards | SP | Continuing to drive improvement 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.<br>In 2025/26 the Trust saw some reductions across HCAIs, with IPC compliance improving. Continuous focus is required to sustain the improvements, with quarter 1 seeing an increase in c'difficile.<br>Ward and department accreditations are demonstrating improvements with the majority of areas now accredited at Silver. Process being reviewed to align with new CQC assessment framework with paper to be reported to Q&S Committee in January 2027. |
| Delivery of operational and constitutional targets | CC | The Trust continues to meet the elective, cancer and diagnostic waiting targets within the Medium Term Plan.<br>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 with improvements in metrics for 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, to improve compliance to the 12 and 4 hours standards. The Trust has extended the UTC opening hours to 10pm for minor illness and injuries.<br>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. In addition to this a new West Cheshire System Leadership Group has been formed, with three initial priority projects including OPEL/Escalation, P1 NCTR, and Pharmacy.<br>To ensure the whole Trust Board is aware of progress for UEC, RTT and Cancer there have been presentations at Board development sessions. |
| Develop a programme of patient and family engagement. | SP | Patient and family engagement events held across some services. A structured programme is in place for 2026/27 with a quarterly meeting with external stakeholders. Divisional plan for patient events/ activities updates to be presented quarterly. MEG being used for FFT across Divisions, with QR codes, realtime responses for services. National Inpatient surveys demonstrate significant improvements. 6 monthly patient experience report to QGG and Q&S Committee. EDS action plans also included. |

| | | |
|---|---|---|
| **SG2 People and Culture** | | |
| Deliver the People Strategy | VW | Dashboard development progressing.<br>Update on delivery against year 1 of the People Strategy to the People Committee scheduled for November 2026.<br>RCN Foundation compassionate leadership programme underway.<br>Focus on targeting sickness hotpots and increasing wellbeing intervention for stress related cases. Integrated EDI action plan and priorities in place.<br>Statutory reporting in place, positive improvements being made and review through established governance structures. Further focus on anti-racism framework progressing with Bronze accreditation application submitted in November 2026. |

| | | |
|---|---|---|
| Deliver the workforce plan | VW | 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. Including income generation schemes and advanced practice roles. |

| **SG3 Leadership** | | |
|---|---|---|
| Deliver the clinical strategy through divisional accountability linked into divisional reviews | NS | Clinical Strategy approved and launched. External engagement events held by the Director of Strategy and Partnerships in 2025.<br>Discussions progressing on delivery priorities and approach to updates.<br>Divisional reviews to be re-established to support assurance on progress and opportunities.<br>Further clinical and operational leads day planned February 2027 to revisit clinical strategies and specialty priorities. |
| Develop our leadership capability | VW | 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 commenced in October 2026 and Divisional triumvirate coaching scheduled for November 2026.<br>Thirlwall Inquiry report and recommendations reviewed with contribution to baseline assessment and national updates awaited. |
| Ensure effective regulatory compliance including governance and risk | KW | 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 scoped to commence in Q3/4 2026/27.<br>Governance presentations continue to be delivered in various forums.<br>Risk management improvement plan actions significantly complete. Moderate assurance opinion on risk management provided by MIAA. Risk Management Committee embeded and final update planned to Audit Committee (January 2027). |

| **SG4 Adding Value** | | |
|---|---|---|
| Deliver the financial plan and deficit recovery | KE | Forecasting delivery of 2026/27 financial plan, with risk remaining. Trust financial delivery assumes delivery of divisional financial recovery plan which have been presented, reviewed, discussed and agreed through Executive Directors.<br>Detailed planning for 2027/28 and rolling three year plan has commenced and is being led by the Director of Transformation and Productivity. |
| Deliver the Data and Digital Strategy | JB | Delivery plan for year 1 of strategy has been developed.<br>Strategy has been updated following feedback from sharing across senior Trust forums. The strategy is undergoing final design changes ahead of publication by end of 2026. Will be presented at Novembers Trust Board. |
| Deliver the transformation and productivity programmes, including CMPC priorities of corporate and clinical services | DN | Continuing to drive the progress in maturity of schemes. Weekly Divisional CIP meetings in place. Fortnightly CIP delivery review meeting with Triumvirates. Transformation Programme Board well established with attendance from Divisions, workstream leads and deputies across professional groups. Weekly CIP delivery group chaired by CEO focussed on 3 schemes where progress has stalled with all projects reporting through Aspyre Software. |

| **SG5 Partnership** | | |
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| Deliver the Research Strategy | NS | Research Strategy approved by the Board in January 2026. Update on progress provided to the Board in March 2026 and further update to be presented aligned to external review report. 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 |

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| | | including use of Trust assets; development of joint research workstreams with the University of Chester. |
| Take a leadership role within the new Cheshire and Merseyside Provider Collaborative on the assessment and development of provider collaborations at all levels | JD | 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 a new programme update for November 2026. Reporting on partnerships and system working continues to evolve.<br>With the changes in ICB functions, senior leadership forums are being refined to ensure strategic and opeartional alignment. The Trust is leading this development particularly in urgent care. |
| Identify and assess options and implications from the CMPC fragile services review | NS | 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.<br>SPOA workstream will also contribute to improved referral pathways and acceptance. CMPC programme update developed for Provider Boards (November 2026). |

| **SG6 Populations** | | |
|---|---|---|
| Develop a health inequalities reporting framework | JD | Update on health inequalities national reporting expectations shared at EDG. Further work to do to develop reporting.<br>An approach to Health Inequalities has been developed and shared with local stakeholders who have endorsed the approach.<br>Health inequality tools are deployed in community services through the CIPHA (data into action) when assessing likelihood of risk and admission to hospital<br>As a statutory function the Trust is required to publish an annual report that focuses on health inequalities. This is coming to the Board in November 2026. |
| Workign with partners to align community services and neighbourhood health development | KW | 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.<br>There is now a collaboration transformation group supporting the development of neighbourhood care. Primary Care, VCFSE, Community and Acute Services are in attendance. |
| Continued implementation of being an Anchor Institute (prevention, green and social value) | JD | Anchor Institute leadership, monitoring and reporting in place. |

Countess of Chester Hospital
NHS Foundation Trust

# Board Assurance Framework 2026 - 27

| Risk Theme: Quality & Patient Experience | | | | | | | | | | | | |
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| **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) **Internal sources of assurance** | **External sources of assurance** | **Overall assurance level** | **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** Planned action | Progress update | **Target risk score** | **Estimated date of achievement of target score** |
| **BAF1**<br>Failure to maintain quality of care would result in poorer patient & family experience<br><br>**Executive Risk Lead:**<br>Director of Nursing and Quality<br><br>**Assurance Committee**:<br>Quality and Safety Committee<br><br>**Last Update:**<br>November 2026 | **Causes:**<br>- Inconsistent compliance with standards.<br>- Hospital capacity not supportive of the high volume of patients presenting to the Emergency Department.<br>- Lack of clinical engagement.<br>- Embedding the approach to patient and familiy engagement<br><br>**Consequences:**<br>- Quality of care<br>- Unintended harm<br>- Poor patient experience<br>- Regulatory compliance | ***4 x 5 = 20*** | C1) Quality priorities (Quality, Safety and Experience Strategy).<br><br>**Control Owner:** Director of Nursing and Quality | - IPR to Board and Q&S Committee<br>- Safety Surveillance Quarterly report<br>- Quality and Safety Committee reports<br>- Quality Governance Group via Q&S Committee<br>- Patient Experience Operational Group via Q&S Committee<br>- Operational Management Board<br>- Quality and Safety Strategy and reporting<br>- Infection, Prevention & Control Quarterly Report via Q&S Committee<br>- Annual Quality Account<br>- PLACE inspection reports<br>- Cleaning standards compliance reports to Q&S Committee | National inpatient survey results.<br>Healthwatch reports.<br>Internal audit reviews.<br>NHS Staff survey results.<br>CQC Inspection Outcomes.<br>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.<br><br>(ii) Programme of ward and departmental accreditation in place.<br><br>**Action owner:** Director of Nursing and Quality<br>**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.<br>In 2025/26 the Trust saw some reductions across HCAIs, with IPC compliance improving. Continuous focus is required to sustain the improvements, with quarter 1 seeing an increase in c'difficile.<br>Ward and department accreditations are demonstrating improvements with the majority of areas now accredited at Silver. Process being reviewed to align with new CQC assessment framework with paper to be reported to Q&S Committee in January 2027. | ***9*** | ***To be reviewed year end 2026/27***<br><br>***(Improvement evidenced but need to see sustained improvement maintained with improved patient and staff feedback, and regulatory assurance to demonstrates this).*** |
| | | | C2) Quality and wider governance structures<br><br>**Control Owner:** Director of Nursing and Quality | - Consolidated CQC and Well Led Action Plan reported to each Board of Directors<br>- Quality and Safety Committee<br>- Quality Governance Group via Q&S Committee | Commissioner reviews of quality (quarterly).<br>CQC reports. | *Acceptable* | | | | | | |
| | | | C3) CQC regulatory compliance<br><br>**Control Owner:** Director of Nursing and Quality | - Quality and Safety Committee<br>- Quality Governance Group via Q&S Committee<br>- Ward accreditation reporting via Q&S<br>- UEC action plan assurance reporting to Q&S Committee | Commissioner reviews of quality (quarterly).<br>CQC reports. | *Acceptable* | | | UEC CQC inspection findings and response. | (i) Deliver the UEC CQC improvement Plan<br><br>**Action owner:** Director of Nursing and Quality<br>**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.<br><br>CQC report received following inspection of UEC (RI), end of life care (Good), and acute medicine (Good) with evidenced improvements reported across services. | | |
| | | | C4) Approach to listening to and acting on Patient and Family Experience<br>**Control Owner:** Director of Nursing and Quality | - Patient expertience improvement framework<br>- Six monthly patient experience report to QGG and Q&S Committee (including FFT)<br>- Survey results to Q&S Committee<br>- PLACE reporting to Q&S Committee | - Healthwatch<br>- National Surveys | *Partial* | | | Structured approach to patient and family engagement. | Develop and deliver a programme of patient and family engagement events<br><br>**Action owner:** Director of Nursing and Quality<br>**Due date:** Q4 2026/27 | Patient and family engagement events held across some services. A structured programme is in place for 2026/27 with a quarterly meeting with external stakeholders. Divisional plan for patient events/ activities updates to be presented quarterly. MEG being used for FFT across Divisions, with QR codes, realtime responses for services. National Inpatient surveys demonstrate significant improvements. 6 monthly patient experience report to QGG and Q&S Committee. EDS action plans also included. | | |
| | | | | | | | | | | | | |
| **BAF2**<br>Failure to maintain safety and prevent harm would result in poorer patient care and outcomes<br><br>**Executive Risk Lead:**<br>Medical Director<br><br>**Assurance Committee**:<br>Quality and Safety Committee<br><br>**Last Update:**<br>November 2026 | **Causes:**<br>- Longer patient waiting lists (ref. Operational effectievness).<br>- inconsitent application of standards.<br>- Culture and accountability<br>- Underdeveloped partnership working arrangements to support clinical strategy delivery.<br>- Lack of reciprocal engagement in the wider health system.<br>- Mental health service provision in A&E and across all Trust sites<br>- Fragile services<br><br>**Consequences:**<br>- Unintended harm<br>- Extended length of stay<br>- De-conditioning of patients | ***4 x 5 = 20*** | C1) Safety priorities (Quality and Safety Strategy)<br><br>**Control Owner:** Medical Director | - IPR<br>- Quality Governance Group via Quality and Safety Committee<br>- Reports to Q&S Committee (including sepsis updates) | CQC Inspection Outcomes.<br>National clinical audit results reported to Q&S Committee.<br>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.<br><br>**Action owner:** Medical Director<br>**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.<br>Improved RTT performance in 2025/26 impacts positively on the risk of harm and further RTT improvements have continued in 2026/27. | ***9*** | ***To be reviewed year end 2026/27***<br><br>***(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)*** |
| | | | | | | | | | 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.<br><br>**Action owner:** Medical Diretor<br>**Due Date:** Quarterly updates | Multi disciplinary Steering Group is in place and meets monthly, including external partners ie Cheshire Police. 136 protocal and action plan developed - New standards operating models in place for clinical practice and escalation. This group is working towards meeting the Core 24 mental health standards for urgent care.<br>MOU signed with ICB, COCH and CWP.<br>Patient Flow Group in place and overseeing work of the Mental Health Steering Group with updates through the Deputy Director of Nursing and Quality.<br>Violence and agression group re-established to support actions and oversight following increased incidents. | | |
| | | | | | | | | | Evidence of consistent application of standards for Sepsis. | To deliver improvements in Sepsis compliance.<br><br>**Action owner:** Medical Director<br>**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. NEWS trigger hard stop on EPR commenced in January 2026 and has shown improvements in compliance for this aspect of the metric. Screening compliance improved to target and focus now remains on timeliness of antibiotics. Oversight through Sepsis group with weekly BI dashboard also in place, and reporting to Q&S Committee. | | |
| | | | C2) Organisational learning including review of deaths<br><br>**Control Owner:** Medical Director/ Director of Governance Risk and Improvement | - Safety Surveillance Quarterly report to Q&S Committee and Board<br>- Quarterly Learning from Deaths report and annual mortality report via Q&S Committee and Board<br>- Quality and Safety Committee reporting to Board<br>- Quality Governance Group via Q&S Committee<br>'- Quarterly Learning from Deaths report and annual mortality report via Q&S Committee and Board<br>- Quality and Safety Committee | Telstra Health (Dr Foster) benchmarking | *Acceptable* | | | | Mortality review backlog | Improvement plan to address historic mortality review backlog.<br><br>**Action owner:** Medical Director<br>**Due Date**: Complete (move to BAU) | Report to Q&S Committee. Work progressing with updates to Q&S and moved to BAU position.<br><br>Learning from deaths and mortality Board reporting being further reviewed in respect of the Thirlwall Inquiry recommendations. | | |
| | | | C3) Delivery of the Clinical Strategy including options and implications for fragile services<br><br>**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.<br><br>**Action owner:** Medical Director<br>**Due Date:** Q3 2026/27 | Clinical Strategy approved and launched. External engagement events held by the Director of Strategy and Partnerships in 2025.<br>Discussions progressing on delivery priorities and approach to updates. Divisional reviews to be re-established to support assurance on progress and opportunities.<br>Further clinical and operational leads day planned February 2027 to revisit clinical strategies and specialty priorities. | | |
| | | | | | | | | | Fragile services review and opportunities (including CMPC programme updates). | Identify and assess options and implications from the CMPC fragile services review.<br><br>**Action owner:** Medical Director<br>**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.<br>SPOA workstream will also contribute to improved referral pathways and acceptance. CMPC programme update developed for Provider Boards (November 2026). | | |

| 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**<br>Inability to deliver operational planning targets, could result in poorer patient outcomes, and result in financial and regulatory consequences to the Trust.<br><br>**Executive Risk Lead:**<br>Chief Operating Officer<br><br>**Assurance Committee:**<br>Finance and Performance Committee<br><br>**Last Update:**<br>November 2026 | **Cause:**<br>- Unable to meet the demand for services within available resources<br>- Increased demand in suspected cancer referrals and ED attendances<br>- Challenges in patient flow including increased number of patients that do not meet the criteria to reside<br>- Unable to accommodate all Non-RTT follow-up patient's within due date because of lack of capacity within some clinical services<br><br>**Consequences:**<br>- Increased patient waits for access to services impacting on patient safety, potential/ actual harm and patient experience.<br>- Failure to meet key targets and regulatory requirements in some areas<br>- Sub-optimal service provision<br>- 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.<br><br>**Control Owner:** Chief Operating Officer | - IPR to Board (each meeting), including enhanced reporting on RTT.<br>- Finance and Performance Committee<br>- Divisional Performance via Operational Management Board<br>- Operations and Performance Executive Led Group via OMB<br>- Quarterly Divisional Performance Reviews<br>- Bi-weekly patient flow meetings. | North West performance report overseen by ICB.<br>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.<br><br>(ii) ED - Continued multidisciplinary discharge events.<br><br>(iii) Flow improvement plan integrated with UEC improvement plan to drive forward clear priority actions and assess the impact.<br><br>**Action Owner:** Chief Operating Officer<br>**Due date:** Q4 2026/27 (with quarterly updates) | The Trust continues to meet the elective, cancer and diagnostic waiting targets within the Medium Term Plan.<br>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 with improvements in metrics for 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, to improve compliance to the 12 and 4 hours standards. The Trust has extended the UTC opening hours to 10pm for minor illness and injuries.<br>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. In addition to this a new West Cheshire System Leadership Group has been formed, with three initial priority projects including OPEL/Escalation, P1 NCTR, and Pharmacy.<br>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***<br><br>***(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.)*** |
| | | | C2) Performance management framework and Governance Structure<br><br>**Control Owner:** Chief Operating Officer | - IPR to Board (each meeting)<br>- Finance and Performance Committee - including System Oversight Framework<br>- Divisional Performance via Operational Management Board<br>- Operations and Performance Executive Led Group via Finance and Performance Committee | North West performance report overseen by ICB.<br>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<br><br>**Action Owner:** Chief Operating Officer<br>**Due date:** TBC (following confirmation of implementation timeframe) | C&M resources secured and have supported validation.<br><br>Continue to focus on non RTT follow up and report through OPELG.<br><br>The AI validation tool has been procured with implementation delayed to Q3 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.<br><br>**Action Owner:** Chief Operating Officer<br>**Due date:** Q4 2026/27 (with quarterly updates)<br><br>(ii) Harm review feedback to continue to be shared at QGG/ Quality Committee via Medical Director<br><br>**Action Owner:** Medical Director<br>**Due date:** Quarterly updates | Action plan for Opthalmology reviewed at EDG and Division. This will also be presented at the Quality Committee in January 2027<br><br>Incident review processes continue.<br><br>To ensure the whole Trust Board is aware of progress for UEC/ RTT and Cancer there have been presentations at Board development sessions.<br><br>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: Internal sources of assurance | Board Assurance: External sources of assurance | Board Assurance: Overall assurance level | Residual risk score (I x L) | Within risk tolerance? | Gaps in Control / Assurance | Actions: Planned action | Actions: Progress update | Target risk score | Estimated date of achievement of target score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF4**<br>Challenges in ensuring a high quality, engaged, diverse and inclusive workforce and culture would affect our ability to deliver patient care.<br><br>**Executive Risk Lead:**<br>Chief People Officer<br><br>**Assurance Committee:**<br>People Committee<br><br>**Last Update:**<br>November 2026 | **Causes**<br>- Poor staff morale and culture<br>- Staff burn-out<br>- Lack of health and wellbeing support<br>- Increased pressures in the hospital<br>- Failure to engage staff, listen to feedback and act<br>- lack of effective systems and processes<br>- Lack of accountability<br>- Poor behaviours<br><br>**Consequences**<br>- Loss of goodwill and staff engagement<br>- Short term sickness absence<br>- Turnover hotspots<br>- A deterioration in the physical and mental wellbeing of our workforce<br>- Increased bank/ temp staff hours<br>- Erosion of skills and knowledge<br>- Reduced leadership capacity and capability<br>- Silo working, lack of collaboration and innovation, ownership of performance and delivery<br>- External scrutiny | *5 x 4 = 20* | C1) Workforce Plan delivery as part of the Medium Term Plan<br>**Control Owner**: Chief People Officer | - Staffing monitored via Strategic Workforce Group and Chair's report to People Committee<br>- 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.<br><br>**Action owner:** Chief People Officer<br>**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. Revised WTE figures to reflect developed CIPs established. | *12* | ***To be reviewed in March 2027***<br><br>***(Reduction when staff feedback supports positive culture shift, not expected at the earliest until end March 2027).*** |
| | | | | | | | | | Longer term workforce plan aligned to MTP and Trust strategy. | To ensure delivery of the workforce MTP expectations.<br><br>**Action Owner:** Chief People Officer<br>**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. Including income generation schemes and advanced practice roles. | | |
| | | | C2) People Strategy delivery<br><br>**Control Owner**: Chief People Officer | - IPR<br>- Workforce dashboard/ SOF via People Committee<br>- GMC Survey via People Committee<br>- Preceptorship survey via People Committee<br>- Staff survey action plan updates via People Committee<br>- FTSU Bi-annual update and via People Committee<br>- Employer relations report via People Committee<br>- People promise report via People Committee<br>- People and Culture Sub Committee AAA report to People Committee<br>- WRES/ WDES and gender pay gap reports via People Committee<br>- CPO report to People Committee<br>- integrated EDI action plan updates to People Committee<br>- EDI annual report to People Committee<br>- Equality Delivery System 2 reports. | NHS Staff Survey results<br>Pulse survey results<br>WRES/ WDES.<br>Gender pay gap results.<br>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)<br>Poor staff experience.<br>Diversity of workforce at all levels. | (i) Develop strategic dashboard for key metrics aligned to the People Startegy priorities.<br><br>(ii) Deliver priority improvements within the People Strategy (relating to wellbeing, EDI, leadership development and workforce development).<br><br>**Action Owner:** Chief People Officer<br>**Due date:** Q4 2026/27 (with quarterly updates) | Dashboard development progressing.<br>Update on delivery against year 1 of the People Strategy to the People Committee scheduled for November 2026.<br>RCN Foundation compassionate leadership programme underway.<br>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 with Bronze accreditation application submitted in November 2026. | | |
| | | | | | | | | | Training needs analysis.<br>Consistency and equity of education offer and application.<br>Development and delivery of action plan in respect of NETS. | (i) Training needs analysis to be developed aligned to national work.<br><br>(ii) Action plan to be developed and delivered in respect of the National Education and Training Survey results.<br><br>(iii) Continue to develop the training and development offer across staff groups<br><br>**Action Owner:** Chief People Officer<br>**Due date:** Q4 2026/27 (with quarterly updates) | Training needs analysis progressing alongside the national work.<br>NETS results awaited (expected in Summer) and action plan will be developed for review and monitoring through the Education, Learning and OD Sub Committee.<br>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 .<br>New appraisal framework developed and being used for appraisals.<br>Reviewing use of talent conversations. | | |
| | | | C3) Leadership and management capabilities<br><br>**Control Owner:** Chief People Officer | - L&D Reports via People Committee<br>- Guardian of Safe Working reports<br>- GMC survey via People Committee<br>- Preceptorship survey via People Committee<br>- Apprenticeship Report to People Committee<br>- Workforce dashbord to People Committee | NHS Staff survey results.<br>GMC Survey results<br>Preceptorship survey results<br>National Education and Training Survey | Acceptable | | | Delivery of talent and succession planning. | Delivery of talent and succession planning.<br><br>**Action Owner:** Chief People Officer<br>**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.<br><br>**Action Owner:** Chief People Officer<br>**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 commenced in October 2026 and Divisional triumvirate coaching scheduled for November 2026.<br>Thirlwall Inquiry report and recommendations reviewed with contribution to baseline assessment and national updates awaited. | | |

**Risk Theme: Finance & Capital**

**RISK APPETITE: OPEN - Upper tolerance limit 12**

**LINKS TO STRATEGIC GOALS:** **SG4: Adding Value**

| Risk description & information | Causes & consequences | Inherent risk score (I x L) | Key controls | Board Assurance: Internal sources of assurance | Board Assurance: External sources of assurance | Board Assurance: Overall assurance level | Residual risk score (I x L) | Within risk tolerance? | Gaps in Control / Assurance | Actions: Planned action | Actions: Progress update | Target risk score | Estimated date of achievement of target score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF5**<br>Failure to deliver financial plan and underlying financial position could impact long term financial sustainability for the Trust and system partners.<br><br>**Executive Risk Lead:**<br>Chief Finance Officer<br><br>**Board Committee**:<br>Finance and Performance Committee<br><br>**Last Update:**<br>November 2026 | **Cause:**<br>The Trust operates in an increasingly challenging financial environment in line with the national position for acute providers.<br>This is driven by:<br>- Increase in non elective activity delivered at premium costs;<br>- High numbers of medically optimised and delayed transfers of care for which costs are not fully reimbursed;<br>- Costs associated with medical and nurse bank and agency usage;<br>- Cheshire & Merseyside system has a challenged deficit position which then relies on providers delivering significant levels of efficiency savings, whilst curtailing investment.<br>- Identification and delivery of recurrent Cost Improvement Plan (CIP)<br>- Different funding models limit income growth counter to the Trust needing to respond to NEL demand alongside challenging targets to deliver RTT improvements.<br>- Lack of internally generated Capital resource<br><br>**Impact:**<br>- 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)<br>- Low cash balances and need for cash preservation actions impacting on operational effectiveness<br>- Inability to maintain safe and effective local services.<br>- Increased external scrutiny from NHSE | *4 x 4 = 16* | C1) Medium Term plan and underlying sustainability<br><br>**Control Owner**: Chief Finance Officer | - Trust board report (monthly)<br>- Finance & Performance Committee<br>- Divisional Boards via Operational Management Board (Monthly)<br>- Capital Steering Group via F&P Committee (Monthly)<br>- Operational Performance Executive Led Group reporting to OMB | System Financial Plan<br>NHSE submissions<br>NHSE monitoring returns<br>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<br><br>**Action Owner**: Chief Finance Officer<br><br>**Due Date:** Q4 for 2026/27 plan (with Quarterly updates) | Forecasting delivery of 2026/27 financial plan, with risk remaining. Trust financial delivery assumes delivery of divisional financial recovery plan which have been presented, reviewed, discussed and agreed through Executive Directors. Detailed planning for 2027/28 and rolling three year plan has commenced and is being led by the Director of Transformation and Productivity. | *12* | ***March 2031***<br><br>***(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)*** |
| | | | C2) Annual Budget and systems of budgetary control including additional grip and control actions comprising pay and non-pay oversight<br><br>**Control Owner**: Chief Finance Officer | - Financial Plan (approved)<br>- Finance Report to Board<br>- Finance & Performance Committee<br>- Forecast processes and reporting within finance reports | Financial Plan<br>NHSE submissions<br>Internal Audit reviews<br>FPRM (as required)<br>NHSE oversight meetings | *Partial* | | | Inquiry costs awaiting confirmation of national funding<br>Unfunded escalation costs to maintain patients safety in light of increased levels of NC2R patient numbers | (i) Continue to work with NHSE.<br><br>(ii) Provide forecasting updates for F&P complying with NHSE template approach.<br><br>**Action Owner**: Chief Finance Officer<br>**Due date**: Quarterly updates | Inquiry funding supported by NHSE for 2025/26 and discussions underway for 2026/27.<br>System work continues on levels of NC2R and subsequent impact on escalation costs with little improvement acheived.<br>Escalation capacity cost pressures continue but are mitigated in year by non-recurrent measures. | | |
| | | | C3) Cost Improvement Programme including Quality Impact Assessments<br><br>**Control Owner**: Director of Transformation and Productivity | - Weekly CIP delivery group.<br>- Finance & Performance Committee papers.<br>- Programme Delivery Office report to Board. | Financial Plan<br>NHSE Template<br>Weekly returns to NHSE and provider benchmarking of progress<br>FPRM (as required) | *Partial* | | | Delivery phase of CIP Programme, low levels of maturity and to be underpinned by productivity expectations.<br>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.<br><br>**Action Owner**: Director of Transformation & Productivity<br>**Due date**: Quarterly updates | Transformation priorities agreed. Programme structure and targets agreed. CIP Delivery Group continues with CEO as Chair.<br><br>CIP workshops held and schemes for 2026/27 captured.<br>Approach to transformation being developed. Completed<br><br>Director of Transformation and Productivity recruited (March 2026) driving significant change in programme approach. | | |
| | | | C4) Cash Management<br><br>**Control Owner**: Chief Finance Officer | - Finance & Performance Committee papers. | Financial Plan<br>NHSE Template<br>Weekly returns to NHSE<br>FPRM (as required) | *Partial* | | | Approach needed to mitigate the new challenges regarding cash and deficit support. | Engagement with NHSE on cash support arrangements<br><br>**Action Owner**: Chief Finance Officer<br>**Due date**: In place (with quarterly updates) | Cash risk associated with DSF withdrawal established. Cash preservation plan developed. Monthly updates to Board. Q1-Q3 DSF confirmed. Q4 requirements being assessed. | | |
| **BAF6**<br>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<br><br>**Executive Risk Lead:**<br>Chief Operating Officer<br><br>**Board Committee:**<br>Finance and Performance Committee<br><br>**Last Update:**<br>November 2026 | **Causes**<br>- Implications of NHSE and capital prioritisation process<br>- Ageing estate and challenging backlog maintenance risks<br>- Womens and Childrens deconstruction programme<br>- Limited development opportunities due to space constraints<br><br>**Consequences**<br>- Impact on delivery of capital plan<br>- insufficient progress on backlog maintenance<br>- Inability to invest in innovations not currently identified in the Trust's medium term plan<br>- Having to re-prioritise the programme if an unidentified need arises<br>- Disruption to operational services during a complex capital programme | *5 x 4 = 20* | C1) Capital management governance<br><br>**Control Owner**: Chief Finance Officer | - Finance and Performance Committee reporting to Board.<br>- 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.<br><br>**Action Owner**: Chief Operating Officer<br>**Due date**: System led timeframes (with quarterly updates) | Continue to engage with national team on prioritisation process and emerging risks. | *12* | ***2026/27***<br><br>***(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)*** |
| | | | C2) Capital planning and prioritisation<br><br>**Control Owner**: Chief Finance Officer | - Quarterly update to the Finance and Performance Committee.<br>- Estates Strategy. | | *Partial* | | | Exploring opportunities for contingency and system capital funding,<br><br>Infrastructure risks | Continue to explore opportunities for system capital<br><br>**Action Owner**: Chief Finance Officer<br>**Due date**: Quarterly updates | Capital allocation confirmed and prioritised plan in place for 2026/27.<br>Successful bid for £0.5m national capital to support ED/ UEC improvements with completion expected late 26/27.<br>26/27 capital planning complete and majority of business cases drawn up and approved.<br>CDC Blacon funding confirmed with completion required by March 2027.<br>2027/28 capital planning in progress utilising a risk based approach, with funding planned at £8.5m. | | |
| | | | C3) Estates strategy<br><br>**Control Owner**: Chief Operating Officer | - Health and Safety Committee reports via Finance and Performance Committee.<br>- Capital Management Group via F&P Committee<br>- Estates report to Finance and Performance Committee<br>- Estates and Facilities Committee reports via Finance and Performance Committee | Six Facet Survey.<br>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.<br><br>**Action Owner:** Chief Operating Officer<br>**Due date:** Q4 2026/27 (with quarterly updates) | Update on the development of the Estates Strategy presented to the Board in July 2026. | | |
| | | | | | | | | | W&C building deconstruction | Deconstruction of old Women and Children's building.<br><br>**Action Owner**: Chief Operating Officer<br>**Due date**: Q3 2026/27 (with quarterly updates) | Full decant now achieved. Deconstruction significantly complete. | | |

## Risk Theme: Digital & Data

**RISK APPETITE: OPEN - Upper tolerance limit 12**

**LINKS TO STRATEGIC GOALS:** SG4: Adding Value

| Risk description & information | Causes & consequences | Inherent risk score (I x L) | Key controls | Board Assurance: Internal sources of assurance | Board Assurance: External sources of assurance | Board Assurance: Overall assurance level | Residual risk score (I x L) | Within risk tolerance? | Gaps in Control / Assurance | Actions: Planned action | Actions: Progress update | Target risk score | Estimated date of achievement of target score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF7**<br>Failure to deliver transformative digital and data solutions and performant, secure and resilient infrastructure could impact on patient and staff experience and organisational productivity<br><br>**Executive Risk Lead:**<br>Chief Digital & Data Officer<br><br>**Assurance Committee**:<br>Finance and Performance<br><br>**Last Update:**<br>November 2026 | **Cause:**<br>- 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)<br>- 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)<br>- Increasing cyber risk profile with more attacks evident, including ransomware and phishing. (Consequence C3)<br>- Failure to identify, develop and maintain the required Digital & Data Services people capability (internal plus partnerships / third parties) (Consequence C4)<br>- Failure to adequately train Trust wide staff in cyber security awareness (Consequence C5)<br>- Failure to adequately assess and take action regarding the quality of data within the Trust digital clinical systems (Consequence C6)<br>- Increasing support and licence costs for key systems (Consequence C7)<br><br>Consequence:<br>C1-Trust will be reliant on systems that are not fit for purpose, impacting productivity and consequently service quality/patient experience.<br>C2- Insecurities within the systems and infrastructure with vulnerabilities that could be exploited through a cyber-attack.<br>C3 - Data loss and regulatory sanctions if personal data is lost, financial consequences of losing access to systems and data.<br>C4 - Reduced level of skills and or capacity in workforce due to inability to develop or recruit staff to required level<br>C5 - Compromised systems and infrastructure would result in business continuity measures being put in place for staff and patients.<br>C6 - Poor data quality could lead to Trust staff making ill-informed decisions and inaccurate external reporting<br>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 and also the 10 year plan.<br><br>**Control Owner:** Chief Digital & Data Officer | Updates into F&PC via Digital Strategic Programme Update<br>Strategy update to Trust Board development session (Jul 2025) and formal Trust Board (Aug 2025)<br>AI policy now in place | MIAA Digital strategy audit (Jan-Mar 25) | *Partial* | *5 x 3 = 15* | **NO** | Delivery of Strategy, programme plan aligned to Medium Term Plan, formalised AI governance approach. | (i) Refresh and deliver Digital and Data Strategy informed by National Digital Maturity Assessment (DMA) and 10 year health plan for England.<br>**Action Owner:** Chief Digital and Data Officer<br>**Due date:** Complete<br><br>(ii) MIAA to conduct audit of Digital and Data Strategy.<br>**Action Owner:** Chief Digital and Data Officer<br>**Due date:** Complete<br><br>(iii) Publication of Digital and Data Strategy.<br>**Action Owner:** Chief Digital and Data Officer<br>**Due date:** Q3 26/27 | Delivery plan for year 1 of strategy has been developed.<br>Strategy has been updated following feedback from sharing across senior Trust forums. The strategy is undergoing final design changes ahead of publication by end of 2026. Will be presented at November Trust Board. | *12* | ***To review end of 2026/27*** |
| | | | KC2) Annual plans that deliver effective management of Cyber security threats and digital infrastructure health<br><br>**Control Owner**: Chief Digital & Data Officer | - DSPT presented to Finance and Performance Committee (F&PC)<br>- SIRO report into F&PC<br>Annual SIRO report to Trust Board July 2026 | - Annual MIAA assurance audit on DSPT submission<br><br>- Microsoft MDE score | *Partial* | | | Information Asset Owner responsibilities for "essential services".<br>Completion of capital infrastructure investment including core network upgrade<br>. | (i) Completion of action plan relating to DSPT and Cyber Assurance Framework (CAF)<br>**Action Owner:** Chief Digital and Data Officer<br>**Due date: Completed**<br><br>(ii) IAO responsibilities to be defined and approved.<br>**Action Owner:** Chief Digital and Data Officer<br>**Due date:** Q3 26/27 | DSPT submission was completed in Jun 26. The Trust reported a standards met submission. Work has started on the 26/27 submission, first interim submission date is end of Dec 2026.<br>Board level Cyber training took place in Oct 2026.<br>IAO responsibilities have been communicated to IAO's. IAO training is being reviewed and request has been made to integrate into ESR to enable reporting and analysis. | | |
| | | | | | | | | | | (ii) Deliver plan to maintain infrastructure health<br>**Action Owner:** Chief Digital and Data Officer<br>**Due date:**<br>Sep 2025 Phase 1 - Completed<br>Mar 2026 Phase 2 | MIAA review of data centres has been completed a programme of work is underway to complete recommendations relating to the audit. This work is on track with regular updates shared at audit committee.<br>Capital funding has been secured to replace a key part of the networking infrastructure (Core network switches) project starts in Q4 26/27 and will complete Q1 27/28. | | |
| | | | | | | | | | | (iii) Deliver Cyber Security protection plan<br>**Action Owner:** Chief Digital and Data Officer<br>**Due date:** March 2027 | New proxy solution has been procured and will be implemented in Q3 26/27<br>New Privileged Access Management solution is being deployed in Nov 26.<br>A Cyber security programme plan for 26/27 has been developed and shared at Information Governance Cyber Security committee and Finance and Performance committee | | |
| | | | KC3) Annual plan for investment, upgrade and optimisation of digital applications (including EPR), supporting delivery of the transformation programme<br><br>**Control Owner**: Chief Digital & Data Officer | - Clinical digital systems progress (including EPR) reported to Finance & Performance Committee<br>- Contract in place with EPR supplier, for upgrades over the next 5 years<br>- Successful EPR upgrade in Sept 2025<br>-Programme updates provided to Digital Clinical System programme board | - MIAA EPR lessons learned review (reported to Audit Committee and F&P Committee)<br>- NHSE EPR Readiness review (reported via F&P Committee) | *Acceptable* | | | Application (including EPR) optimisation structures, engagement and assurance reporting. | Undertake optimisation programme.<br>Participate in national EPR usability survey and develop action plan based on results.<br><br>**Action Owner:** Chief Digital and Data Officer<br>**Due date**:<br>EPR Optimisation Phase 1 to August 2025 - complete<br>EPR Upgrade September 2025 - complete<br>EPR Optimisation phase 2 to Mar 2026<br>Ophthalmology EPR by Mar 2026 - procurement 26/27 - go live Q3 26/27<br>CRV digitisation project in progress - programme has started<br>AVT - underway<br>Patient flow solution review - new contract has been agreed with existing supplier. | New ophthalmology EPR solution has been procured, go live expected Dec 26<br>Large scale EPR development work underway focusing on discharge, CRV digitisation.<br>Documentation reviews are being planned for maternity and nursing.<br>AVT solution is being rolled out across the organisation, roll out is planned to be completed by Dec 26. | | |
| | | | KC4) Analytics capability, culture and data governance<br><br>**Control Owner**: Chief Digital & Data Officer | - Annual report to F&P Committee<br>-Data governance group in place<br>-Data governance update included in strategic update to finance and performance committee | Clinical coding audit | *Acceptable* | | | Assessment of data quality through framework and assurance reporting. | Develop and deploy data quality framework with enhanced assurance reporting.<br>**Action Owner:** Chief Digital and Data Officer<br>**Due date:** Phase 1 October 2025, Phase 2 March 2026 | New NOF metrics have been reviewed, internal reporting has been update to reflect these changes.<br>DQAM framework is now in place<br>MIAA audit of DQAM due for completion in Q3 | | |
| | | | | | | | | | | Adopt NCF Framework for internal service development<br><br>**Action Owner:** Chief Digital and Data Officer<br>**Due date:** Quarterly update | Progress continues to adopt the National Competency Framework (NCF) - apprenticeship schemes have been introduced for Trust staff supporting development of Data and AI skills.<br>Cohort 1 starts Nov 26 | | |
| | | | KC5) Digital and Data organisation wide awareness plan ensuring, opportunities for development of the Digital and Data team and wider workforce.<br><br>**Control Owner**: Chief Digital & Data Officer | National staff survey | - National digital workforce survey (reported via F&P Committee)<br><br>DSDN Level 3 accreditation. (April 2025) | *Partial* | | | Organisation wide Digital and Data skills enhancement programme, including local training and apprenticeships | 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<br><br>**Action Owner:** Chief Digital and Data Officer<br>**Due date:** Q4 26/27 - | Local Target Operating Model (TOM) is being developed following reduction in WTE inline with regional headcount reduction target. Aimed for completion end of 26/27.<br><br>AI Apprenticeship schemes are now in place.<br><br>Local data awareness sessions are offered across the organisation. Covering analysing Trust data with tools such as excel and Power Bi | | |

## Risk Theme: Governance

**RISK APPETITE: CAUTIOUS - Upper tolerance limit 9**

**LINKS TO STRATEGIC GOALS:** SG3: Leadership, SG4: Adding Value, SG5: Partnerships

| Risk description & information | Causes & consequences | Inherent risk score (I x L) | Key controls | Board Assurance: Internal sources of assurance | Board Assurance: External sources of assurance | Board Assurance: Overall assurance level | Residual risk score (I x L) | Within risk tolerance? | Gaps in Control / Assurance | Actions: Planned action | Actions: Progress update | Target risk score | Estimated date of achievement of target score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF8**<br>Failure to ensure effective corporate governance could impact our ability to comply with legislation and regulation.<br><br>**Executive Risk Lead:**<br>Director of Governance and Risk<br><br>**Board Committee**:<br>Audit Committee<br><br>**Last Update:**<br>November 2026 | **Causes**<br>- implementation of changes in legislation<br>- effectiveness of governance structures<br>- clarity of accountability, decision making and assurance reporting<br>- new partnership arrangements developing<br>- organisational learning and sharing<br><br>**Consequences**<br>- Legal and regulatory action<br>- Board effectiveness<br>- Public confidence | ***4 x 3 = 12*** | C1) Effective Governance Structures<br><br>**Control Owner:** Director of Governance and Risk | - Well led action plan.<br>- Annual report.<br>- Committee effectiveness annual reports via Audit Committee. | - Head of Internal Audit Opinion (via Audit Committee).<br>- VFM opinion (via Audit Committee).<br>- CQC Reports. | *Partial* | ***4 x 2 = 8*** | **YES** | Assurance on the effectiveness of sub committee level and Divisional Governance.<br><br>Delivery of the risk management improvement plan. | (i) To review and support effectiveness of Divisional governance organogram and embedding of the Accountability Framework.<br><br>(ii) Embed risk management through delivery of risk management improvement plan.<br><br>**Action Owner**: Director of Governance and Risk<br>**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 scoped to commence in Q3/4 2026/27.<br><br>Governance presentations continue to be delivered in various forums.<br><br>Risk management improvement plan actions significantly complete. Moderate assurance opinion on risk management provided by MIAA. Risk Management Committee embeded and final update planned to Audit Committee (January 2027). | ***9*** | ***Target Score Achieved (Jan 2026)***<br><br>***(Risk has reduced and is now within risk appetite. Further assurance on effectiveness of sub governance structures and Divisional accountability framework planned)*** |
| | | | C2) Compliance with relevant codes of governance, regulation and legislative requirements<br><br>**Control Owner:** Director of Governance and Risk | - Annual report<br>- code of governance compliance (via Audit Committee)<br>- Provider licence compliance (via Audit Committee) | - CQC reports<br>- 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.<br><br>**Action Owner:** Director of Governance and Risk<br>**Due date:** Q4 2026/27 | Regulatory compliance map being developed to be populated by Divisions and teams in 2026/27.<br><br>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 at year end 2025/26. Provider capability assessment by NHSE improved to amber-red in Q1 2026/27. | | |
| | | | C3) Partnership Governance<br><br>**Control Owner:** Director of Governance, Risk and Improvement | - CEO report | - CMPC updates throguh CEO report (joint working agreement and Leadership Board TOR approved) | *Acceptable* | | | Clarity of governance for emerging partnerships and collaborations. | To support collaborations and emerging partnerships with effective governance.<br><br>**Action Owner:** Director of Governance and Risk<br>**Due date:** As required (with quarterly updates) | Support provided on discreet projects/ developments including research developments.<br><br>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 Groupfor 2026/27. Ad hoc support also provided to CMPC Managing Director. | | |
| | | | C4) Public Inquiry<br><br>**Control Owner:** Director of Governance and Risk | - Thirlwall Inquiry Updates<br>- Legal cost updates (via F&P Committee) | | *Acceptable* | | | Corporate records management lessons learned.<br><br>Inquiry Report to be published. | (i) Corporate records management policy to be updated and work to support embedding and improvement.<br><br>**Action Owner:** Director of Governance and Risk<br>**Due date:** Q4 2026/27 (with quarterly updates)<br><br>(ii) Response to the Inquiry report.<br><br>**Action Owner**: Director of Governance and Risk<br>**Due date:** Q3 2026/27 | Corporate records management added to Information security and information governance committee, with corporate records management policy revised.<br><br>Multidisciplinary group approach to establishing the baseline assessment against the Thirlwall Inquiry recommendations (reported to the Board in September 2026). Further update on road map, national actions and wider learning scheduled for November Board. | | |

## Risk Theme: System Working and Collaboration

**RISK APPETITE: SEEK - Upper tolerance limit 16**

**LINKS TO STRATEGIC GOALS:** SG1: Patient and Family Experience, SG5: Seeking Partnership Opportunities, SG6: Populations

| Risk description & information | Causes & consequences | Inherent risk score (I x L) | Key controls | Board Assurance: Internal sources of assurance | Board Assurance: External sources of assurance | Board Assurance: Overall assurance level | Residual risk score (I x L) | Within risk tolerance? | Gaps in Control / Assurance | Actions: Planned action | Actions: Progress update | Target risk score | Estimated date of achievement of target score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF9**<br>System working and provider landscape changes may present challenges in ensuring COCH is engaged with system partners, placing the Trust in the best strategis position and with aligned priorities.<br><br>**Executive Risk Lead:** Director of Strategy & Partnerships<br><br>**Board Committee**: Board of Directors<br><br>**Last Update:**<br>November 2026 | **Causes**<br>- Clarity of system leadership and management roles<br>- Maturity of the ICS and emerging Neighbourhoods<br>- Further development of Provider Collaborative<br>- Changes in commissioning<br>- Unclear system clinical priorities<br>- 10 year health plan implications<br><br>**Consequences**<br>- Potential conflicting priorities between organisations and systems<br>- Diversion of COCH leadership capacity<br>- Loss of autonomy<br>- Disruption to established clinical networks | ***4 x 4 = 16*** | C1) Take a Leadership role<br><br>**Control Owner:** Director of Strategy & Partnerships | Chief Executive Officer reports to Board. | Regular reporting from CMPC CiC<br>Regular reporting from Mental Health, Learning Disabilities and Community Servcies CiC<br>Cheshire West Health and Well Being Board<br>Cheshire West Partnership Group<br>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.<br><br>**Action Owner**: Director of Strategy & Partnerships<br>**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 a new programme update for November 2026. Reporting on partnerships and system working continues to evolve. With the changes in ICB functions, senior leadership forums are being refined to ensure strategic and opeartional alignment. The Trust is leading this development particularly in urgent care. | ***16*** | ***Target Score Achieved***<br><br>***(Risk is within risk appetite. Further work progressing on stakeholder engagement and collaboration)*** |
| | | | | | | | | | Clarity and changes to stakeholders. | To update stakeholder map and actions.<br><br>**Action Owner:** Director of Strategy & Partnerships<br>**Due date:** Q3 2026/27 | Stakeholder map being reviewed and updated to reflect changes. Priorities, roles and actions to be agreed.<br>Stakeholder mapping has been completed to reflect Changes in ICB functions, Primary Care Group Boundaries and the development of neighbourhood planning<br>The Trust supports bespoke user engagement events within specialities and specific events such as development of transport plans where community engagement is essential. | | |
| | | | C2) Embed a Trust approach to health inequalities and prevention, and population health<br><br>**Control Owner:** Director of Strategy & Partnerships | | Cheshire West Partnership Group | *Partial* | | | Health inequalities reporting framework to meet national requirements.<br>C2AI and Cipha into action reporting. | (i) Embed population health and health inequalities framework and develop reporting.<br>(ii) Embed population health tools into community services as a means of managing those patients most at risk of hospital admission.<br><br>**Action Owner:** Director of Strategy & Partnerships<br>**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.<br>An approach to Health Inequalities has been developed and shared with local stakeholders who have endorsed the approach.<br>Health inequality tools are deployed in community services through the CIPHA (data into action) when assessing likelihood of risk and admission to hospital<br>As a statutory function the Trust is required to publish an annual report that focuses on health inequalities. This is coming to the Board in November 2026. | | |
| | | | C3) Anchor institution workstreams (green / social value / prevention)<br><br>**Control Owner:** Director of Strategy & Partnerships | Anchor Institute Group Chairs report to Finance & Performance Committee | ICB Net zero Group<br>ICB Prevention Pledge Group<br>Population Health Board<br>National quarterly data collection via Foundary platform<br>Anchor Institute Accreditation | *Acceptable* | | | | Further develop anchor institute reporting.<br>**Action Owner:** Director of Strategy & Partnerships<br>**Due date:** Complete (Q2) | A new Annual Report has been developed to capture the work of the Anchor Institution Group. This is going to Board in November 2026. | | |
| | | | C4) Collaborative models<br><br>**Control Owner**: Chief Operating Officer/ Director of Strategy & Partnerships | CEO Report to Board.<br>COCH/CWP Community Services updates through OMB. | CMPC reporting. | *Partial* | | | Alignment and development of Community services.<br>Involvement and influence to support Neighbourhood developments. | (i) Progress discussions with partners regarding development and alignment of community services.<br><br>(ii) Active involvement alongside partners in the establishment of local Neighbourhoods.<br><br>**Action Owner:** Director of Strategy & Partnerships<br>**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.<br>Engagement with Neighbourhood development, recognising this is at its infancy.<br>There is now a collaboration transformation group supporting the development of neighbourhood care. Primary Care, VCFSE, Community and Acute Services are in attendance. | | |
| | | | | | | | | | Clairty of opportunities and priorities for local collaboration. | Explore opportunities for local collaboration.<br><br>**Action Owner:** Director of Strategy & Partnerships<br>**Due date:** Quarterly updates | Continued to work with WUTH/ WCHC to develop understanding of collaboration opportunities through joint working group.<br>As an Alliance of hospitals, The Tust is also developing its work with Warrington, Mid Cheshire, East Cheshire and Mersey and West Lancashire Hospitals on specific services where hub and spoke models of care may be indicated; and with Alder Hey as a specialist centre. | | |

## Risk Theme: Research and Innovation

**RISK APPETITE: SEEK - Upper tolerance limit 16**

**LINKS TO STRATEGIC OBJECTIVES:** SG5: Partnerships

| Risk description & information | Causes & consequences | Inherent risk score (I x L) | Key controls | Board Assurance: Internal sources of assurance | Board Assurance: External sources of assurance | Board Assurance: Overall assurance level | Residual risk score (I x L) | Within risk tolerance? | Gaps in Control / Assurance | Actions: Planned action | Actions: Progress update | Target risk score | Estimated date of achievement of target score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF10**<br>Inability to deliver the Research and Innovation agenda to exploit future opportunities<br><br>**Executive Risk Lead:**<br>Medical Director<br><br>**Board Committee**:<br>Board of Directors<br><br>**Last Update:**<br>November 2026 | **Causes**<br>- Lack of leadership capacity and succession planning<br>- Funding sources<br>- Early stages of partnerships and strategic focus<br>- Lack of capacity and focus on Innovation opportunities<br>- Capacity and capability to deliver commercial research activity in the CRU<br><br>**Consequences**<br>- Ability to maintain R&I function<br>- Alignment of R&I activity<br>- Ability to secure funds and missed opportunities<br>- Future leadership plans | ***4 x 3 = 12*** | C1) Research Strategy<br><br>**Control Owner**: Medical Director | Quarterly Board reports.<br>Research updates via OMB. | Annual report to RRDN.<br>Annual reports on additional strategic funding to RRDN. | *Partial* | ***4 x 3 = 12*** | **YES** | Strategy delivery. | Delivery of the Research Strategy<br><br>**Action Owner:** Medical Director<br>**Due date**: Year 1 end of 2026/27 (with quarterly updates) | Research Strategy approved by the Board in January 2026.<br>Update on progress provided to the Board in March 2026 and further update to be presented aligned to external review report.<br>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***<br><br>***(Risk is within risk appetite. Further work progressing on partnerships to support delivery of Research Strategy)*** |
| | | | C2) Team structure, SOPs and expertise<br><br>**Control Owner:** Medical Director | Quarterly Board reports.<br>Research updates via OMB.<br>R&D Executive Chairs Report to Board. | MHRA inspections.<br>GCP inspections.<br>HTA inspections.<br>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.<br><br>**Action Owner:** Medical Director<br>**Due date**: Q2 2026/27 | External review completed sept 2026 and presented to OMB. Job description for new senior leadership post drafted and awaiting review.<br>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.<br>Recruited 2 new research practitioners which provides route for non nursing clinical staff to progress in research roles. | | |
| | | | | | | | | | Further strengthening of governance and SOPs. | Continued review of governance and SOPs (including Trust vehicle).<br><br>**Action Owner:** Medical Director<br>**Due date:** Q3 2026/27 | Further work to streamline this to meet new 150 targets from NIHR which wil be integral to funding going forward.<br>List of Standard Oprating Procedures (SOPs) in place and team engaged in further review and development. Progress made to develop manuals for Mobile Research Unit.<br>Exploring establishment of a sponsorship committee to support internal research projects using well established and tested models at other providers. | | |
| | | | | | | | | | Lack of financial expertise embedded in the team. | To discuss financial support needs and resolve the gap.<br><br>**Action Owner:** Medical Director<br>**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.<br>This was considered within the external review with a recommendation made, but funding constraints recognised at this time. | | |
| | | | C3) Funding including RRDN (Regional Research delivery network) Arrangements<br><br>**Control Owner**: Medical Director | Quarterly Board reports.<br>Research updates via OMB. | Annual report to RRDN.<br>Annual reports on additional strategic funding to RRDN. | *Partial* | | | Funding levels and income streams. | Continued focus on funding streams, including securing grants and commercial funding.<br><br>**Action Owner :** Medical Director<br>**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.<br>Improved performance evidenced on 150 targets which ensures funding likely to remain at current levels or increase next year.<br>Work ongoing with the Universities and commercial companies on grant opportunities.<br>Commercial Research Delivery Centre involvement live from April 2025 providing a pipeline for greater research opportunities and commercial income.<br>New research finance policy approved aligned to the research team and specialty resource and delivery, to be discussed with the Trust Primary Investigators in December. | | |
| | | | C4) Partnership Arrangements (including academic appts)<br><br>**Control Owner:** Medical Director | Quarterly Board reports.<br>Research updates via OMB | | *Partial* | | | Increasing academic appointments.<br>Partnership agreements and governance. | To continue to develop our partnership arrangements, including education institutes and commercial.<br><br>**Action Owner:** Medical Director<br>**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 including new reaerch sharepoint hub.<br>Framework agreed between COCH and the University of Chester (UoC) to progress partnership arrangements.<br>Also building relationships with Primary Care Networks (PCNs) and the Primary Care CRDC to develop a regional primary care research network. Development of a final draft SLA with Marine Lake GP Practice (lead site for Primary Care CRDC) progressing.<br>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. Meetign with the UoC medical school representative awaited to progress this.<br>Increase in academic appointments mostly teaching through UoC medical school and focus on this continuing. | | |
| | | | C5) Innovation Strategy<br><br>**Control Owner**: Medical Director | CAEG reporting to QGG and upto to Q&S. | | *Partial* | | | Innovation strategy.<br>Capacity and leadership to drive innovation. | Partnership with University of Chester to continue to be explored to support Innovation ambitions.<br><br>**Action Owner:** Medical Director<br>**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.<br>Operational innovation continues to be encouraged including Trust wide engagement in system led Innovation fortnight (November 2025) and shift to transformation programmes in 2026/27.<br>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: Internal sources of assurance | Board Assurance: External sources of assurance | Board Assurance: Overall assurance level | Residual risk score (I x L) | Within risk tolerance? | Gaps in Control / Assurance | Actions: Planned action | Actions: Progress update | Target risk score | Estimated date of achievement of target score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BAF11**<br>Inability to deliver transformation and productivity programme would impact our ability to deliver our Medium Term Plan<br><br>**Executive Risk Lead:**<br>Director of Transformation and Productivity<br><br>**Board Committee**:<br>Board of Directors<br><br>**Last Update:**<br>November 2026 | **Causes**<br>- organisational culture and expertise<br>- scale of change required<br>- CIP and underlying deficit drivers<br>- external factors and ability to influence stakeholders to drive change and improvement<br><br>**Consequences**<br>- Ability to deliver transformation at pace required<br>- Underdelivery of CIP target aligned to plan profile with consequences on funding<br>- Ability to progress CIP scheme maturity | ***4 x 4 = 16*** | C1) Transformation plan delivery as part of the Medium Term Plan<br><br>**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.<br><br>**Action Owner:** Director of Transformation and Productivity<br>**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. Transformation Programme Board well established with attendance from Divisions, workstream leads and deputies across professional groups. Weekly CIP delivery group chaired by CEO focussed on 3 schemes where progress has stalled with all projects reporting through Aspyre Software. | ***16*** | ***Target Score met.***<br><br>***(New strategic risk for 2026/27 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<br><br>**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.<br><br>**Action Owner:** Director of Transformation and Productivity<br>**Due date**: Q3 | Aspire system procured and training delivered (June 2026). Programmes all being managed through Aspyre. Drive for engagement continues as cultural shift needed becomes embedded. | | |
| | | | | | | | | | Team and organisation capacity and expertise. | (i) Recruitment to team including Assoc. Director.<br><br>(ii) Training programme, engagement and transformation leads aligned to support Divisions.<br><br>**Action Owner:** Director of Transformation and Productivity<br>**Due date**: Quarterly updates | Associate Director Transformation in post from October 2026, with further vacanies recruited into the Team. Transformation leads aligned and working with Divisions. Process mapping training commencing December 2026 with two dates fully subscribed. | | |
| | | | | | | | | | Governance and assurance reporting. | (i) Development of reporting and assurance.<br><br>**Action Owner:** Director of Transformation and Productivity<br>**Due date**: Q2 onwards<br><br>(ii) Embedding the Transformation Programme Board governance and assurance reporting.<br><br>**Action Owner:** Director of Transformation and Productivity<br>**Due date**: Q2 onwards (with quarterly updates) | Aspyre reporting used for Transformation Programme Board and Board reporting. Transformation Programme Board fully established and focus of CIP delivery group reset. | | |
| | | | C3) Benchmarking framework<br><br>**Control Owner:** Director of Transformation and Productivity | | Model Health System. HED benchmarking. | *Partial* | | | 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.<br><br>**Action Owner:** Director of Transformation and Productivity<br>**Due date**: Q2 onwards (with quarterly updates) | Speciality pack roll out continues with recent developments including service line reporting (SLR) and PLICS data. Rotational reporting into Transformation Programme Board with actions tracked throguh Aspyre. | | |

## Board Assurance Framework

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

**5x5 risk scoring matrix:**

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

**Risk Appetite Levels**

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

**PUBLIC – Board of Directors**
**24th November 2026**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Report** | **Agenda Item 9b.** | **Significant Risks Report (November 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<br>BAF 2 Safety<br>BAF 3 Operational<br>BAF 4 People<br>BAF 5 Finance<br>BAF 6 Capital<br>BAF 7 Digital<br>BAF 8 Governance<br>BAF 9 Partnerships<br>BAF 10 Research<br>BAF 11 Transformation | | | **X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X** | Potential to link to all BAF risk areas. | | | |
| **Strategic goals** | Patient and Family Experience<br>People and Culture<br>Purposeful Leadership<br>Adding Value<br>Partnerships<br>Population Health | | | | | | | **X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X** |
| **CQC Domains** | Safe<br>Effective<br>Caring<br>Responsive<br>Well led | | | | | | | **X**<br>**X**<br>**X**<br>**X**<br>**X** |
| **Previous considerations** | Not applicable | | | | | | | |
| **Executive summary** | As at end of October 2026, the Trust has 11 risks with a residual risk score of 15 or above. Since the previous report, two risks have been removed from the significant risk report and one risk have been escalated (due to increased score) into the report.<br><br>The current significant risks primarily relate to patient access and flow, infrastructure and equipment safety, workforce capacity, digital resilience and patient safety. Several risks remain long-standing and reflect structural or system-wide challenges rather than short-term control failures.<br><br>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.<br><br>Risks with a residual score of 15 and above are also 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 (November 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>** | **11** |
| 15 | 3 |
| 16 | 8 |
| 20 | 0 |
| No. Risks removed/reduced | 2 |
| No. of risks escalated | 1 |
| No. Risks open >12 months | 7 |

The significant risk profile primarily relates to patient access and flow, infrastructure and equipment safety, workforce capacity, digital resilience and patient safety. Several risks are long-standing and reflect structural or system-wide challenges rather than short-term control failures. A number of risks remain dependent on longer-term operational, workforce or capital solutions, with mitigating actions continuing while these are progressed.

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 end October 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:<br>• Ophthalmology | Planned Care | 4x4 | 16 | Waiting lists being validated and monitored through the Divisions and through OPELG.<br>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.<br>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. | Digital and Data Services | 5x3 | 15 | DSPT submission for 2026 has been completed with a “Standards Met” outcome. MIAA audit of DSPT shows low risk and high veracity. Risk score remains at 15 whilst DSPT action plan for 26/27 is reviewed and considering | March 2027 | 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 |
|---|---|---|---|---|---|---|---|---|---|
| | | Separate risks have been raised for these areas and this risk is to hold the overarching risk of a Cyber attack. | | | | heightened national security concerns. Target date extended from Nov 2026 to March 2027 but with an expectation that risk score will remain high in line with the national position.<br>Next key action is deployment of a new internet proxy device. 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.<br>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. | | | |

| 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 |
|---|---|---|---|---|---|---|---|---|---|
| 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. 2026/27 work planned but risk remains high due to nature of remaining work. | Q3 2026/27 | Karen Edge | ⇔ |
| 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.<br>The number of NCTR patients also requires the Trust to maintain a high level of escalation capacity at additional cost.<br>For individual NCTR Patients that are ready for discharge they risk higher chances of deconditioning and developing hospital acquired | 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 |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | infections that could result in poorer outcomes.<br>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 response team to support Flintshire patient discharges. System Chief executive meeting convened In July to agree high level actions required to achieve target.<br>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 | 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 |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | reliant on reduction in NC2R position.<br>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. | | | |
| 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.<br>Currently also progressing a formal consultation to provide a Foundation Year 1 doctor on call for general surgery and orthopaedics. 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.<br>Surgical 'team' job planning now commenced which will allow an informed understanding of the requirements to ensure robust SDEC surgical cover.<br>Once these measures are in place then risk will be mitigated down. | 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 |
|---|---|---|---|---|---|---|---|---|---|
| **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.<br>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 | Obtained quotes for new lead gowns, supported by the Capital Management Group and procurement underway. This will mitigate aspects of the risk relating to our staff.<br>Possibility of looking to use the next significant Trust charity appeal to build an IR theatre to be discussed at EDG. | Q3 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.<br>Recent changes to EPR direct users to NICE guidance for assessment and prescribing and make timely administration easier. | 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 |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Compliance is improving. Monitored through Quality Governance Group. 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** | | | | | | | | | |
| 25/09/2024 | 3320 | Delivery of annual workforce plan (WTE reduction) | Corporate | 4x4 | 16 | Continued oversight is in place to ensure that operational workforce requirements, CIP delivery, transformation assumptions and financial plans remain aligned. Focused work ongoing to reduce vacancy gaps, enabling reduction in Bank WTE. | March 2027 | Vicki Wilson | ★ |

**PUBLIC – Board of Directors**
**24th November 2026**

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|---|---|---|---|---|---|---|---|---|
| **Report** | **Agenda Item 10*.** | **GMC National Training Survey 2026 Report** | | | | | | |
| **Purpose of the Report** | Decision | | Ratification | | Assurance | | Information | **X** |
| **Accountable Executive** | Dr Nigel Scawn | | | Medical Director | | | | |
| **Author(s)** | Dr Lyndsay Cheater | | | Director of Medical Education | | | | |
| **Board Assurance Framework** | BAF 1 Quality<br>BAF 2 Safety<br>BAF 3 Operational<br>BAF 4 People<br>BAF 5 Finance<br>BAF 6 Capital<br>BAF 7 Digital<br>BAF 8 Governance<br>BAF 9 Partnerships<br>BAF 10 Research<br>BAF 11 Transformation | | | **X**<br>**X**<br><br>**X**<br><br><br><br>**X** | BAF impact on quality (1) and safety (2) of medical care in the trust, educational governance (8) and experience of trainees and trainers in the trust (4) | | | |
| **Strategic goals** | Patient and Family Experience<br>People and Culture<br>Purposeful Leadership<br>Adding Value<br>Partnerships<br>Population Health | | | | | | | **X** |
| **CQC Domains** | Safe<br>Effective<br>Caring<br>Responsive<br>Well led | | | | | | | **X**<br>**X**<br>**X**<br>**X**<br>**X** |
| **Previous considerations** | Verbal presentation of main findings at Operational Management Board - 24th September 2026.<br>People Committee – 16th November 2026. | | | | | | | |
| **Executive summary** | The purpose of this report is to summarise the key findings from the CoCH GMC National Training Survey 2026<br><br>This report confirms:<br>1. CoCH has above national average completion rates for trainees and trainers.<br>2. There is a continued trend of improvement in overall results.<br>3. The educational leads are engaged in providing comments and action plans for departments with one or more negative outlier results.<br>4. There were no free text comments regarding patient safety or bullying and undermining, versus three comments last year.<br>5. All of the overall trust results this year are in the interquartile range for the first time since 2023.<br>6. Induction is now rated 2nd out of the 9 trusts in the report, having been reported as lowest in the region last year. | | | | | | | |

| | |
|---|---|
| | 7. The only department currently on the NHSE quality team "intensive support framework" is Emergency Medicine who have this year been reduced from level 2 to level 1 (improvement). Obstetrics and gynaecology have been removed from the framework (were at level 1).<br>8. The gastroenterology results have significantly improved this year from a position of having several significant negative outliers a year ago, to now having several significant positive outliers. Together with vascular surgery they are no longer considered departments of concern by NHSE.<br>9. The number of departments of concern (multiple negative outliers/ intensive support framework) has reduced from seven to four in 2026.<br>10. The quality team recognised the specialty of ophthalmology for their good results, as being a small department results aren't always available (need over 3 responses for the results to be analysed).<br><br>The issues raised are that:<br>1. In addition to Emergency Medicine remaining on the intensive support framework, three other departments are listed by the NHSE quality team as having significant negative outliers this year. These departments are paediatrics, respiratory medicine and endocrine and diabetes<br>2. Endocrine and diabetes have had several negative outliers for several years. Paediatrics also had multiple negative outliers last year, as did respiratory medicine in 2024 - but had improved in 2025.<br>3. The relevant Associate Medical Directors and Divisional Directors of the four departments of concern are aware of the results and have been asked to add this to their divisional risk registers and to monitor the progress of the action plans locally.<br>4. In the trainer survey results the highest number of multiple negative outliers are regarding the themes of "supportive environment","rota issues" and "support for training".<br>5. Departments with one or more negative outliers have provided action plans which will be monitored locally (9 departments).<br><br>The next steps are:<br>1. Results to be presented at OMB in October<br>2. Updates of the action plans will be requested from the four departments above, and progress presented quarterly to the Education, Learning and Organisational development subcommittee.<br>3. Divisional leads to ensure monitoring of other action plans within Divisions. |
| **Recommendations** | The Board of Directors is asked to note the results of the GMC National Training Survey 2026, and the educational governance process regarding monitoring progress of the action plans. |

| Corporate Impact Assessment | |
|---|---|
| **Statutory/regulatory requirements** | CQC/Constitution/other regulation/legislation |
| **Risk** | The four departments of concern risk included on divisional risk registers (urgent care, women and children's) |
| **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. |

Countess of Chester Hospital NHS Foundation Trust

# GMC National Training Survey 2026 Report

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Director of Medical Education
September 2026

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# Introduction

The General Medical Council (GMC) National Training Survey is the UK's largest annual survey of medical training. It provides a comprehensive picture of:

- resident doctors' experiences of the quality of their education and working environments; and
- the experiences of clinical and educational supervisors across the UK.

The 2026 survey was open from 24 March to 6 May. Responses to the trainee and trainer questions were analysed and reported under a series of themes.

**Reporting concerns and publication dates**

Doctors may also use the survey to report unresolved concerns about patient safety, bullying or undermining. These are submitted as free-text comments and shared with Trusts for investigation and response before the full results are released.

On 8 June, the Trust was informed that no free-text comments had been submitted in 2026, compared with three in 2025. The full GMC trainee and trainer results were released on 21 July 2026.

**NHSE regional quality review**

The NHS England regional Workforce, Training and Education quality team reviews each Trust's results against previous years. It identifies areas of good practice and concern and communicates its findings to Trusts and the GMC.

Departments with multiple significant negative outliers may be identified for monitoring or placed on the Intensive Support Framework (ISF), with escalating intervention:

- **Level 1 — minor concerns:** meetings are established to monitor the learning environment.
- **Level 2 — significant concerns:** an NHSE quality visit is arranged.
- **Level 3 — major concerns:** enhanced intervention is required.
- **Level 4 — highest level of concern:** resident doctors may be removed from the placement.

The regional quality team's findings for the Trust were received on 14 September 2026.

**Accessing the results**

The 2026 national report is available through the GMC Education Data Tool. The Chester data have been analysed, with the main findings set out in the Executive Summary.

The survey questions and accompanying explanatory notes are available at: S:drive/public/allstaff/medicaleducation/GMC2025.

# Executive Summary for the Countess of Chester

**Survey participation and engagement**

Completion rates (page 7) show strong engagement from resident doctors and clinical and educational supervisors, supporting a meaningful interpretation of the results. Most clinical and educational leads also provided timely reflective comments and action plans when requested for departments with one or more results in the bottom quartile of the trainee and/or trainer survey.

**Overall Trust performance**

- Overall results continue to improve, and all Trust-level results are now within the interquartile range.
- “Adequate experience” improved from the bottom 5% nationally to the interquartile range.
- Induction improved from the lowest score in the region in 2025 to second among the nine Trusts included in the regional report.
- Feedback was also ranked second in the region, while the remaining results were broadly in the middle of the regional range.
- No free-text concerns about patient safety, bullying or undermining were received, compared with three in 2025.

**NHSE quality ratings and departmental progress**

- **Emergency Medicine** remains the only department on the ISF, but has improved from Level 2 to Level 1. This reflects NHSE intervention, departmental action plans and substantial educational quality-improvement work. Continued monitoring is required because several significant negative outliers remain.
- **Obstetrics and Gynaecology** has been removed from the ISF following excellent results in both 2025 and 2026.
- The regional quality team also recognised the continued engagement of Trust leadership in supporting Emergency Medicine.

**Departments showing significant improvement**

- **Gastroenterology** moved from significant negative outliers in 2025 to several positive outliers in 2026, reflecting substantial work by the educational lead.
- **Vascular** also improved and is no longer under monitoring. Both departments have returned to green status.

**Departments requiring observation**

- **Paediatrics** remains under observation following significant negative outliers in both 2025 and 2026.
- **Respiratory** has returned to this level of concern after improving in 2025.
- **Endocrinology and Diabetes** continues to show several negative outliers. Rota design has been a significant negative outlier for three consecutive years, creating a material risk of escalation to the ISF if results do not improve in 2027.

- **Ophthalmology** was recognised for good results, although data are not always available because fewer than three responses cannot be reported.

**Key themes from the trainer survey**

The themes with the greatest number of multiple negative outliers were:

- **Supportive environment:** negative outliers in 9 of 16 departments.
- **Rota issues:** negative outliers in 6 of 16 departments.
- **Support for training:** negative outliers in 4 of 16 departments.

“Supportive environment” was also the lowest-scoring theme across all specialties in 2025. A questionnaire is to be sent out to trainers in October 2026 to explore reasons behind this.

**Governance and follow-up**

On 14 September, all departments named in the regional quality team’s letter, together with the relevant Associate Medical Directors and Divisional Directors, were informed of the interpretation of their results. The four departments of concern were asked to:

- record the concerns on divisional risk registers; and
- monitor and update their action plans regularly through divisional meetings.

Quarterly updates will be requested for review by the Education, Learning and Organisational Development Subcommittee.

**Structure of this report**

The following pages present:

1. survey completion rates and guidance on interpreting the results;
2. Trust results over time and comparison with other regional Trusts;
3. overall specialty-level results from the trainee and trainer surveys;
4. detailed results and action plans, beginning with specialties of concern and followed by departments with at least one negative outlier; and
5. departments for which full results are unavailable because fewer than three responses were received.

## RAG report of NHSE quality team ratings of clinical departments 2025 vs 2026

| Specialty | 2025 | 2026 |
|---|---|---|
| Acute Internal Medicine | | |
| Anaesthetics | | |
| Cardiology | | |
| Clinical Radiology | | |
| COTE | | |
| Dermatology | | |
| Emergency Medicine | L2 | L1 |
| Endocrine & Diabetes | | |
| Gastroenterology | | |
| Haematology | | |
| General Surgery | | |
| Intensive Care Medicine | | |
| Obs & Gynae | L1 | |
| Ophthalmology | | |
| Orthopaedics | | |
| Paediatrics | | |
| Respiratory | | |
| Vascular | | |

Key

| | |
|---|---|
| | No concerns |
| | Under observation for multiple outlier negative results |
| | On Intensive Support framework L1-4 |
| | Not enough responses (<3) |

## Appendix

### 1. Completion rates

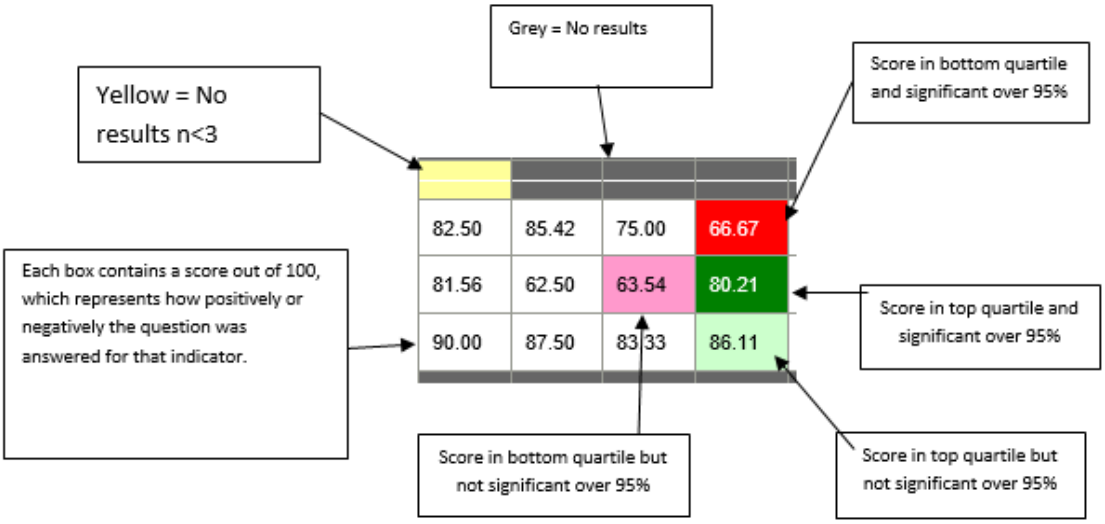
The completion rates are shown in Table 1 below, showing that both resident doctors and supervisors are engaged in providing feedback at the Countess of Chester Hospital. The Medical Education team are very proactive in communicating when the survey has been released, the importance of completing and sending regular reminders to trainees and trainers.

Table 1 – Percentage completion rates for GMC trainee and trainer survey, at CoCH, the Northwest and nationally

| | CoCH | Northwest | National |
|---|---|---|---|
| Trainee survey completion rate | 72.3% | 77.26% | 66.88% |
| Trainer survey completion rate | 58.4 | 52.77% | 33.42% |

### 2. Interpreting the results

Each box contains a score out of 100, which represents how positively or negatively trainee or trainers answered the questions for that theme. If the score is significantly negative or positive compared to the national average, the box is highlighted red or green. Where it is negative or positive but shares a confidence interval with the national average, the box is highlighted pink or light green. The figure in the box below explains this.



## 3. Overall Trainee Results 2023-2026

| Survey Year | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|
| **Indicator** | **Score** | **Outcome** | **Score** | **Outcome** | **Score** | **Outcome** | **Score** | **Outcome** |
| Overall Satisfaction | 77.38 | Within IQR | 72.6 | Within IQR | 75.49 | Within IQR | 80.25 | Within IQR |
| Clinical Supervision | 87.91 | Within IQR | 85.74 | Within IQR | 88.6 | Within IQR | 90.45 | Within IQR |
| Clinical Supervision out of hours | 84.71 | Within IQR | 83.71 | Within IQR | 86.67 | Within IQR | 90.55 | Within IQR |
| Reporting Systems | 73.14 | Within IQR | 67.83 | Within IQR | 71.6 | Within IQR | 76.63 | Within IQR |
| Workload | 46.48 | Within IQR | 48.17 | Within IQR | 48.47 | Within IQR | 51.34 | Within IQR |
| Teamwork | 73.74 | Within IQR | 74.02 | Within IQR | 75.33 | Within IQR | 76.03 | Within IQR |
| Handover | 64.78 | Within IQR | 66.89 | Within IQR | 73.49 | Within IQR | 73.38 | Within IQR |
| Supportive Environment | 75.43 | Within IQR | 74.14 | Within IQR | 76.53 | Within IQR | 79.42 | Within IQR |
| Induction | 77.58 | Within IQR | 76.11 | Within IQR | 76.62 | Within IQR | 81.99 | Within IQR |
| Adequate Experience | 79.08 | Within IQR | 71.32 | Below | 74.35 | Below | 80.89 | Within IQR |
| Educational Governance | 70.21 | Within IQR | 69.38 | Within IQR | 70.56 | Within IQR | 74.93 | Within IQR |
| Educational Supervision | 86.17 | Within IQR | 86.3 | Within IQR | 87.38 | Within IQR | 87.81 | Within IQR |
| Feedback | 72.2 | Within IQR | 68.37 | Within IQR | 75.13 | Within IQR | 77.87 | Within IQR |
| Local Teaching | 64.5 | Within IQR | 60.55 | Below | 68.56 | Within IQR | 67.61 | Within IQR |
| Regional Teaching | 63.24 | Within IQR | 64.24 | Within IQR | 65.37 | Within IQR | 67.37 | Within IQR |
| Study Leave | 63.21 | Within IQR | 64.67 | Within IQR | 66.42 | Within IQR | 70.25 | Within IQR |
| Rota Design | 55.06 | Within IQR | 50.47 | Within IQR | 55.6 | Within IQR | 57.48 | Within IQR |
| Facilities | 64.78 | Within IQR | 64.31 | Within IQR | 64.56 | Within IQR | 66.87 | Within IQR |

The table above shows the overall results for the Countess of Chester Hospital for a 4-year period from 2023 to 2026, for the 18 themes in the trainee survey. All scores are higher than 4 years ago, and within the interquartile range for the first time since 2023.

## 4. Regional Trust Comparison Results

| | Alder Hey Childrens NHS Foundation Trust | Countess of Chester NHS Foundation Trust | Liverpool Heart and Chest Hospital NHS Foundation Trust | Liverpool University Hospitals NHS Foundation Trust | Liverpool Womens Hospital | North Cheshire and Mersey NHS Foundation Trust (previously Warrington) | The Walton Centre NHS Foundation Trust | University Hospital Aintree | Wirral University Teaching Hospital |
|---|---|---|---|---|---|---|---|---|---|
| Overall Satisfaction | 77.8 | 80.25 | 83.05 | 80.63 | 76.52 | 67.14 | 78.94 | 81.37 | 78.93 |
| Clinical Supervision | 89.76 | 90.45 | 95.81 | 90.83 | 92 | 85.8 | 92.93 | 90.63 | 89.6 |
| Clinical Supervision out of hours | 89.78 | 90.55 | 94.49 | 87.38 | 91.6 | 85.06 | 93.13 | 89.1 | 87.13 |
| Reporting Systems | 75.65 | 76.63 | 79.06 | 75.2 | 77.54 | 64.72 | 73.78 | 75.14 | 73.5 |
| Workload | 47.03 | 51.34 | 59.96 | 50.73 | 44.41 | 42.54 | 60.77 | 48.7 | 49.85 |
| Teamwork | 78.46 | 76.03 | 83.64 | 75.26 | 79.32 | 66.7 | 79.17 | 77.26 | 74.44 |
| Handover | 67.3 | 73.38 | 75.4 | 71.42 | 72 | 67.53 | 72.47 | 75.97 | 74.26 |
| Supportive Environment | 74.24 | 79.42 | 81.1 | 77.2 | 71.84 | 68.5 | 80 | 74.91 | 76.83 |
| Induction | 86 | 81.99 | 90.55 | 82.21 | 85.79 | 77.93 | 84.2 | 83.52 | 82.33 |
| Adequate Experience | 77.5 | 80.89 | 85.06 | 79.57 | 74.68 | 69.91 | 81.91 | 80.87 | 78.21 |
| Educational Governance | 72.51 | 74.93 | 78.25 | 74.62 | 71.52 | 61.23 | 73.4 | 73 | 70.32 |
| Educational Supervision | 87.8 | 87.81 | 87.65 | 89.53 | 86.79 | 84.73 | 86.17 | 87.83 | 88.69 |
| Feedback | 70.91 | 77.87 | 76.45 | 76.75 | 70.26 | 69.31 | 74.63 | 75.63 | 78.52 |
| Local Teaching | 65.67 | 67.61 | 75.81 | 72.9 | 61.52 | 55.93 | 68.66 | 71.72 | 67.42 |
| Regional Teaching | 65.12 | 67.37 | 75.91 | 70.85 | 55.25 | 65.81 | 61.59 | 68.08 | 68.32 |
| Study Leave | 72.85 | 70.25 | 85.37 | 73.08 | 73.42 | 60.25 | 77.66 | 74.72 | 68.19 |
| Rota Design | 60.16 | 57.48 | 75.16 | 67.64 | 58.95 | 40.97 | 71.42 | 65.95 | 56.34 |
| Facilities | 73 | 66.87 | 73.29 | 67.76 | 73.85 | 60.39 | 67.59 | 66.14 | 68.82 |

This table shows the overall results for trusts in the region. All our results are in the interquartile range. Our score for induction has improved from being the lowest in the region to being second. The result for “feedback” is second in the region; the other results are “in the middle of the pack” regionally which has improved from being in the bottom third last year.

## 5. Trainee survey results per Specialty

| | Acute Internal Medicine | Anaesthetics | Cardiology | Clinical Radiology | Emergency Medicine | Endocrinology & Diabetes Mellitus | Gastroenterology | Geriatric Medicine | Intensive Care Medicine | Obstetrics & Gynaecology | Ophthalmology | Paediatrics | Respiratory | Trauma & Orthopaedics | Vascular |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Overall Satisfaction | 77.5 | 97.08 | 73.75 | 92.5 | 67.5 | 55 | 93.75 | 74.29 | 86.67 | 77.86 | 91.67 | 80.45 | 71.43 | 83.75 | 76 |
| Clinical Supervision | 76.04 | 97.57 | 85.42 | 89.58 | 89.06 | 67.71 | 96.87 | 85.42 | 96.53 | 93.57 | 95.83 | 95.68 | 77.38 | 96.87 | 92.5 |
| Clinical Supervision out of hours | 83.33 | 97.92 | 80 | 79.69 | 89.29 | 86.25 | 81.25 | 73.33 | 98.13 | 96.35 | 96.25 | 95.56 | 77.5 | 96.25 | 90 |
| Reporting Systems | 80 | 90.5 | 61.67 | 87.5 | 70 | 48.33 | 80 | 66 | 80 | 75.45 | | 77.22 | 71 | 73.33 | 80 |
| Workload | 42.19 | 60.42 | 61.98 | 64.24 | 35.68 | 43.33 | 45.31 | 50 | 62.5 | 40.77 | 61.81 | 54.55 | 39.88 | 56.25 | 55 |
| Teamwork | 83.33 | 79.86 | 77.09 | 87.5 | 67.71 | 58.33 | 87.5 | 70.24 | 81.95 | 81.55 | 83.33 | 70.46 | 71.43 | 68.75 | 76.67 |
| Handover | 73.44 | 83.33 | 62.5 | | 75.78 | 60.94 | 64.58 | 75 | 88.33 | 73.21 | 68.75 | 72.71 | 74.31 | 71.88 | 58.33 |
| Supportive Environment | 80 | 92.92 | 65 | 94.17 | 70.63 | 68 | 95 | 67.86 | 90 | 77.14 | 93.33 | 76.36 | 67.86 | 75 | 82 |
| Induction | 71.25 | 97.92 | 55 | 95.83 | 80 | 66 | 96.25 | 78.39 | 86.67 | 86.25 | 88.33 | 86.36 | 62.14 | 86.25 | 73 |
| Adequate Experience | 75 | 97.92 | 81.25 | 95.83 | 71.88 | 57.5 | 90.63 | 75 | 79.17 | 75 | 87.5 | 79.55 | 78.57 | 81.25 | 70 |
| Educational Governance | 77.08 | 90.97 | 56.25 | 88.89 | 73.96 | 60 | 85.42 | 60.72 | 76.39 | 73.81 | 91.67 | 66.67 | 76.19 | 75 | 63.33 |
| Educational Supervision | 81.25 | 95.31 | 76.56 | 89.58 | 93.75 | 70 | 98.44 | 84.82 | 91.67 | 89.73 | 85.42 | 86.36 | 76.79 | 95.31 | 77.5 |
| Feedback | | 95.47 | 71.67 | 95.25 | 78.04 | 51.25 | | 74.5 | | 84.13 | | 57.81 | 60.63 | | 70.94 |
| Local Teaching | 45.83 | 84.86 | 68.89 | 90.83 | 65.71 | 70.55 | 63.61 | 75.67 | 60.67 | 50 | 82.22 | 55.83 | | 83.33 | 46.11 |
| Regional Teaching | 70.83 | 77.78 | 69.44 | 53.47 | 78.57 | 62.5 | 80.55 | 53.33 | 50.83 | 61.86 | 80.56 | 46.25 | | 77.08 | 77.78 |
| Study Leave | 31.25 | 90.63 | 41.67 | 89.58 | 71.88 | 46.88 | 70.83 | 90 | 68.75 | 41.07 | 91.67 | 65 | 95.83 | 90.63 | 62.5 |
| Rota Design | 53.13 | 76.56 | 56.25 | | 45.31 | 30 | 62.5 | 54.46 | 80.21 | 51.79 | 79.17 | 46.59 | 35.71 | 82.81 | 43.75 |
| Facilities | 66.88 | 64.29 | 63.33 | 58.33 | 53.75 | | | 75 | 65.83 | 71.48 | | 72 | 65 | | 64.69 |

There are several departments who have received results in the trainee survey which are above the interquartile range in the 2026 survey. These are (in alphabetical order) anaesthetics, gastroenterology, obstetrics and gynaecology, ophthalmology and trauma and orthopaedics. Ophthalmology has been referenced by the NHSE quality team as there often aren’t enough responses to analyse with it being a small department.
The department with the highest number of negative outliers is endocrinology and diabetes, followed by respiratory, emergency medicine (improving over time) paediatrics and cardiology.

## 6. Trainer survey results per Speciality

| | Acute Internal Medicine | Cardiology | Clinical Radiology | Dermatology | Emergency Medicine | Endocrinology & Diabetes Mellitus | Gastroenterology | General Surgery | Geriatric Medicine | Intensive Care Medicine | Obstetrics & Gynaecology | Ophthalmology | Paediatrics | Respiratory | Trauma & Orthopaedics | Vascular |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Supportive Environment | 55 | 72.5 | 76.79 | 54.17 | 55 | 87.5 | 65.63 | 70.83 | 66.67 | 67.5 | 60.71 | 58.33 | 55 | 55 | 51.79 | 46.43 |
| Educational Governance | 52.08 | 50.42 | 68.75 | 54.86 | 38.75 | 72.92 | 55.21 | 69.79 | 58.33 | 70.31 | 64.58 | 64.58 | 45.14 | 60 | 37.2 | 60.71 |
| Professional Development | 60 | 56.25 | 72.32 | 83.33 | 62.5 | 75 | 65.63 | 81.25 | 67.71 | 70 | 74.11 | 75 | 68.75 | 64.58 | 67.26 | 70.54 |
| Appraisal | 37.5 | 57.5 | 60.71 | 25 | 52.5 | 83.33 | 43.75 | 66.67 | 66.67 | 77.5 | 69.64 | 79.17 | 67.5 | 37.5 | 66.07 | 66.07 |
| Support for Training | 65 | 57.5 | 70.24 | 75 | 60 | 80.56 | 55.21 | 73.61 | 70.14 | 75 | 75 | 72.22 | 64.17 | 70.83 | 60.12 | 70.24 |
| Time to Train | 55 | 35 | 53.57 | 47.22 | 23.33 | 77.78 | 45.84 | 48.61 | 54.17 | 51.67 | 66.67 | 22.22 | 57.5 | 46.67 | 52.38 | 60.71 |
| Rota Issues | 15 | 55 | 66.67 | | 25 | 58.33 | 25 | 37.5 | 20.83 | 40 | 17.86 | 25 | 12.5 | 20 | 21.43 | 42.86 |
| Handover | 65 | 37.5 | | | 85 | 83.33 | 56.25 | 70.83 | 60 | 70 | 78.57 | | 77.78 | 43.75 | 71.43 | 82.14 |
| Resources to Train | 55 | 55 | 82.14 | 75 | 50 | 75 | 62.5 | 79.17 | 62.5 | 75 | 78.57 | 75 | 67.5 | 55 | 71.43 | 67.86 |

In the trainer survey, there are multiple positive outliers in endocrinology and diabetes (in contrast to the negative trainee results), and multiple negative outliers in trauma and orthopaedics (in contrast to positive trainee results). There are multiple negative outliers in Acute internal Medicine, cardiology and emergency medicine (less than last year in the latter).

Looking at the themes across all specialities, there are multiple negative outliers in the following questions **supportive environment** (9/16 departments), **rota issues** (6/16 departments), and **support for training** (4/16 departments). “Supportive environment” is the question that also scored the lowest across all specialities in 2025.

There are multiple positive outliers in **appraisal** (3/16 departments) and **resources to train** (3/16 departments).

## 7. Free text comments

There were no free text comments in the 2026 GMC survey results, in 2025 there were three - one related to bullying and undermining (the way Emergency department doctors are spoken to by doctors of other specialities) and two concerning patient safety (both about the out of hours rota cover in general surgery).

## 8. Department under monitoring on Intensive Support Framework level 1- Emergency Medicine

Trainee

| Post sp | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
|---|---|---|---|---|---|---|---|---|---|
| Emergency Medicine | Overall Satisfaction | 63.08 | Below | 65 | Below | 76.39 | Within IQR | 67.5 | Q1 but not below |
| | Clinical Supervision | 86.15 | Within IQR | 79.43 | Below | 87.99 | Within IQR | 89.06 | Within IQR |
| | Clinical Supervision out of ho | 79.97 | Below | 71.21 | Below | 87.89 | Within IQR | 89.29 | Within IQR |
| | Reporting Systems | 58.33 | Below | 72.5 | Within IQR | 68.44 | Within IQR | 70 | Within IQR |
| | Workload | 31.57 | Within IQR | 34.47 | Within IQR | 38.89 | Within IQR | 35.68 | Within IQR |
| | Teamwork | 66.03 | Q1 but not below | 71.97 | Within IQR | 69.91 | Within IQR | 67.71 | Within IQR |
| | Handover | 47.54 | Below | 60.42 | Within IQR | 72.22 | Within IQR | 75.78 | Within IQR |
| | Supportive Environment | 63.46 | Within IQR | 73.18 | Within IQR | 73.33 | Within IQR | 70.63 | Within IQR |
| | Induction | 73.46 | Below | 78.64 | Q1 but not below | 68.89 | Below | 80 | Within IQR |
| | Adequate Experience | 66.35 | Q1 but not below | 71.59 | Q1 but not below | 75.69 | Within IQR | 71.88 | Q1 but not below |
| | Educational Governance | 59.62 | Within IQR | 70.45 | Within IQR | 74.54 | Within IQR | 73.96 | Within IQR |
| | Educational Supervision | 76.92 | Within IQR | 85.23 | Within IQR | 89.58 | Within IQR | 93.75 | Within IQR |
| | Feedback | 73.75 | Within IQR | 64.02 | Within IQR | 79.29 | Within IQR | 78.04 | Within IQR |
| | Local Teaching | 61.48 | Q1 but not below | 67.92 | Within IQR | 73.7 | Within IQR | 65.71 | Q1 but not below |
| | Regional Teaching | 60.65 | Within IQR | 64.58 | Within IQR | 74.08 | Within IQR | 78.57 | Within IQR |
| | Study Leave | 50.46 | Within IQR | 61.11 | Within IQR | 32.81 | Within IQR | 71.88 | Within IQR |
| | Rota Design | 41.35 | Below | 41.25 | Below | 46.88 | Q1 but not below | 45.31 | Within IQR |
| | Facilities | 53.47 | Within IQR | 64.63 | Within IQR | 75.8 | Within IQR | 53.75 | Below |

Trainer

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Trainer | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Emergency medicine | Supportive Environment | 33.34 | Below | 47.5 | In Q1 but not a below outlier | 35 | Below | 55 | In Q1 but not a below outlier |
| | Educational Governance | 26.04 | Below | 37.5 | In Q1 but not a below outlier | 42.08 | Below | 38.75 | Below |
| | Professional Development | 60.94 | In Q1 but not a | 75 | Within IQR | 61.25 | Below | 62.5 | Within IQR |
| | Appraisal | 62.5 | Within IQR | 65 | Within IQR | 57.5 | Within IQR | 52.5 | Within IQR |
| | Support for Training | 70.83 | Within IQR | 68.33 | Within IQR | 50 | Below | 60 | Below |
| | Time to Train | 2.08 | Below | 20 | Below | 30 | Below | 23.33 | Below |
| | Rota Issues | 0 | Below | 15 | Below | 0 | Below | 25 | Within IQR |
| | Handover | 43.75 | In Q1 but not a | 70 | Within IQR | 70 | Within IQR | 85 | Above |
| | Resources to Train | 37.5 | In Q1 but not a | 60 | Within IQR | 50 | Within IQR | 50 | Within IQR |

The Education Lead for the Emergency department provided the following comments/ action plan.

## CONCERN 1:

TRAINEE RESPONSE TO GMC SURVEY FOR "FACILITIES" FELL IN THE BOTTOM QUARTILE NATIONALLY

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| Purchase chairs / seating for:<br>- Clinical areas<br>- Education room<br>- Registrars office | | UEC Ops | December 26 | Red |
| Add more information regarding library services to ED departmental induction | | ALB | August 26 | Green |
| Purchase more lockers to be reserved for resident doctors | | UEC Ops | December 26 | Red |
| Purchase drawers / cubby spaces for registrars office | | UEC Ops | December 26 | Red |

## CONCERN 2:

TRAINEE RESPONSE TO GMC SURVEY FOR "LOCAL TEACHING" FELL IN THE BOTTOM QUARTILE NATIONALLY

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| SHO grade teaching now takes place for 4 hours once a month with all SHO grade doctors released from clinical work to attend | Regular review of rotas and feedback | ALB | Completed | Green |
| EDT / SDT now built into patchwork rotas | Regular review of rotas | ALB / Med Staffing | Completed | Green |

## CONCERN 3:

TRAINEE RESPONSE TO "ADEQUATE EXPERIENCE" AND OVERALL SATISFACTION FELL WITHIN BOTTOM QUARTILE NATIONALLY

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| Department to explore whether SHO grade doctors can be assigned resus or procedures shifts to prioritise training | | ALB | December 26 | Red |

## CONCERN 4:

TRAINER RESPONSE TO GMC SURVEY FELL IN THE BOTTOM QUARTILE NATIONALLY IN MULTIPLE AREAS

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| Capacity and demand model for departmental staffing | | UEC Ops | December 26 | Red |
| Increase Friday morning registrar staffing to allow better attendance at educational governance meetings | | UEC Ops | December 26 | Red |
| Impact assessment of increased senior led roles on education and training | | UEC Ops / ALB | December 26 | Red |
| Trust to explore impact of increased supervisor burden on ED team in next round of job planning (including allocating time for the supervision of ACPs and PAs) | | UEC senior leadership team | December 26 | Red |

## 9. Departments under observation with multiple negative outliers

### Endocrinology and Diabetes

Trainee

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Post sp | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Endocrinology and diabetes mellitus | Overall Satisfaction | 61.67 | Q1 but not below | 49.17 | Q1 but not below | 56.67 | Below | 55 | Below |
| | Clinical Supervision | 72 | Q1 but not below | 67.08 | Below | 80 | Within IQR | 67.71 | Q1 but not below |
| | Clinical Supervision out of ho | 73.75 | Q1 but not below | 73.75 | Q1 but not below | 77.43 | Within IQR | 86.25 | Within IQR |
| | Reporting Systems | 62.5 | Within IQR | 68 | Within IQR | 65 | Within IQR | 48.33 | Q1 but not below |
| | Workload | 40.97 | Within IQR | 31.6 | Within IQR | 32.64 | Within IQR | 43.33 | Within IQR |
| | Teamwork | 61.11 | Q1 but not below | 76.39 | Within IQR | 70.84 | Within IQR | 58.33 | Below |
| | Handover | 72.5 | Within IQR | 59.58 | Within IQR | 62.5 | Within IQR | 60.94 | Within IQR |
| | Supportive Environment | 66.67 | Within IQR | 75 | Within IQR | 65.83 | Within IQR | 68 | Within IQR |
| | Induction | 67.5 | Within IQR | 61.67 | Below | 67.29 | Q1 but not below | 66 | Q1 but not below |
| | Adequate Experience | 68.75 | Within IQR | 52.08 | Q1 but not below | 62.5 | Within IQR | 57.5 | Below |
| | Educational Governance | 70.84 | Within IQR | 54.17 | Q1 but not below | 59.72 | Within IQR | 60 | Within IQR |
| | Educational Supervision | 79.17 | Within IQR | 80.21 | Q1 but not below | 79.17 | Q1 but not below | 70 | Below |
| | Feedback | 70.83 | Within IQR | 38.33 | Below | 46.25 | Q1 but not below | 51.25 | Below |
| | Local Teaching | 68.75 | Within IQR | 31.25 | Below | 65.42 | Within IQR | 70.55 | Within IQR |
| | Regional Teaching | 67.71 | Within IQR | 44.79 | Below | 70.83 | Within IQR | 62.5 | Within IQR |
| | Study Leave | 61.25 | Within IQR | 47.5 | Within IQR | 32.5 | Below | 46.88 | Within IQR |
| | Rota Design | 40.97 | Within IQR | 14.58 | Below | 36.46 | Below | 30 | Below |
| | Facilities | 70.5 | Within IQR | 57.08 | Within IQR | 53.75 | Within IQR | | N less than 3 |

Trainer

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Trainer | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Endocrinology and diabetes | Supportive Environment | | N less than 3 | | N less than 3 | 75 | Within IQR | 87.5 | In Q4 but not an above outlier |
| | Educational Governance | | N less than 3 | | N less than 3 | 78.13 | In Q4 but not an above outlier | 72.92 | Within IQR |
| | Professional Development | | N less than 3 | | N less than 3 | 71.88 | Within IQR | 75 | Within IQR |
| | Appraisal | | N less than 3 | | N less than 3 | 75 | Within IQR | 83.33 | Above |
| | Support for Training | | N less than 3 | | N less than 3 | 72.92 | Within IQR | 80.56 | Within IQR |
| | Time to Train | | N less than 3 | | N less than 3 | 72.92 | Within IQR | 77.78 | In Q4 but not an above outlier |
| | Rota Issues | | N less than 3 | | N less than 3 | 62.5 | Within IQR | 58.33 | Within IQR |
| | Handover | | N less than 3 | | N less than 3 | 81.25 | Above | 83.33 | Above |
| | Resources to Train | | N less than 3 | | N less than 3 | 75 | Within IQR | 75 | Within IQR |

The Education Lead provided the following comments/ action plan. I have asked for an update in December 2026.

**CONCERN 1:**
Clinical Supervision

Q1 but not below

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| We are now more proactive about supervisor allocation. I have done the allocation for trainees and trust doctors for current cohort and intend to do this for the upcoming ones. I am trying to ensure equitable distribution of the allocations in the team. In terms of quality of supervision, a detailed initial meeting would help understand the trainees' career aspirations, their views on the | A mid-rotation feedback meeting with resident doctors to see what has gone well and what more can be done to improve things going forward. | Dr SHA We have new consultants joining us who may wish to take over responsibility | 12 months | Amber |

| | | | | |
|---|---|---|---|---|
| challenges ahead and how they would think that their current training with us would contribute to their journey of leaning and training. A conversational meeting would help in this regard. Resident doctors will be introduced to the department secretaries and all the consultants and their specialised areas of interest in the department. We will encourage small scale quality improvement projects and/ or audits. The supervisors will work towards being good listeners and being approachable. Consultants should be given protected time in their job plan for supervision (ongoing discussion with management) | | | | |

**CONCERN 2:**
Reporting systems

Q1 but not below

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| We will encourage resident doctors to report any issues within training, the work culture etc. They will be encouraged to report anything that is positive, report their mistakes and celebrate their achievements to help us gather how much they have learned and what knowledge gaps. They will be signposted to use the DATIX system for reporting concerns and commendations. They will be encouraged to present cases in the Morbidity and Mortality meetings. | A mid-rotation feedback meeting with resident doctors to see what has gone well and what more can be done to improve things going forward. | All the Clinical Supervisors in the team | 12 Months | Red |

**CONCERN 4:**
Induction

Q1 but not below

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| Induction is done in the beginning of the year in August. A quarterly or 4 monthly inductions shared by the consultants over the year would help the incoming doctors understand their roles, responsibilities and know other team members. | A mid-rotation feedback meeting with resident doctors to see what has gone well and what more can be done to improve things going forward. | Induction historically provided by Service Lead Dr SN with the help of Dr MAN, team-based specialty doctor. We have new consultants joining us who may wish to contribute to the proposed quarterly induction | 12 months | Red |

**CONCERN 5:**
Adequate experience

**BELOW IQR**

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| Registrar trainees in Diabetes & Endocrinology have expressed dissatisfaction over the breadth of experience they are rostered to receive as service provision. They only see follow-ups in General Diabetes & General Endocrine clinics [and foot clinics]; they do not have mandated exposure to other subdomains like antenatal, pump, metabolic bone, bariatric, YPC. They do make an effort in supporting a | A mid-rotation feedback meeting with resident doctors to see what has gone well and what more can be done to improve things going forward. | All the Clinical Supervisors in the team | 12 months | Red |

| | | | | |
|---|---|---|---|---|
| few of these clinics as supernumerary.<br>Mandated Follow-up clinics are by telephone, and trainees have expressed dissatisfaction that they are not able to assess patients comprehensively by this route and likewise patients have reported dissatisfaction that they are not getting enough from their appointments.<br>Trainees would like to see and assess new patients. We have issues with clinic space; we are looking into this and see if a balance can be achieved.<br>We are encouraging trainees at all tiers of training to try and attend OP clinics when they are less busy on the wards.<br>Residents are being encouraged to accompany consultants during inpatient ward referrals to bolster the learning the specialty has to offer. | | | | |

**CONCERN 6:**
Educational supervision

**BELOW IQR**

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| We are now more proactive about supervisor allocation. I have done the allocation for trainees and trust doctors for current cohort and intend to do this for the upcoming ones. In terms of quality of supervision, a detailed initial meeting would help understand the trainees' career aspirations, their views on the challenges ahead and how they would think that their current training with us would contribute to their journey of learning and training. A | A mid-rotation feedback meeting with resident doctors to see what has gone well and what more can be done to improve things going forward. | All the Educational Supervisors in the team. Responsibility for supervisor allocation is Dr SHA. We have new consultants joining us who may wish to take over responsibility | 12 months | Red |

| | | | | |
|---|---|---|---|---|
| conversational meeting would help in this regard. Resident doctors will be introduced to the department secretaries and all the consultants and their specialized areas of interest in the department. We will encourage small scale quality improvement projects and/or audits. The supervisors will work towards being good listeners and being approachable | | | | |

**CONCERN 7:**
Feedback

**BELOW IQR**

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| A mid-rotation feedback meeting with resident doctors to see what has gone well and what more can be done to improve things going forward. Feedback can be formal or informal in the form of a chat in the office after a ward round or after discussing patient care etc. A time slot can be set aside on a one day in the week to discuss feedback. | A mid-rotation feedback meeting with resident doctors to see what has gone well and what more can be done to improve things going forward. | All the Clinical Supervisors in the team | 12 months | Red |

**CONCERN 8:**
Rota design

**BELOW IQR**

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| Rota can be designed weeks in advance so that trainees would know well in advance what ward/clinic commitments they are doing so that they | A mid-rotation feedback meeting with resident doctors to see what has gone well and what more | Dr MAN Speciality doctor, rota manager/leave co-ordinator | 12 months | Red |

| | | | | |
|---|---|---|---|---|
| can plan meetings, non-speciality clinics, taster days etc. Whilst every effort will be made to incorporate protected SPA & Clinical Admin times in the rota, patient safety is a priority, which is why we have to ensure that there is adequate cover for inpatients and outpatient clinics at the same time. We have fairly large bed base of inpatients, we also support Day2 patients in ED and do many OP clinics. The SPA time would cover activities such as audit, QIP, research, service development etc.<br>Trainees are advised to request leave with a 6-week notice period | can be done to improve things going forward. | for the resident doctors in the team. Overarching responsibility is that of the Service Lead Dr SN. Moving forward, we feel all consultants should contribute to improve the rota design. | | |

## Paediatrics

### Trainee

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Post sp | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Paediatrics | Overall Satisfaction | 85 | Within IQR | 82.65 | Within IQR | 75 | Within IQR | 80.45 | Within IQR |
| | Clinical Supervision | 92.87 | Within IQR | 94.19 | Within IQR | 90.75 | Within IQR | 95.68 | Within IQR |
| | Clinical Supervision out of ho | 91.67 | Within IQR | 94.14 | Above | 93.75 | Within IQR | 95.56 | Within IQR |
| | Reporting Systems | 83.67 | Within IQR | 76.54 | Within IQR | 73.5 | Within IQR | 77.22 | Within IQR |
| | Workload | 57.35 | Above | 51.1 | Within IQR | 49.81 | Within IQR | 54.55 | Within IQR |
| | Teamwork | 72.55 | Within IQR | 72.06 | Within IQR | 75.76 | Within IQR | 70.46 | Within IQR |
| | Handover | 76.3 | Within IQR | 83.07 | Within IQR | 74.43 | Within IQR | 72.71 | Within IQR |
| | Supportive Environment | 77.94 | Within IQR | 78.24 | Within IQR | 77.27 | Within IQR | 76.36 | Within IQR |
| | Induction | 75.88 | Within IQR | 86.18 | Within IQR | 89.09 | Within IQR | 86.36 | Within IQR |
| | Adequate Experience | 80.88 | Within IQR | 75 | Within IQR | 64.77 | Q1 but not below | 79.55 | Within IQR |
| | Educational Governance | 72.55 | Within IQR | 68.14 | Within IQR | 70.46 | Within IQR | 66.67 | Within IQR |
| | Educational Supervision | 84.19 | Within IQR | 84.93 | Within IQR | 82.95 | Within IQR | 86.36 | Within IQR |
| | Feedback | 62.12 | Within IQR | 46.97 | Within IQR | 53.19 | Q1 but not below | 57.81 | Q1 but not below |
| | Local Teaching | 71 | Within IQR | 63.78 | Within IQR | 56.67 | Within IQR | 55.83 | Below |
| | Regional Teaching | 57.78 | Within IQR | 55 | Within IQR | 48.86 | Within IQR | 46.25 | Within IQR |
| | Study Leave | 69.05 | Within IQR | 57.81 | Within IQR | 69.32 | Within IQR | 65 | Within IQR |
| | Rota Design | 62.5 | Within IQR | 58.59 | Within IQR | 56.82 | Within IQR | 46.59 | Below |
| | Facilities | 71.02 | Within IQR | 72.36 | Within IQR | 53 | Q1 but not below | 72 | Within IQR |

### Trainer

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Trainer | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Paediatrics | Supportive Environment | 65.91 | Within IQR | 64.77 | Within IQR | 61.36 | In Q1 but not a below outlier | 55 | In Q1 but not a below outlier |
| | Educational Governance | 53.6 | Within IQR | 51.14 | Within IQR | 46.53 | Below | 45.14 | Below |
| | Professional Development | 68.18 | Within IQR | 66.48 | Within IQR | 64.2 | Within IQR | 68.75 | Within IQR |
| | Appraisal | 56.82 | Within IQR | 65.91 | Within IQR | 62.5 | Within IQR | 67.5 | Within IQR |
| | Support for Training | 73.11 | Within IQR | 65.53 | Within IQR | 68.56 | Within IQR | 64.17 | Within IQR |
| | Time to Train | 47.73 | Within IQR | 55.3 | Within IQR | 57.58 | Within IQR | 57.5 | Within IQR |
| | Rota Issues | 25 | Within IQR | 22.5 | Below | 20 | Below | 12.5 | Below |
| | Handover | 80 | Above | 72.5 | Within IQR | 65 | Within IQR | 77.78 | Above |
| | Resources to Train | 70.45 | Within IQR | 68.18 | Within IQR | 63.64 | Within IQR | 67.5 | Within IQR |

The Education Lead provided the following comments/ action plan.

## CONCERN 1:

Rated as a negative outlier for rota design in the GMC trainee survey and rota issues in the GMC trainer survey 2026. Paediatrics at CoCH has fewer tier 1 and tier 2 doctors than national recommendations and peer units. Residents rotating from the deanery are usually less than the allocated placements. This has worsened now that a greater proportion of residents are working less than full time. Rota gaps are difficult to cover within local staffing, and external locums are difficult to find. Consultants are required to act down to cover shifts which are not covered.

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| -Recruitment of educational fellow working 50% education/50% acute shifts<br>-Rota management to be undertaken by business management team with clinician support, rather than fully undertaken by senior clinicians.<br>-Ongoing use of trust doctors to support tier 1 rota<br>-Twilight shift on tier 1 rota adjusted based on resident feedback<br>-Longer-term plans to integrate ANNP role onto tier 1 rota, this will improve tier 1 hour's/rota design. | -Number of vacant shifts covered by consultants<br>-Informal feedback from residents<br>-GMC survey 2027 | **VG** | Starting September 2026 | Amber |

## CONCERN 2:

GMC trainee survey 2026 rated local teaching as a negative outlier. It has been difficult to facilitate residents attending teaching due to rota gaps over the last 6—12 months

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| -Changes to staffing as above<br>-Trial of differing time slots to improve ability to attend<br>-Re-organisation of rotating programme to reflect | -Informal feedback from residents<br>-GMC survey 2027 | Dr KM | Ongoing | Amber |

| | | | | |
|---|---|---|---|---|
| progress+ curriculum and GP curriculum. | | | | |

## CONCERN 3:

Facilities assessed as a negative outlier in GMC survey 2025. We were previously in an old building with outdated facilities particularly lack of quiet desk space for resident doctor admin. We have now moved to a new building with improved facilities. The rating has improved from 53 to 72.

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| New building with purpose designed facilities | -Informal feedback from residents<br>-GMC survey 2027 | VG | Completed | Green |

## CONCERN 4:

Continued drop in ratings in the GMC Trainers survey 2026 particularly relating to supportive environment, educational governance and rota issues. These issues relate to broader hospital issues and are beyond the scope of our department to fix.

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| Previously raised at Medical Education Committee by AT and will be raised again. | GMC survey 2027 | **AT** | Ongoing | Red |

### Respiratory

Trainee

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Post sp | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Respiratory Medicine | Overall Satisfaction | 73.57 | Within IQR | 54.38 | Below | 66.82 | Within IQR | 71.43 | Within IQR |
| | Clinical Supervision | 81.61 | Within IQR | 78.13 | Below | 83.64 | Within IQR | 77.38 | Q1 but not below |
| | Clinical Supervision out of ho | 74.4 | Q1 but not below | 73.44 | Below | 76.25 | Within IQR | 77.5 | Q1 but not below |
| | Reporting Systems | 71.25 | Within IQR | 57.5 | Below | 71 | Within IQR | 71 | Within IQR |
| | Workload | 28.57 | Below | 31.51 | Within IQR | 38.45 | Within IQR | 39.88 | Within IQR |
| | Teamwork | 78.57 | Within IQR | 64.58 | Q1 but not below | 72.73 | Within IQR | 71.43 | Within IQR |
| | Handover | 57.81 | Within IQR | 38.75 | Below | 69.64 | Within IQR | 74.31 | Within IQR |
| | Supportive Environment | 70 | Within IQR | 61.25 | Within IQR | 72.27 | Within IQR | 67.86 | Within IQR |
| | Induction | 78.57 | Within IQR | 63.13 | Q1 but not below | 69.55 | Q1 but not below | 62.14 | Below |
| | Adequate Experience | 78.57 | Within IQR | 56.25 | Below | 61.36 | Below | 78.57 | Within IQR |
| | Educational Governance | 67.86 | Within IQR | 69.27 | Within IQR | 71.97 | Within IQR | 76.19 | Within IQR |
| | Educational Supervision | 85.71 | Within IQR | 74.22 | Q1 but not below | 82.39 | Within IQR | 76.79 | Q1 but not below |
| | Feedback | 77.5 | Within IQR | 47.4 | Q1 but not below | 57.03 | Q1 but not below | 60.63 | Below |
| | Local Teaching | 64.58 | Within IQR | 45.83 | Below | 61 | Within IQR | | N less than 3 |
| | Regional Teaching | 72.92 | Within IQR | 80.56 | Within IQR | 70.83 | Within IQR | | N less than 3 |
| | Study Leave | 45.31 | Within IQR | 27.5 | Below | 60.71 | Within IQR | 95.83 | Above |
| | Rota Design | 41.07 | Within IQR | 29.69 | Below | 37.5 | Within IQR | 35.71 | Q1 but not below |
| | Facilities | 70.89 | Within IQR | 69.75 | Within IQR | 65.5 | Within IQR | 65 | Within IQR |

Trainer

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Trainer | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Respiratory medicine | Supportive Environment | 66.67 | Within IQR | 65 | Within IQR | 58.33 | In Q1 but not a below outlier | 55 | In Q1 but not a below outlier |
| | Educational Governance | 55.56 | Within IQR | 56.77 | Within IQR | 48.61 | In Q1 but not a below outlier | 60 | Within IQR |
| | Professional Development | 77.08 | In Q4 but not a | 68.75 | Within IQR | 59.72 | In Q1 but not a below outlier | 64.58 | Within IQR |
| | Appraisal | 58.33 | Within IQR | 50 | Within IQR | 58.33 | Within IQR | 37.5 | Within IQR |
| | Support for Training | 69.44 | Within IQR | 73.33 | Within IQR | 63.89 | Within IQR | 70.83 | Within IQR |
| | Time to Train | 33.33 | In Q1 but not a | 28.33 | Below | 25 | Below | 46.67 | Within IQR |
| | Rota Issues | 41.67 | Within IQR | 35 | Within IQR | 41.67 | Within IQR | 20 | Below |
| | Handover | 50 | Within IQR | 50 | Within IQR | | N less than 3 | 43.75 | Below |
| | Resources to Train | 83.33 | In Q4 but not a | 75 | Within IQR | 58.33 | Within IQR | 55 | Within IQR |

The Lead Clinician provided the following comments/ action plan

## CONCERN 1: TRAINEE GMC SURVEY – 'INDUCTION' - BELOW IQR

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| Induction is comprised locally of:<br><br>- Trust induction<br><br>- Medical divisional induction<br><br>- Departmental induction (face to face)<br><br>- Departmental induction paperwork<br><br>Local department has no control over divisional and Trust Induction; but induction paperwork has been distributed, and face to face induction has been completed for all current trainees.<br><br>Paper copy of induction paperwork was delayed until start date of most recent rotation due to lack of trainee contact information given to local department by staffing.<br><br>Local face to face induction has been instituted since | Internal trainee survey data is taken each rotation with both qualitative and quantitative areas specifically covering induction.<br><br>To date no specific issues regarding quality of induction have been flagged locally. | Dr RC | December 26 | Amber |

| | | | | |
|---|---|---|---|---|
| last GMC survey and may take time to filter through into the results.<br><br>Otherwise, more information will be needed to improve quality in this area above the current setup | | | | |

## CONCERN 2: TRAINEE GMC SURVEY – 'FEEDBACK' – BELOW IQR

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| Feedback issues were assessed by trainees between; General medical on-calls and respiratory ward. The overall pattern from data given to dissect this fully at a local departmental level.<br><br>Based on internal monitoring of departmental trainee feedback however – concerns had been raised about 2 named supervisors<br><br>Due to concerns regarding specific supervisor's feedback which were noted in last rotation; departmental lead has had internal discussion with a named consultant who has taken feedback for this issue on board. A second consultant has reduced educational supervision of trainees PAs as a result of a related issue.<br><br>I will identify educational supervision training needs within department and recommend attendance at relevant courses. | Internal trainee survey data is taken each rotation, which will have ongoing monitoring and proactive steps taken if issues identified (as already enacted).<br><br>Audit of educational supervisor training within department | Dr RC | December 2026 | Amber |

## Requirement 3: TRAINEE GMC SURVEY – 'CLINICAL SUPERVISION IN HOURS– Q1, WITHIN IQR

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| In hours supervision is by named consultant on ward who attends ward twice/day.<br><br>Specific issue here is uncertain as degree of supervision/over-supervision can inhibit development of independent practise in Resident trainees.<br><br>Face to face induction meeting has clarified supervision arrangements.<br><br>Staff changes at named clinical supervisor level may alleviate some of the issue.<br><br>Ongoing lack of sufficient middle grade presence remains an issue that may be the actual root cause of the dissatisfaction reported. This has been escalated to Guardian of Safe Working, and at the regional STEC committee meeting for respiratory training. | Internal trainee survey data is taken each rotation to identify emerging trends in feedback.<br><br>Escalation of deanery middle grade provision to STEC committee regionally | Dr RC | August 2027 | Amber |

## Requirement 4: TRAINEE GMC SURVEY – 'CLINICAL SUPERVISION OUT OF HOURS HOURS– Q1, WITHIN IQR

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| Out of remit of local department.<br><br>If ongoing concerns and multi-departmental within division; will need escalation | | | | Red |

| | | | | |
|---|---|---|---|---|
| to divisional level for audit of out of hours supervision. | | | | |

### Requirement 5: TRAINEE GMC SURVEY – 'EDUCATIONAL SUPERVISION' – Q1, WITHIN IQR

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| Specific feedback identified 2 named supervisors within department regarding concerns.<br><br>One has dropped educational supervision role as a result; one has been fed-back issues by departmental lead and will be monitored within department regarding ongoing trainee satisfaction and concerns. Interim solution was found for named trainees in last rotation and contingency plan is in place if further issues for transfer of educational supervision. | Internal trainee survey data is taken each rotation to identify emerging trends in feedback. | Dr RC | August 2027 | Amber |

### Requirement 7: TRAINEE GMC SURVEY – 'ROTA DESIGN' – Q1, WITHIN IQR

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| Beyond remit of local department.<br>Divisional approach needed if pervasive issue across medicine. | | | | Red |

### Requirement 7: TRAINER GMC SURVEY – 'ROTA ISSUES' – BELOW IQR

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| Feedback from trainers - pervasive shortages in staff allocation relating to ability to run ward care safely, given expanded bed-base and intermittent LED support for additional bed-base.<br><br>Escalated at divisional level regarding patient safety and at STEC level with regards to specialty trainee allocations | | Dr RC | Open | Red |

### Requirement 8: TRAINER GMC SURVEY – 'HANDOVER' – BELOW IQR

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| Ward morning Board Round instituted following recent RIE to optimise respiratory flow.<br><br>Ongoing discussions with ward staff at departmental level to facilitate safe handover environment with MDT working on ward round | Board Round attendance now mandatory and attendance taken by ward manager | Mrs AC | Completed | Green |

### Requirement 9: TRAINER GMC SURVEY – 'SUPPORTIVE ENVIRONMENT – Q1 NOT BELOW IQR

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| Feedback from Trainer body – degree of supportive environment for training limited by low staff allocations and poor continuity of care, and low productivity by resident medical staff due to combination of on-call commitments and stretched human capital | | Dr RC | Open | Red |

| | | | | |
|---|---|---|---|---|
| Escalations as previous. | | | | |

## 10. Departments with at least one result in lower quartile (in alphabetical order)

### 1, Acute Internal Medicine

Trainee

| Post sp | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
|---|---|---|---|---|---|---|---|---|---|
| Acute Internal Medicine | Overall Satisfaction | 78.75 | Within IQR | 70 | Within IQR | 65.83 | Within IQR | 77.5 | Within IQR |
| | Clinical Supervision | 92.5 | Within IQR | 84.29 | Within IQR | 86.46 | Within IQR | 76.04 | Q1 but not below |
| | Clinical Supervision out of ho | 87.5 | Within IQR | 80.65 | Within IQR | 88.75 | Within IQR | 83.33 | Within IQR |
| | Reporting Systems | 83.75 | Above | 48 | Below | 59 | Q1 but not below | 80 | Within IQR |
| | Workload | 52.61 | Within IQR | 41.37 | Within IQR | 30.21 | Below | 42.19 | Within IQR |
| | Teamwork | 83.33 | Q4 but not above | 61.91 | Below | 69.45 | Within IQR | 83.33 | Q4 but not above |
| | Handover | 64.58 | Within IQR | 50 | Below | 55.9 | Q1 but not below | 73.44 | Within IQR |
| | Supportive Environment | 92.5 | Above | 63.57 | Within IQR | 74.17 | Within IQR | 80 | Within IQR |
| | Induction | 77.5 | Within IQR | 62.86 | Q1 but not below | 51.67 | Below | 71.25 | Within IQR |
| | Adequate Experience | 90.63 | Above | 57.14 | Below | 60.42 | Q1 but not below | 75 | Within IQR |
| | Educational Governance | 72.92 | Within IQR | 60.72 | Within IQR | 66.67 | Within IQR | 77.08 | Within IQR |
| | Educational Supervision | 98.44 | Within IQR | 87.5 | Within IQR | 88.54 | Within IQR | 81.25 | Within IQR |
| | Feedback | 91.67 | Within IQR | 48.33 | Q1 but not below | 71.67 | Within IQR | | N less than 3 |
| | Local Teaching | 65.42 | Within IQR | 48.33 | Q1 but not below | 59.66 | Within IQR | 45.83 | Q1 but not below |
| | Regional Teaching | 70.83 | Within IQR | 63.09 | Within IQR | 67.5 | Within IQR | 70.83 | Within IQR |
| | Study Leave | 63.54 | Within IQR | 51.79 | Within IQR | 64.58 | Within IQR | 31.25 | Below |
| | Rota Design | 62.5 | Within IQR | 32.14 | Below | 39.58 | Within IQR | 53.13 | Within IQR |
| | Facilities | 80.83 | Above | 47.75 | Q1 but not below | 55.25 | Within IQR | 66.88 | Within IQR |

Trainer

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Trainer | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Acute Internal Medicine | Supportive Environment | 68.75 | Within IQR | 52.5 | In Q1 but not a below outlier | 65.63 | Within IQR | 55 | Below |
| | Educational Governance | 65.63 | Within IQR | 47.5 | In Q1 but not a below outlier | 60.94 | Within IQR | 52.08 | Within IQR |
| | Professional Development | 65.63 | Within IQR | 67.5 | Within IQR | 64.06 | Within IQR | 60 | Below |
| | Appraisal | 62.5 | Within IQR | 50 | Within IQR | 53.13 | Within IQR | 37.5 | Within IQR |
| | Support for Training | 68.75 | Within IQR | 62.5 | Within IQR | 71.88 | Within IQR | 65 | Within IQR |
| | Time to Train | 60.42 | Within IQR | 48.33 | Within IQR | 54.17 | Within IQR | 55 | Within IQR |
| | Rota Issues | 50 | Within IQR | 35 | Within IQR | 31.25 | Within IQR | 15 | Below |
| | Handover | 56.25 | Within IQR | 60 | Within IQR | 56.25 | Within IQR | 65 | Within IQR |
| | Resources to Train | 75 | Within IQR | 70 | Within IQR | 50 | Within IQR | 55 | Within IQR |

The Clinical Lead provided comments and following action plan.

**CONCERN 1:**

GMC Survey Outcome for Department
Trainee outcomes: Clinical supervision (pink), Local teaching (pink), Study leave (red)
Trainer outcomes: Supportive environment (red), Professional development (red), rota issues (red)

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| Clinical Supervision – all resident doctors & ACPs are allocated a clinical supervisor when they rotate to the department which is shared with them during their local induction. I am not aware of any difficulties | This will be monitored by means of the GMC survey – we have previous been seeking feedback from resident | Clinical Lead for AIM | 12 months | Amber |

| | | | | |
|---|---|---|---|---|
| during the last 12 months where a resident doctor has not been able to meet with their CS. The day-to-day clinical supervision is performed by the consultants allocated to the patient areas, in which the resident doctor will have done the ward round with them or be informed at medical handover of the contact details for the on-call consultants covering ED/SDEC. | doctors who have rotated from department which is being centralised. One of the questions was to rate the quality of clinical supervision and to rate your clinical supervisor (out of 10) anonymously. Clinical supervision was 8.3/10 and Clinical supervisors were rated as 9.5/10. | | | |
| Local teaching – we offer a weekly peer-led teaching session which is rostered among the resident doctors occurring at Monday lunchtime. There has been a decrease in the number of teaching sessions done due to sickness/annual leave of the resident doctors. Reminders of the timetable have been sent out to them with no improvement in the sessions. We have recently appointed a consultant who is interested in medical education. The aim is for them to become the education lead for the department with a redesign of the weekly teaching offer in the department. | This will be monitored by the GMC survey and from feedback of AMU departmental teaching. | Clinical Lead for AIM/ AMU Education lead when in post | 12 months | Amber |
| Study leave – Study leave is approved depending on the number of resident doctors, time of notice given and if a locum is required/available. Over the last 12 months there has been a high number of vacancies/gaps which have not been covered by the medical staffing department. This has made it difficult to pre-approve a number of study leave requests. | There has been an improvement in the number of vacancies/gaps over the last few months and the Trust has recently switched rostering software which will hopefully make approving study leave easier. | Clinical Lead for AIM | 12 months | Amber |
| Supportive environment/professional development/rota issues – as a consequence of increased | We are currently in the process of recruiting additional | Clinical Lead for AIM/ AMU Education lead when in post | 12 months | Amber |

| | | | | |
|---|---|---|---|---|
| clinical activity/patient numbers/escalation procedures/medical staffing gaps/external agency improvements (GIFRT) – it has led to a reduction in clinical teaching due to a pressure of seeing patients within target times. | consultants to Acute Medicine with an intension for one of the appointed consultants (due to start Nov 2026) to be the educational lead for the department | | | |

## 2, Cardiology

Trainee

| Post sp | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
|---|---|---|---|---|---|---|---|---|---|
| Cardiology | Overall Satisfaction | 77.86 | Within IQR | 60 | Q1 but not below | 83.75 | Within IQR | 73.75 | Within IQR |
| | Clinical Supervision | 89.29 | Within IQR | 77.92 | Q1 but not below | 95 | Within IQR | 85.42 | Within IQR |
| | Clinical Supervision out of ho | 72.32 | Below | 60.42 | Q1 but not below | 90.63 | Within IQR | 80 | Within IQR |
| | Reporting Systems | 62.5 | Within IQR | 55 | Q1 but not below | 82.5 | Q4 but not above | 61.67 | Within IQR |
| | Workload | 31.25 | Within IQR | 39.58 | Within IQR | 39.06 | Within IQR | 61.98 | Q4 but not above |
| | Teamwork | 70.24 | Within IQR | 58.33 | Q1 but not below | 87.5 | Q4 but not above | 77.09 | Within IQR |
| | Handover | 52.08 | Q1 but not below | 41.67 | Below | 75 | Within IQR | 62.5 | Within IQR |
| | Supportive Environment | 67.14 | Within IQR | 66.67 | Within IQR | 82.5 | Within IQR | 65 | Within IQR |
| | Induction | 62.86 | Q1 but not below | 60 | Below | 83.75 | Within IQR | 55 | Below |
| | Adequate Experience | 78.57 | Within IQR | 75 | Within IQR | 81.25 | Within IQR | 81.25 | Within IQR |
| | Educational Governance | 69.05 | Within IQR | 61.11 | Within IQR | 58.34 | Within IQR | 56.25 | Q1 but not below |
| | Educational Supervision | 85.71 | Within IQR | 68.75 | Q1 but not below | 82.81 | Within IQR | 76.56 | Below |
| | Feedback | 54.17 | Within IQR | | N less than 3 | 86.25 | Within IQR | 71.67 | Within IQR |
| | Local Teaching | 52 | Q1 but not below | 63.89 | Within IQR | 82.5 | Within IQR | 68.89 | Within IQR |
| | Regional Teaching | 60.83 | Within IQR | 50 | Within IQR | 83.33 | Above | 69.44 | Within IQR |
| | Study Leave | 37.15 | Q1 but not below | 33.33 | Below | 68.75 | Within IQR | 41.67 | Within IQR |
| | Rota Design | 35.71 | Within IQR | 27.08 | Q1 but not below | 57.81 | Within IQR | 56.25 | Within IQR |
| | Facilities | 51.5 | Within IQR | | N less than 3 | 63.33 | Within IQR | 63.33 | Within IQR |

Trainer

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Trainer | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Cardiology | Supportive Environment | 72.92 | Within IQR | 68.75 | Within IQR | 59.38 | In Q1 but not a below outlier | 72.5 | Within IQR |
| | Educational Governance | 60.94 | Within IQR | 56.25 | Within IQR | 54.69 | Within IQR | 50.42 | Within IQR |
| | Professional Development | 62.5 | Within IQR | 56.25 | In Q1 but not a below outlier | 62.5 | Within IQR | 56.25 | Below |
| | Appraisal | 53.13 | Within IQR | 46.88 | Within IQR | 37.5 | Within IQR | 57.5 | Within IQR |
| | Support for Training | 61.46 | Within IQR | 58.33 | Within IQR | 58.33 | In Q1 but not a below outlier | 57.5 | In Q1 but not a below outlier |
| | Time to Train | 27.09 | Below | 45.84 | Within IQR | 64.58 | Within IQR | 35 | In Q1 but not a below outlier |
| | Rota Issues | 50 | Within IQR | 50 | Within IQR | 62.5 | Within IQR | 55 | Within IQR |
| | Handover | 37.5 | Below | 50 | Within IQR | 37.5 | Below | 37.5 | Below |
| | Resources to Train | 56.25 | Within IQR | 50 | Within IQR | 62.5 | Within IQR | 55 | Within IQR |

The Clinical and Education Leads have provided the following comments and action plan.

### CONCERN 1:

Induction (Cardiology – Trainee)

Flagged on GMC survey in 2026 as “below”. It is not clear if this refers to Cardiology or Trust induction which limits ability to interpret result. However, we send an internal survey to all trainees at the end of placement. From 7 responses this year 6 report receiving an induction to Cardiology. The 7th only received the rota.

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| I am meeting with the new trainees next week (almost all of them were timetabled on call for the first week of the placement). We will continue to send the internal survey. | Internal survey. | Dr JR and NC | Ongoing | Green |

**CONCERN 2:**

Educational Supervision (Cardiology – Trainee)

Flagged on GMC survey in 2026 as "below". I am not sure how to address this. All of the trainees are allocated an educational supervisor when they rotate (co-ordinated by Dr Redfern). We ensure that the supervisors repeatedly support the same level of trainee (so they learn the requirements and expected level). To my knowledge all of the meetings happen. We collate internal data form our own survey and the feedback was unanimously excellent. All trainees said they received constructive feedback, felt valued as a team member and all commented on how supportive the consultant body is as a team.

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| I will feedback the concerns to the consultant body. I don't believe there is anything else specifically to change without more detail of the concerns. | Ongoing GMC and internal survey. | Dr JR and NC | 1 year | Amber |

**CONCERN 3:**

Professional Development (Cardiology – Trainee)

Flagged on GMC survey in 2026 as "below". This refers to opportunities available to the consultant body to develop their educational skills. I will feed this back to the team. Local and regional educational opportunities are circulated regularly by the Medical Education Team. Over the past year these have included compassionate leadership, Clinical/Educational Supervisor updates and various other opportunities.

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| I will feedback the concerns to the consultant body and | GMC survey. Feedback from | Dr JR | 1 year | Amber |

| | | | | |
|---|---|---|---|---|
| enquire about what additional support they would like. | consultant meeting. | | | |

## CONCERN 4:

Handover (Cardiology – Trainer)

Flagged on GMC survey in 2026 as “below”. I do not understand this result. Is it referring to handover with the cardiology department clinically, or handover of educational supervision from 1 supervisor to the next? I don’t believe that any of the Cardiologists have any concern with either. I will raise at the Cardiology meeting.

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| No plans to make changes. I will discuss at consultant meeting to ensure there are no concerns. | GMC Survey | Dr JR | 1 year | Green |

## 3, Care of the Elderly

### Trainee

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Post sp | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Geriatric medicine | Overall Satisfaction | 80.63 | Within IQR | 74.5 | Within IQR | 64.44 | Below | 74.29 | Within IQR |
| | Clinical Supervision | 82.66 | Within IQR | 85.63 | Within IQR | 82.08 | Within IQR | 85.42 | Within IQR |
| | Clinical Supervision out of ho | 79.95 | Within IQR | 80.09 | Within IQR | 76.3 | Within IQR | 73.33 | Below |
| | Reporting Systems | 70.71 | Within IQR | 65.63 | Within IQR | 70 | Within IQR | 66 | Within IQR |
| | Workload | 42.97 | Within IQR | 40.42 | Within IQR | 30.56 | Below | 50 | Within IQR |
| | Teamwork | 78.13 | Within IQR | 70 | Within IQR | 73.15 | Within IQR | 70.24 | Within IQR |
| | Handover | 57.81 | Within IQR | 53.13 | Q1 but not below | 59.38 | Within IQR | 75 | Within IQR |
| | Supportive Environment | 74.38 | Within IQR | 66 | Within IQR | 68.89 | Within IQR | 67.86 | Within IQR |
| | Induction | 78.28 | Within IQR | 74.63 | Within IQR | 71.81 | Within IQR | 78.39 | Within IQR |
| | Adequate Experience | 78.13 | Within IQR | 67.5 | Within IQR | 66.67 | Within IQR | 75 | Within IQR |
| | Educational Governance | 75 | Within IQR | 73.33 | Within IQR | 69.45 | Within IQR | 60.72 | Within IQR |
| | Educational Supervision | 89.84 | Within IQR | 91.25 | Within IQR | 86.11 | Within IQR | 84.82 | Within IQR |
| | Feedback | 72.92 | Within IQR | 70.83 | Within IQR | 50.78 | Below | 74.5 | Within IQR |
| | Local Teaching | 70.42 | Within IQR | 72.5 | Within IQR | 63.61 | Within IQR | 75.67 | Within IQR |
| | Regional Teaching | 60.42 | Within IQR | 76.39 | Within IQR | 62.5 | Within IQR | 53.33 | Within IQR |
| | Study Leave | 55.73 | Within IQR | 91.67 | Above | 72.92 | Within IQR | 90 | Above |
| | Rota Design | 66.41 | Within IQR | 61.88 | Within IQR | 56.94 | Within IQR | 54.46 | Within IQR |
| | Facilities | 73.13 | Within IQR | 70.75 | Within IQR | 57.03 | Within IQR | 75 | Within IQR |

### Trainer

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Trainer | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Geriatric medicine | Supportive Environment | 60 | Within IQR | 65.28 | Within IQR | 70 | Within IQR | 66.67 | Within IQR |
| | Educational Governance | 54.58 | Within IQR | 60.42 | Within IQR | 53.33 | Within IQR | 58.33 | Within IQR |
| | Professional Development | 57.5 | In Q1 but not a | 60.42 | Below | 66.25 | Within IQR | 67.71 | Within IQR |
| | Appraisal | 52.5 | Within IQR | 68.06 | Within IQR | 60 | Within IQR | 66.67 | Within IQR |
| | Support for Training | 63.33 | Within IQR | 66.2 | Within IQR | 68.33 | Within IQR | 70.14 | Within IQR |
| | Time to Train | 35.83 | Below | 33.33 | Below | 51.67 | Within IQR | 54.17 | Within IQR |
| | Rota Issues | 35 | Within IQR | 44.44 | Within IQR | 25 | Within IQR | 20.83 | Below |
| | Handover | 45 | Below | 50 | Within IQR | 50 | Within IQR | 60 | Within IQR |
| | Resources to Train | 70 | Within IQR | 58.33 | Within IQR | 60 | Within IQR | 62.5 | Within IQR |

The Educational Lead provided the following comments/ action plan.

## CONCERN 1:

GMC National training survey report for Care of the elderly department 2026 shows a score in bottom quartile for clinical supervision out of hours. The Care of the elderly department at the Countess of Chester hospital is a predominantly weekday (09:00–17:00) specialty. Out-of-hours work is undertaken via the General Internal Medicine (GIM) rota rather than within the COTE department.

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| Discuss findings with GIM and Medical Education leads to determine whether similar themes are present across the GIM rota and ensure any recurrent concerns are addressed. | Feedback reviewed jointly and any GIM-wide actions identified. | COTE Education Lead / Medical postgraduate team | Within 3 months | Amber |
| To ensure clarity of whether trainee feedback relates to COTE placement or GIM on-call experience, COTE department will continue departmental trainee feedback at end of placement, including a specific question distinguishing daytime COTE supervision from GIM on-call supervision. | Local feedback to be undertaken and reviewed at end of every rotation. | COTE Education Lead | Ongoing every 4 months rolling review | Amber |
| Maintain high-quality supervision | Local feedback to be undertaken and reviewed at | All COTE consultants | Ongoing every 4 months rolling review | Amber |

| | | | | |
|---|---|---|---|---|
| within areas under COTE control. Continue consultant led ward rounds, accessible senior advice, educational supervision and trainee induction, including clarification of escalation pathways during on-call duties. | end of every rotation. Review of annual GMC training survey. | | | |

## 4, Dermatology

Trainer

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Trainer | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Dermatology | Supportive Environment | 58.33 | Within IQR | 75 | Within IQR | 54.17 | In Q1 but not a below outlier | 54.17 | In Q1 but not a below outlier |
| | Educational Governance | 60.42 | Within IQR | 52.78 | Within IQR | 62.5 | Within IQR | 54.86 | Within IQR |
| | Professional Development | 77.08 | In Q4 but not a | 70.83 | Within IQR | 77.08 | Within IQR | 83.33 | Above |
| | Appraisal | 75 | Within IQR | 70.83 | Within IQR | 50 | Within IQR | 25 | Within IQR |
| | Support for Training | 79.17 | Within IQR | 70.83 | Within IQR | 70.83 | Within IQR | 75 | Within IQR |
| | Time to Train | 48.61 | Within IQR | 38.89 | In Q1 but not a below outlier | 45.83 | Within IQR | 47.22 | Within IQR |
| | Rota Issues | | N less than 3 | | N less than 3 | | | | N less than 3 |
| | Resources to Train | 83.33 | In Q4 but not a | 58.33 | Within IQR | 66.67 | Within IQR | 75 | Within IQR |

The Clinical Lead provided the following comments/ action plan.

**CONCERN 1:**
Supportive environment score 54.17 (pink)

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| It is difficult to know how to interpret this score without some detail pertaining to the context. This trainee has also scored us highly for “support for training” and “professional development” which indicates that the | We support all our trainees by being open, friendly and encouraging whilst challenging them to develop their professional/clinical skills in order to become confident and highly trained drs. I believe the environment is very supportive, but I am happy to have detailed | Dr AJ as Educational Supervisor | 12 months | Amber |

| | | | | |
|---|---|---|---|---|
| environment is supportive enough to attain high scores in these other questions. Hence, I am unsure as to how to address the issue without understanding the specific problem that resulted in the low score. | constructive feedback in order to improve our educational delivery. | | | |

## 5, Intensive Care Medicine

Trainee

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Post sp | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Intensive care medicine | Overall Satisfaction | 83.33 | Within IQR | 94.17 | Within IQR | 85.63 | Within IQR | 86.67 | Within IQR |
| | Clinical Supervision | 95.83 | Within IQR | 95.83 | Within IQR | 90.63 | Within IQR | 96.53 | Within IQR |
| | Clinical Supervision out of ho | 94.79 | Within IQR | 94.79 | Within IQR | 92.19 | Within IQR | 98.13 | Within IQR |
| | Reporting Systems | 81.25 | Within IQR | 76.67 | Within IQR | 80 | Within IQR | 80 | Within IQR |
| | Workload | 60.42 | Within IQR | 63.54 | Within IQR | 63.28 | Within IQR | 62.5 | Within IQR |
| | Teamwork | 77.78 | Within IQR | 76.39 | Within IQR | 72.92 | Within IQR | 81.95 | Within IQR |
| | Handover | 78.82 | Within IQR | 83.75 | Within IQR | 90.63 | Above | 88.33 | Above |
| | Supportive Environment | 76.67 | Within IQR | 88.33 | Within IQR | 81.88 | Within IQR | 90 | Within IQR |
| | Induction | 85 | Within IQR | 95 | Within IQR | 98.75 | Within IQR | 86.67 | Within IQR |
| | Adequate Experience | 81.25 | Within IQR | 100 | Within IQR | 85.94 | Within IQR | 79.17 | Within IQR |
| | Educational Governance | 61.11 | Q1 but not below | 76.39 | Within IQR | 75 | Within IQR | 76.39 | Within IQR |
| | Educational Supervision | 89.58 | Within IQR | 85.42 | Within IQR | 94.53 | Within IQR | 91.67 | Within IQR |
| | Feedback | 56.67 | Q1 but not below | 80.56 | Within IQR | 83.57 | Within IQR | | N less than 3 |
| | Local Teaching | 65.33 | Within IQR | 83.33 | Within IQR | 84.72 | Within IQR | 60.67 | Q1 but not below |
| | Regional Teaching | 67.5 | Within IQR | 60 | Within IQR | 77.08 | Q4 but not above | 50.83 | Within IQR |
| | Study Leave | 80.21 | Within IQR | 93.75 | Within IQR | 89.06 | Within IQR | 68.75 | Q1 but not below |
| | Rota Design | 72.92 | Within IQR | 91.67 | Above | 85.94 | Within IQR | 80.21 | Within IQR |
| | Facilities | 65.42 | Within IQR | | N less than 3 | 67.32 | Within IQR | 65.83 | Within IQR |

The Education Lead provided the following comments/ action plan.

### CONCERN 1: LOCAL TEACHING

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| Local teaching was altered 2025-2026 to fewer but longer sessions with more topics planned for dates where more residents available to | Topic list and teaching dates produced and disseminated to residents. Plan to review number of sessions delivered and survey for feedback on | RG (CICM tutor) | In place now | Green |

| | | | | |
|---|---|---|---|---|
| attend. Verbal feedback was very good, but score dropped in GMC survey. Discussion amongst consultant body and agreement to trial weekly teaching on Friday from Consultant on call for ICU. | teaching every 3 months | | | |

**CONCERN 2: STUDY LEAVE**

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| Difficult to know what the issue is as the residents have a request rota where the rota is built around their requests for years. Discussion with rota lead and secretary and NO study leave request has been declined in last year. All requests written into rota or facilitated. Questionnaire sent to previous residents asking if they had any problem taking study leave while on ICU- 6 responses received and no issues with taking study leave reported. | Same system in place as for previous 3 years where no issues were raised so continuing with request rota. Will include a question on post feedback questionnaire asking if the resident had any difficulty in taking study leave. | RG (CICM tutor) | In place now | Green |

## 6, Obstetrics and Gynaecology

Trainer

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Trainer | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Obstetrics and gynaecology | Supportive Environment | 66.67 | Within IQR | 50 | In Q1 but not a below outlier | 66.07 | Within IQR | 60.71 | In Q1 but not a below outlier |
| | Educational Governance | 52.08 | Within IQR | 41.25 | Below | 61.9 | Within IQR | 64.58 | Within IQR |
| | Professional Development | 69.79 | Within IQR | 70 | Within IQR | 61.61 | Below | 74.11 | Within IQR |
| | Appraisal | 47.92 | Within IQR | 30 | Within IQR | 55.36 | Within IQR | 69.64 | Within IQR |
| | Support for Training | 62.5 | Within IQR | 66.67 | Within IQR | 66.67 | Within IQR | 75 | Within IQR |
| | Time to Train | 63.89 | Within IQR | 50 | Within IQR | 66.67 | Within IQR | 66.67 | Within IQR |
| | Rota Issues | 33.33 | Within IQR | 20 | Below | 28.57 | Within IQR | 17.86 | Below |
| | Handover | 79.17 | Above | 70 | Within IQR | 60.71 | Within IQR | 78.57 | Above |
| | Resources to Train | 66.67 | Within IQR | 55 | Within IQR | 67.86 | Within IQR | 78.57 | Above |

The Education Lead provided the following comments/ action plan.

### CONCERN 1:

### ROTA ISSUES IN TRAINER SURVEY

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| Team consulted as to what the specific issues were. Frequent rota gaps at registrar and SHO level requiring acting down from consultant team. This is an ongoing and worsening problem due to LTFT resident doctor rotas and rota templates not allowing flexibility within their work patterns as well as increasing numbers of resident doctors not able to contribute to out of hours workload leaving long term gaps. Consultants becoming burnout from gaps within own team as well as at every level. Can impact the ability to provide good training. This is | This needs a nationally driven workforce plan and is an issue throughout the region.<br><br>Consultant rota gaps filled although remains one gap through sickness currently. Therefore, the impact of this should lessen but work with the rota team to try to be more proactive and less last minute in order to plan essential workload better. Aim to review in 3/12 | Not able to solve at trust level | VF/SB | Red |

| | | | | |
|---|---|---|---|---|
| recognised nationally.<br><br>Last minute changes to job plans to cover emergency/essential aspects of role. Has been as a result of consultant gaps. Removing teaching opportunities from specialist sessions and lessening job satisfaction for trainers. | | | | |
| Clinical sessions leave little time to teach/allow development particularly operating. Lists very full and have to be managed very tightly to avoid overruns and cancellations. | Balance of service due to current gynae position. Consultants need to manage their lists in order to try and get the balance right. | VF | | Red |

## 7, Ophthalmology

Trainer

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Trainer | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Ophthalmology | Supportive Environment | 52.78 | In Q1 but not a below ou | | N less than 3 | | N less than 3 | 58.33 | In Q1 but not a below outlier |
| | Educational Governance | | N less than 3 | | N less than 3 | | N less than 3 | 64.58 | Within IQR |
| | Professional Development | 62.5 | Within IQR | | N less than 3 | | N less than 3 | 75 | Within IQR |
| | Appraisal | 0 | Within IQR | | N less than 3 | | N less than 3 | 79.17 | Above |
| | Support for Training | 66.67 | Within IQR | | N less than 3 | | N less than 3 | 72.22 | Within IQR |
| | Time to Train | 41.67 | In Q1 but not a below ou | | N less than 3 | | N less than 3 | 22.22 | Below |
| | Rota Issues | 58.33 | Within IQR | | N less than 3 | | N less than 3 | 25 | Within IQR |
| | Handover | | N less than 3 | | N less than 3 | | N less than 3 | | N less than 3 |
| | Resources to Train | 75 | Within IQR | | N less than 3 | | N less than 3 | 75 | Within IQR |

The Education lead provided the following comments. An action plan was not necessary as Ophthalmology are a small department with only trainer feedback.

### CONCERN 1:

Feedback from resident doctors is excellent with no concerns.
We had 2 areas of concern raised by trainers
Supportive environment
Time to train

I have reached out to our consultant body to receive feedback regarding concerns as without knowing where the issue is and within which clinics I cannot comment on ways to improve.

I have had very minimal responses from my colleagues regarding concerns. We are a small département with low numbers of responses. (only 3 people completed the feedback survey)

Our first poor response - Supportive environment – the first question is 100% agree just not strongly agree
The second question one person has strongly disagreed however without comment or feedback from that colleague I cannot formulate an action plan

With regards to the second issue – Time to train - we have very limited time within job plans to train and this has been reduced even further recently with the latest job planning exercise. Just 0.125Pas for a named clinical supervisor and 0.125 for an educational supervisor which requires paperwork and a very complex new portfolio to complete which takes significantly more time before even including time to teach and train. We get no time within our job plans for other clinical supervision at all. With relation to the educational supervision question, we have only had 2 responses as the other response to make it up to 3 is not an educational supervisor.
Our time as with everyone's always interrupted when trying to teach and support residents. This is not a new issue.

If you still need me to complete the table below, please let me know, however it is difficult to create an action plan when it is not clear what the issue is (1st question) and we are not going to be allocated any more PA time for supervision and there will always be extreme demand on out time as clinicians.

## 8, Orthopaedics

Trainer

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Trainer | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Trauma and orthopaedic surgery | Supportive Environment | 46.87 | In Q1 but not a | 48.44 | In Q1 but not a below outlier | 62.5 | Within IQR | 51.79 | Below |
| | Educational Governance | 37.76 | Below | 45.54 | In Q1 but not a below outlier | 48.21 | In Q1 but not a below outlier | 37.2 | Below |
| | Professional Development | 52.34 | Below | 63.8 | Within IQR | 66.41 | Within IQR | 67.26 | Within IQR |
| | Appraisal | 43.75 | Within IQR | 56.25 | Within IQR | 60.94 | Within IQR | 66.07 | Within IQR |
| | Support for Training | 37.5 | Below | 51.56 | Below | 56.25 | Below | 60.12 | Below |
| | Time to Train | 55.73 | Within IQR | 45.31 | Within IQR | 60.94 | Within IQR | 52.38 | Within IQR |
| | Rota Issues | 28.13 | Within IQR | 28.13 | Within IQR | 40.63 | Within IQR | 21.43 | Below |
| | Handover | 78.13 | Above | 78.13 | In Q4 but not an above outlier | 75 | Within IQR | 71.43 | Within IQR |
| | Resources to Train | 37.5 | Below | 53.13 | Within IQR | 62.5 | Within IQR | 71.43 | Within IQR |

There is no action plan for orthopaedics but the educational lead provided the following comments. A plan to review the processes of allocation of resident doctors to outpatient clinics will be taken by the Clinical Lead, DME and AMD as a result of this feedback.

The main issue we have is with STRs in outpatients.
There is clear guidance from COPMED regarding this, which I have highlighted several times over the years in our departmental meetings.

Link to document here: Drs_in_training_and_clinical_supervision_at_out-patient_clinics.pdf

In essence STRs in their early years should not be seeing patients on their own in OPD & that the responsible Consultant should be present.
As they progress in experience, they may see patients themselves, but a responsible Consultant still needs to able should be able to attend & supervise if required.
Before patients are allocated to an STR to see in clinic their competence should be assessed and agreed in their portfolio. This is in line with the MCR/CiPs which look specifically at the trainee's competence in different domains, including OPDs.

In T&O it has been & remains standard practice to allocate patients to registrar streams regardless of their stage of training.
I do not believe this is in line with best practice as outlined above, but despite raising this, the practice continues.

I & our department would welcome a comparison of our T&O OPD streams and throughput with other surgical specialties - my suspicion is that T&O STRs are being used for service and not given the opportunities for training in OPD.

The second issue I wished to highlight was the introduction of an increasing number of medical students in OPD. Whilst we welcome their presence, we are keen to be able to deliver high-quality training for them as well. We have not seen any accommodation in terms of time or numbers in OPD to allow us to deliver this.

We also don't have enough Educational Supervisor provision which I will discuss expanding at our next STEC meeting in November.

## 9, Vascular

Trainee

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Post sp | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Vascular surgery | Overall Satisfaction | 87.5 | Within IQR | 90 | Within IQR | 70 | Within IQR | 76 | Within IQR |
| | Clinical Supervision | 95 | Within IQR | 91 | Within IQR | 91.25 | Within IQR | 92.5 | Within IQR |
| | Clinical Supervision out of ho | 90.63 | Within IQR | 85 | Within IQR | 87.5 | Within IQR | 90 | Within IQR |
| | Reporting Systems | 77.5 | Within IQR | 85 | Above | 47.5 | Q1 but not below | 80 | Within IQR |
| | Workload | 48.96 | Within IQR | 51.25 | Within IQR | 47.4 | Within IQR | 55 | Within IQR |
| | Teamwork | 79.17 | Within IQR | 83.33 | Q4 but not above | 60.42 | Within IQR | 76.67 | Within IQR |
| | Handover | 88.89 | Q4 but not above | 89.58 | Above | 64.58 | Within IQR | 58.33 | Within IQR |
| | Supportive Environment | 72.5 | Within IQR | 85 | Within IQR | 57.5 | Within IQR | 82 | Within IQR |
| | Induction | 75 | Within IQR | 85.25 | Within IQR | 66.25 | Within IQR | 73 | Within IQR |
| | Adequate Experience | 90.63 | Within IQR | 85 | Within IQR | 65.63 | Within IQR | 70 | Within IQR |
| | Educational Governance | 81.25 | Within IQR | 80 | Within IQR | 54.17 | Q1 but not below | 63.33 | Within IQR |
| | Educational Supervision | 84.38 | Within IQR | 92.5 | Within IQR | 79.69 | Below | 77.5 | Q1 but not below |
| | Feedback | | N less than 3 | 90.63 | Within IQR | 81.25 | Within IQR | 70.94 | Within IQR |
| | Local Teaching | 82.78 | Within IQR | 72.22 | Within IQR | 50.56 | Within IQR | 46.11 | Within IQR |
| | Regional Teaching | 91.67 | Above | 97.22 | Above | 72.22 | Within IQR | 77.78 | Within IQR |
| | Study Leave | 84.03 | Above | 100 | Within IQR | 83.33 | Within IQR | 62.5 | Within IQR |
| | Rota Design | 75 | Within IQR | 78.75 | Above | 51.56 | Within IQR | 43.75 | Within IQR |
| | Facilities | 76.67 | Q4 but not above | 71.25 | Within IQR | | N less than 3 | 64.69 | Within IQR |

Trainer

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Trainer | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Vascular surgery | Supportive Environment | 54.17 | In Q1 but not a | 54.69 | In Q1 but not a below outlier | 58.33 | In Q1 but not a below outlier | 46.43 | In Q1 but not a below outlier |
| | Educational Governance | 53.13 | Within IQR | 49.11 | In Q1 but not a below outlier | 56.94 | Within IQR | 60.71 | Within IQR |
| | Professional Development | 64.58 | Within IQR | 60.16 | In Q1 but not a below outlier | 64.58 | Within IQR | 70.54 | Within IQR |
| | Appraisal | 50 | Within IQR | 46.88 | Within IQR | 36.11 | Within IQR | 66.07 | Within IQR |
| | Support for Training | 66.67 | Within IQR | 59.38 | Within IQR | 68.06 | Within IQR | 70.24 | Within IQR |
| | Time to Train | 43.06 | Within IQR | 47.92 | Within IQR | 59.26 | Within IQR | 60.71 | Within IQR |
| | Rota Issues | 33.33 | Within IQR | 34.38 | Within IQR | 44.44 | Within IQR | 42.86 | Within IQR |
| | Handover | 79.17 | Above | 59.38 | Within IQR | 75 | Within IQR | 82.14 | Above |
| | Resources to Train | 62.5 | Within IQR | 65.63 | Within IQR | 69.44 | Within IQR | 67.86 | Within IQR |

The Education Lead provided the following comments/ action plan regarding GMC survey results 2025 and 2026.

| How is the concern being addressed | How is improvement being monitored and sustained | Who is responsible | Timeline | RAG rating (*) |
|---|---|---|---|---|
| Refining AES and CS Allocation: We reviewed and updated our AES and CS allocations in line with consultant job plans. Each trainee now has a clearly assigned supervisor. We have also allocated one supervisor specifically for non-trainees, allowing others to focus on their AES and CS duties with NTNs. | Continuous update the supervisors list | TG & GH | Completed Jan 2026 and ongoing work for allocating the new cohort of trainees | Amber |
| Raising Awareness Within the Consultant Team: We are presenting the GMC survey outcomes at the consultant meeting to ensure the whole team is aware of the areas requiring improvement. | In agenda for next consultant meeting | TG & GH | Completed Jan 2026 and will rediscuss again in next consultant meeting | Amber |
| Strengthening resident Doctor Engagement: We have supported | Resident doctor forum regular meeting | TG | Completed New forum to start September 2026 | Green |

| | | | | |
|---|---|---|---|---|
| our resident doctors in leading the vascular doctor forum to enable open discussion of concerns, which are then escalated to our business meeting. | | | | |
| Increasing Leadership Opportunities for Resident Doctors: Our resident doctors are now more actively engaged in leadership roles within education and research. | Giving leadership roles for different res | All team | Completed March 2026 and August 2026 | Green |
| Strengthening Educational Governance: We continue to monitor trainees' educational objectives and facilitate their achievement. We are working to minimise the impact of long waiting lists on training, support trainees working LTFT (currently one), and ensure access to key training resources (e.g. clinics, day cases, theatres, annual/study leave, etc.). | Current rota support our residents' doctors to achieve their objectives | All team | Completed June 2026 as full number of trainees and 4 trust grades | Green |
| GIRFT stated Volume of work and rota number should expand to minimum 8 SpR. To balance training opportunities. | Manager is working on business case for that. Currently we have 7 registrars (2 on same rota as one LTFT and one will upgrade to speciality trust | Vascular Manager | Not Achieved | Red |

| | | | | |
|---|---|---|---|---|
| | grade soon) will require appointing more SpRs | | | |
| Departmental teaching: Although within IQR but there is an observed decline in the percentage of satisfaction/delivery over the last 3 years. A robust program with all consultants' participation is required. There are already daily teaching and training, but a dedicated session for departmental focused teaching is required. | Discussed in the consultant meeting and Friday afternoon would be potential for a consultant delivering teaching regularly | TG, GH, DMD, Manager | Partially Achieved | Amber |

**Update on our progression: 24.02.2026**

We have refined our supervisor allocation. It is now clear for every trainer and trainee who undertakes this role and it is reflected into the trainers' job plan.

The outcome of the trainee GMC survey was discussed in our business meeting last Friday 20.02.26. Unfortunately, we have a gap in the registrars & SHO's rota, and this is risking training opportunities. We have recruited 2 new SHOs and completed their rota gap (One started and one will start soon). Re: SpR rota, the divisional director of planned care has helped the department to expedite recruiting a new SpR (Pending paperwork). We also offered escalated rate to avoid gap in duties. Currently, the team is a bit stretched due to these gaps! As per GIRFT report, there was a recommendation to our unit to recruit 2 more registrars in our rota due to large volume of work. Our service manager is working on business case to offer expansion in our registrar's rota that will help to offer more training opportunities to our trainees.

New leadership opportunities were offered to resident doctors such as to lead the vascular resident doctor forum, undergraduate education, departmental teaching, quality improvement projects and research. They were offered full support in these leadership.

Resident welfare is maintained through approving their required leaves and support covering the gaps with escalated rates, offering AES & CS meetings, mentorship and coaching when needed.

**Up to date reflections from last GMC Survey 17.09.2026**

There has been a **noticeable improvement in the overall feedback from trainees regarding the Vascular Unit at COCH**, which is encouraging and reflects the efforts made by the department to improve the training experience. There appears to have been improvement in both **educational and clinical supervision**, suggesting that trainees are experiencing greater support and engagement from the consultant and wider clinical team.

However, the feedback also highlights several areas where further improvement is required. **Departmental teaching** represents an important opportunity for development. Although the current feedback is positive in some respects, the department has historically performed above the national average in this area, and there is therefore scope to regain and sustain that level of performance. We should review the structure, content and delivery of the local teaching programme, ensuring that sessions are relevant to trainees, aligned with the curriculum and protected from competing service pressures. Greater trainee involvement in selecting topics and providing feedback may also help to make the programme more responsive to their needs.

Another important area for improvement is the **resident rota and its management**. We recognise that rota gaps and service pressures can have a direct impact on both the trainee experience and access to training opportunities. The department is therefore working towards securing additional Specialty Registrars (SpRs), in line with the workforce recommendations highlighted in the **GIRFT report**, over the next few years. In the interim, continued review of the rota, workload distribution and access to training will be important to minimise the impact of service pressures on trainees.

The **trainer feedback** also identifies the supporting environment as an area requiring further attention. This highlights the need to continue strengthening the support provided through **educational and clinical supervision, direct training and workplace-based teaching**. We should ensure that supervisors have sufficient opportunities to engage with trainees, provide timely and constructive feedback, and identify individual learning needs and career development goals.

**Overall reflection**

Overall, the survey demonstrates **positive progress within the Vascular Unit**, particularly in relation to supervision and the overall trainee experience. The findings also provide a clear opportunity to consolidate these improvements while addressing the areas where performance has not been maintained at previous levels. Our priorities should be to **strengthen the local teaching programme, improve rota stability and workforce capacity, and further develop the educational and supportive environment provided by trainers**. These areas will form the basis of ongoing departmental improvement work, with continued trainee feedback used to assess the impact of the changes.

## 11. Department with significant improvement -Gastroenterology

### Trainee

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Post sp | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Gastroenterology | Overall Satisfaction | 73.75 | Within IQR | 64.29 | Q1 but not below | 68 | Within IQR | 93.75 | Above |
| | Clinical Supervision | 79.38 | Q1 but not below | 82.86 | Within IQR | 76.56 | Q1 but not below | 96.87 | Above |
| | Clinical Supervision out of ho | 74.74 | Q1 but not below | 72.32 | Q1 but not below | 76.04 | Within IQR | 81.25 | Within IQR |
| | Reporting Systems | 75 | Within IQR | 63.57 | Within IQR | 61.25 | Within IQR | 80 | Within IQR |
| | Workload | 29.95 | Below | 28.27 | Below | 40.83 | Within IQR | 45.31 | Within IQR |
| | Teamwork | 73.96 | Within IQR | 70.24 | Within IQR | 60 | Q1 but not below | 87.5 | Q4 but not above |
| | Handover | 59.38 | Within IQR | 45.31 | Below | | N less than 3 | 64.58 | Within IQR |
| | Supportive Environment | 78.75 | Within IQR | 62.86 | Within IQR | 55 | Q1 but not below | 95 | Above |
| | Induction | 80 | Within IQR | 59.29 | Below | 68 | Q1 but not below | 96.25 | Above |
| | Adequate Experience | 81.25 | Within IQR | 71.43 | Within IQR | 77.5 | Within IQR | 90.63 | Q4 but not above |
| | Educational Governance | 69.79 | Within IQR | 53.57 | Q1 but not below | 48.33 | Below | 85.42 | Q4 but not above |
| | Educational Supervision | 85.16 | Within IQR | 86.61 | Within IQR | 77.5 | Q1 but not below | 98.44 | Within IQR |
| | Feedback | 69.64 | Within IQR | 57.64 | Within IQR | 89.17 | Within IQR | | N less than 3 |
| | Local Teaching | 70.42 | Within IQR | 37.08 | Below | 60 | Within IQR | 63.61 | Within IQR |
| | Regional Teaching | 67.71 | Within IQR | 45.83 | Below | 55.56 | Within IQR | 80.55 | Within IQR |
| | Study Leave | 56.25 | Within IQR | 25 | Below | 62.5 | Within IQR | 70.83 | Within IQR |
| | Rota Design | 35.16 | Within IQR | 29.46 | Below | 27.5 | Q1 but not below | 62.5 | Within IQR |
| | Facilities | 62.86 | Within IQR | 65.54 | Within IQR | 54.69 | Within IQR | | N less than 3 |

### Trainer

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Trainer | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Gastroenterology | Supportive Environment | 56.67 | In Q1 but not a | 62.5 | Within IQR | 70 | Within IQR | 65.63 | Within IQR |
| | Educational Governance | 47.92 | In Q1 but not a | 56.25 | Within IQR | 61.25 | Within IQR | 55.21 | Within IQR |
| | Professional Development | 67.5 | Within IQR | 61.67 | In Q1 but not a below outlier | 62.08 | In Q1 but not a below outlier | 65.63 | Within IQR |
| | Appraisal | 35 | Within IQR | 47.5 | Within IQR | 50 | Within IQR | 43.75 | Within IQR |
| | Support for Training | 55.83 | In Q1 but not a | 58.33 | Within IQR | 62.5 | Within IQR | 55.21 | In Q1 but not a below outlier |
| | Time to Train | 38.33 | In Q1 but not a | 56.67 | Within IQR | 56.67 | Within IQR | 45.84 | Within IQR |
| | Rota Issues | 43.75 | Within IQR | 40 | Within IQR | 45 | Within IQR | 25 | Within IQR |
| | Handover | 68.75 | Within IQR | 50 | Within IQR | 62.5 | Within IQR | 56.25 | Within IQR |
| | Resources to Train | 60 | Within IQR | 70 | Within IQR | 65 | Within IQR | 62.5 | Within IQR |

## 12. Specialty noted by quality team for good results- Ophthalmology

### Trainee

| Survey Year | | 2023 | | 2024 | | 2025 | | 2026 | |
|---|---|---|---|---|---|---|---|---|---|
| Post sp | Indicator | Score | Outcome | Score | Outcome | Score | Outcome | Score | Outcome |
| Ophthalmology | Overall Satisfaction | 86.67 | Within IQR | 95 | Within IQR | | N less than 3 | 91.67 | Within IQR |
| | Clinical Supervision | 93.33 | Within IQR | 98.33 | Within IQR | | N less than 3 | 95.83 | Within IQR |
| | Clinical Supervision out of ho | 93.75 | Within IQR | 95.83 | Q4 but not above | | N less than 3 | 96.25 | Above |
| | Reporting Systems | 70 | Within IQR | | N less than 3 | | N less than 3 | | N less than 3 |
| | Workload | 60.42 | Within IQR | 52.08 | Within IQR | | N less than 3 | 61.81 | Within IQR |
| | Teamwork | | N less than 3 | | N less than 3 | | N less than 3 | 83.33 | Within IQR |
| | Handover | 61.11 | Within IQR | | N less than 3 | | N less than 3 | 68.75 | Within IQR |
| | Supportive Environment | 88.33 | Within IQR | 95 | Above | | N less than 3 | 93.33 | Above |
| | Induction | 70 | Within IQR | 78.33 | Within IQR | | N less than 3 | 88.33 | Within IQR |
| | Adequate Experience | 75 | Within IQR | 100 | Within IQR | | N less than 3 | 87.5 | Within IQR |
| | Educational Governance | 72.22 | Within IQR | 100 | Above | | N less than 3 | 91.67 | Above |
| | Educational Supervision | 91.67 | Within IQR | 91.67 | Within IQR | | N less than 3 | 85.42 | Within IQR |
| | Feedback | | N less than 3 | | N less than 3 | | N less than 3 | | N less than 3 |
| | Local Teaching | 77.78 | Within IQR | 92.22 | Q4 but not above | | N less than 3 | 82.22 | Within IQR |
| | Regional Teaching | 80.56 | Within IQR | 91.67 | Within IQR | | N less than 3 | 80.56 | Within IQR |
| | Study Leave | | N less than 3 | 95.83 | Within IQR | | N less than 3 | 91.67 | Within IQR |
| | Rota Design | 81.25 | Within IQR | 91.67 | Above | | N less than 3 | 79.17 | Within IQR |
| | Facilities | | N less than 3 | | N less than 3 | | N less than 3 | | N less than 3 |

Dr Lyndsay Cheater
Director of Medical Education
Countess of Chester Hospital NHS Foundation Trust

By email: lyndsay.cheater@nhs.net

NHS England – North West
Workforce, Training & Education
3 Piccadilly Place
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## GMC National Training Survey 2026: action plan required

As you are aware the GMC survey of all doctors in training in the UK was undertaken during March to May 2026. The results are published and available on the GMC website (www.gmc-uk.org). We have reviewed the results at your trust for 2026 and compared them with previous years.

Firstly, thank you very much for supporting the survey. With the support of the trusts in the region, the North West region achieved the highest response rate of all the regions in England for both the trainee (77.26%) and the trainer (52.77%) surveys. We acknowledge the trust's hard work and would like to thank all involved in maintaining teaching and coping with workforce pressures whilst still supporting positive training experiences.

We are aware of your proactive approach to the results of this survey, and that you have engaged with each of the divisions with at least one survey domain in the bottom quartile, namely: Acute Internal Medicine, Cardiology, Emergency Medicine, Endocrinology and diabetes, Geriatric medicine, Paediatrics, and Respiratory Medicine.

We have reviewed the results for **Emergency medicine** in the wider context of intelligence from our quality interventions, your ongoing trust action plans and data available to us. We have held a related risk on our Intensive Support Framework at level 2 (ISF2) for two years. We note that there is a negative outlier in the 2026 National Training Survey for the facilities indicator in post view (though not in programme view) and several potential outliers in addition. However, a critical threshold for the difference between items at ISF1 and ISF2 is the existence and execution of a credible plan by the trust, and evidence of progress towards resolving the risk. Due to recent departmental improvements, the lowering acuity of the risks, the successful return of nursing students to the learning environment, the more positive assessment of the clinical environment in the most recent CQC inspection and the ongoing engagement of the trust leadership on this issue, we are de-escalating this from ISF2 to ISF1. We will continue to monitor this risk with progress updates against the action plan.
We would like to draw specific attention to **Endocrinology and diabetes,** which is on the GMC priority list due to numerous red flags and indicators which have been red in previous years. *Overall satisfaction* is a negative outlier in 2026, as it was in 2025. *Rota design* has been a negative outlier for three consecutive years.

In addition to endocrinology and diabetes, we would be grateful to receive the action plan for **Paediatrics** and **Respiratory medicine**.

We are very pleased to report that the hospital has very positive results for **Ophthalmology**, as it did in the previous year we had data.

**Action:** Please could you investigate and submit an action plan to address the above areas of concern by the 14 October 2026. To reduce the duplication of work, we would accept a copy of the paper due to be submitted to the trust's People Committee in October.

Please note we are sharing this letter with the GMC to demonstrate our region-wide follow up to the survey results and ensure all their priorities are addressed. Please do engage with the patch Associate Dean to inform us of any actions you take to improve on these concerns. We look forward to reviewing any progress made along with the next set of survey results as they become available.

Yours sincerely,



**Dr Raghu Paranthaman**
**Deputy Postgraduate Dean, Hospital and Community Medicine**

**CC:**

| | |
|---|---|
| Janet Ellis | Medical Education Manager |
| Sallie Kelsey | Head of Clinical Education |
| Lyndsey Dodd | Education Quality Assurance Manager, GMC |
| Gurinder Tack | Associate Dean, NHS England |
| Helen Duff | Quality Senior Manager, NHS England |

**PUBLIC – Board of Directors**
**24th November 2026**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Report** | **Agenda Item 11.** | **Freedom to Speak Up Report (FTSU) (April 2026 – September 2026)** | | | | | | |
| **Purpose of the Report** | Decision | | Ratification | | Assurance | **X** | Information | |
| **Accountable Lead** | Cathy Chadwick | | | Chief Operating Officer | | | | |
| **Author(s)** | Helen Ellis | | | Freedom to Speak Up Guardian | | | | |
| **Board Assurance Framework** | BAF 1 Quality<br>BAF 2 Safety<br>BAF 3 Operational<br>BAF 4 People<br>BAF 5 Finance<br>BAF 6 Capital<br>BAF 7 Digital<br>BAF 8 Governance<br>BAF 9 Partnerships<br>BAF 10 Research<br>BAF 11 Transformation | | | **X**<br>**X**<br>**X**<br>**X** | BAF impact is that the Freedom to Speak Up Vision and Strategy offers a supportive framework to 'speak up' about issues in the workplace. This will contribute to the Trust's work to improve culture, morale and provide learning on how the Trust can improve services. | | | |
| **Strategic goals** | Patient and Family Experience<br>People and Culture<br>Purposeful Leadership<br>Adding Value<br>Partnerships<br>Population Health | | | | | | | **X**<br>**X**<br>**X** |
| **CQC Domains** | Safe<br>Effective<br>Caring<br>Responsive<br>Well led | | | | | | | **X**<br>**X**<br>**X**<br>**X**<br>**X** |
| **Previous considerations** | Not applicable | | | | | | | |
| **Executive Summary** | This report provides assurance to the Trust Board that the Freedom to Speak Up (FTSU) arrangements at the Countess of Chester Hospitals NHS Foundation Trust continue to reflect national best practice and support a culture of openness and psychological safety.<br><br>Key highlights include:<br><br>• **FTSU function transferred to NHS England:** Initial recommendations completed, awaiting further information.<br>• **Data:** Significant work has been undertaken to improve data collection, review reporting templates and create a FTSU dashboard. Divisional reporting supports triangulation of data and the identification of learning. Q1&2 data is reported however comparative data will be limited due to the new changes in data collection from April.<br>• **Staff groups reporting concerns:** The categories recorded now align to those used within People Services. Nurses remain the highest number of reporters of concerns<br>• **Governance and leadership**: Strong executive oversight continues, with regular reporting to the People Committee and sub-committees. All thirty-five actions within the FTSU Action Plan have been completed. | | | | | | | |

| | |
|---|---|
| | • **Training compliance**: Most staff groups exceed the ninety percent compliance target for mandatory FTSU modules: Medical/ Dental and Facilities and Estates remain slightly below the threshold for 'Listen Up' but have improved on the previous reporting period.<br>• **Champion network**: Over sixty champions support staff across the Trust, with newly developed divisional hubs providing greater peer support, improved learning and clearer identification of localised trends and themes.<br>• **Education and Training**: FTSU is now embedded within both the Essential Managers and Aspiring Leaders programs. There are also established links with Chester University's Nursing Course.<br><br>The FTSU Action Plan remains a key driver for ongoing development, improvement, and embedding best practice across the Trust. |
| **Recommendations** | The Board of Directors is asked to **note** the report and receive assurance that local FTSU arrangements are in place and continue to meet best practice. |

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

# Freedom to Speak Up Report (FTSU) (April 2026 – September 2026)

## 1. Introduction

This paper provides the Trust Board with an update of the work of the Freedom to Speak Up (FTSU) Guardian and Champions in supporting the safety culture within the Trust, reflect on the progress made by the FTSU Network in empowering staff to speak up freely and to encourage ongoing positive cultural change. The report will update the Board on the changes since the closure of the National Guardians Office and the progress made in improving how local data is both recorded and reported. An overview of data for Q1 & 2 will be presented, however only limited comparative data for the same periods last year can be made due to the changes in the data that is now collected. Mandatory training compliance and the progress of the FTSU Champion Hubs will be outlined.

## 2. Background

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

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

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

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

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

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

## 3. Purpose

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

## 4. National Guardians Office/NHSE

Following the closure of the National Guardians Office on June 30th this year, FTSU functions now sit with NHSE, delivering some activities previously undertaken by the NGO. NHSE remains committed to Freedom to Speak Up, with guardians continuing to be supported by their organisations and playing a vital role in fostering safe speaking-up cultures. Initial guidance was published in May 2026 with further information expected towards the end of the summer. The Guardian and Executive Lead for FTSU have completed all requirements to date to ensure ongoing compliance. FTSU information onto the public facing Trust website and registering with NHS England's national data collection systems.

## 5. Data Reporting

Quarterly quantitively data from July 2026 is now submitted to NHSE and will be reported through Model Hospital. There are concerns from the Regional Guardians Networks regarding the consistency of the data submitted by each organisation and this has been raised with NHSE. More information will be shared when available.

We have taken this opportunity to expand the data that is collected when concerns are raised so that reporting internally can be improved. Substantial work has been undertaken in partnership with Business Intelligence colleagues to update systems and develop a robust FTSU dashboard. Although this work is not yet complete, significant progress has been made. Some of the improvements are:

- Aligning categories such as staff groups and EDI with those used within the People function of the organisation.
- To include outcomes following conclusion of an FTSU case
- Recording themes and trends within divisions that improve the ability to triangulate broader data and identify learning.
- Reasons for using FTSU to raise concerns as opposed to other routes to better understand culture.
- Categorizing themes as primary, secondary and tertiary

It is anticipated that the new data framework will be completed by January 2027 and reports following this date will give more detail and triangulation.

## 6. Overview of FTSU concerns

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

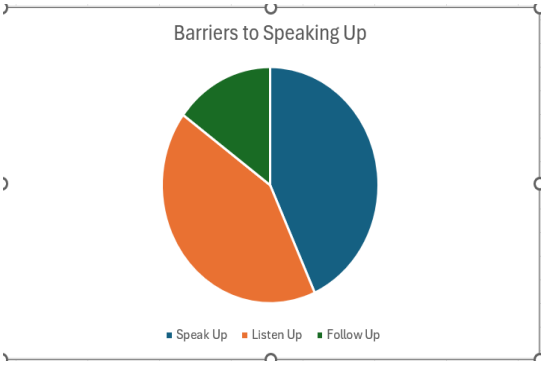
a route of escalation when other reporting channels have been explored.

Overview Q1 & Q2 2026-27

Seventy-Four concerns were raised with thirteen remaining open, all still within an expected timeframe. This is an increase of ten concerns being raised compared to the same period last year.
Two anonymous concerns were raised but through a channel that still allowed on-going communication and the ability to feedback.
Of the concluded cases all but three (two staff had left the organisation) answered 'yes' when asked, 'would you contact the guardian again in the future if needed'.

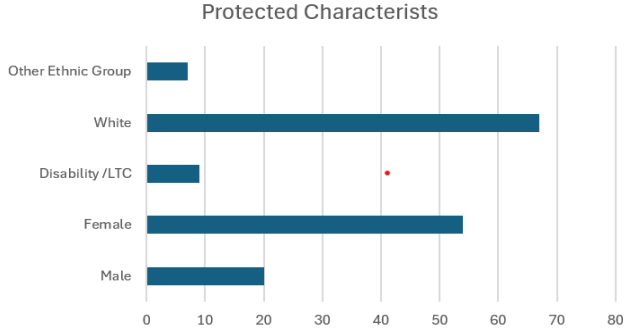
From April colleagues were asked why they chose to raise concerns via FTSU as opposed to other routes:

- Speak Up Barrier: for whatever reason did not feel able to speak up through other routes
- Listen Up: Concerns had been raised but colleagues did not feel they had been listened to
- Follow Up: No action/feedback has been shared since raising concern through another route.




Eleven concerns were raised through FTSU because of 'follow up' barriers, with very similar numbers raised through FTSU due to speak up or listen up.

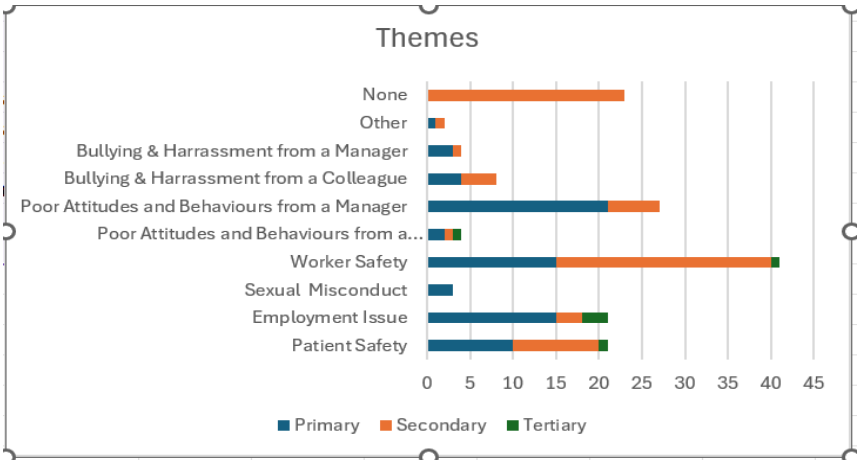
Data relating to barriers to speaking up has be shared with divisions to help identify actions needed to improve speaking-up arrangements and identify learning. This data will be reported in the next People Committee report.




Protected characteristics data has only been included since April 2026 with the categories aligned to those used across People Services for improved triangulation.

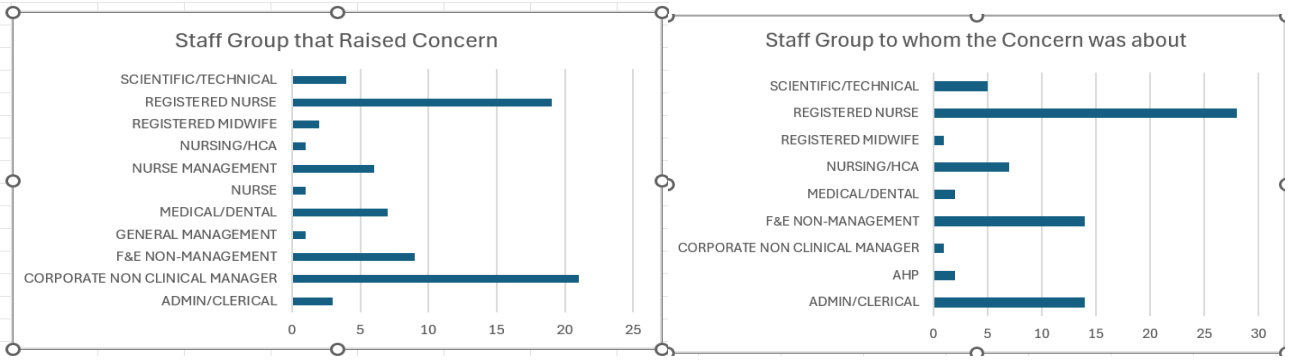
Primary concerns of poor attitudes and behaviours and worker safety mirror those from the last quarter and for the same period last year. Additional breakdown has been included to identify if poor behaviours are alleged from peers or managers. From April concerns have been categorised to primary, secondary and tertiary for concerns to be more focused and support improved learning.

One case of detriment was reported, information contained within the FTSU policy was shared to support completion of a risk assessment and action plan. Executive oversight was provided and a formal investigation is on-going. Concerns relating to sexual safety have been reported to the executive lead for FTSU and People Services and managed in line with policy.



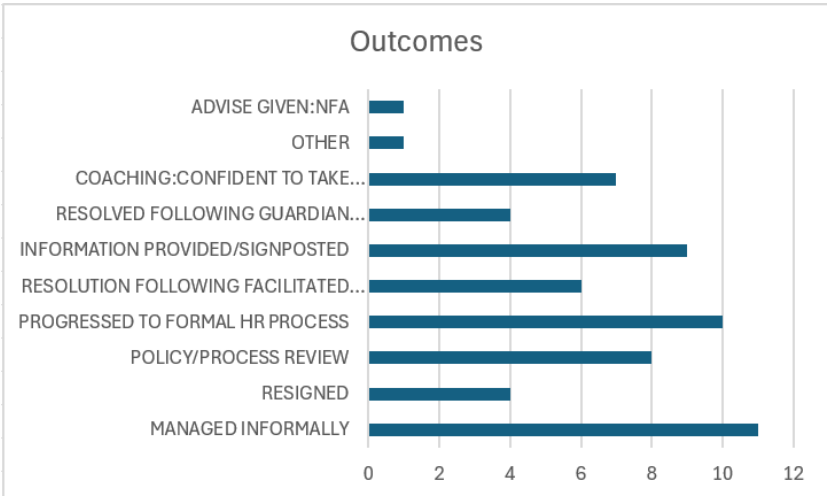

Examples of concerns raised:

- Behaviours of colleague: shared with manager: no apparent action
- Lack of response from manager when escalating concerns : patient & staff safety issue
- Behaviours of senior colleague: escalated to two different managers: no response
- Sexual safety of a patient: escalated to senior exec/HR/senior manager: investigation in progress
- Employment issue: perceived delay response from HR and management colleagues: resolved following support from the guardian
- Alleged bullying from manager: facilitated conversation: resolved: changed role and dept




There appears to be an increase in the number of colleagues within the corporate non-clinical manager staff group raising concerns, however this may be due to the change in categories from previous reporting periods. Outcomes have been recorded within categories for the first time this quarter.

Less than 16.4% of all concerns needed to be managed through a formal HR process. The guardian provided coaching, advice, information or signposted to more appropriate services in 27.9% of cases resulting in early resolution. It is paramount that FTSU promotes the confidence of colleagues to speak up to managers so they are resolved at the earliest opportunity and prevent escalation into formal processes if they can be prevented.




Divisional data is shared quarterly through the People and Culture Sub-Committee to support triangulation of data from local sources.

## 7. Progress on Internal Assessments and Governance

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

A review of all FTSU reporting purposes and templates has been undertaken .

Trust Board and People Committee reporting will continue bi-annually, People and Culture Sub-Committee quarterly, with Audit Committee and Quality and Safety Committee annually.

## 8. Freedom to Speak Up Action Plan:

The Trust Board is due to undertake its two yearly FTSU Self-Assessment, facilitated by The FTSU Executive Lead and Guardian. Following completion any actions identified will form part of the updated FTSU action plan with progress monitored quarterly as a minimum and reported through this committee.

## 9. FTSU Mandatory Training

‘Speak Up’ is now at 97.18% with only two staff groups reporting less than 95%. ‘Listen Up’ has reached 93.94% compliance with only two reporting less than 90%; Estates and Facilities reporting 83.73% with Medical and Dental at 88,68%.

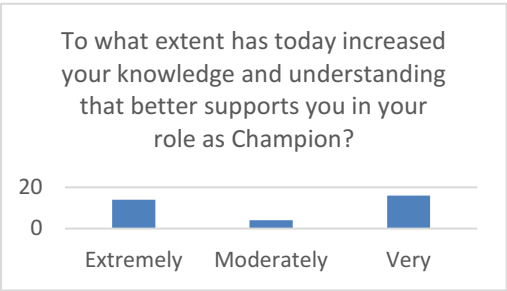
FTSU Champions are 95% compliant in the Understanding Sexual Misconduct in the Workplace mandatory training.

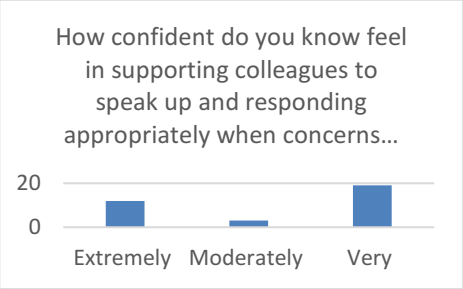
## 10. Freedom to Speak Champions Network

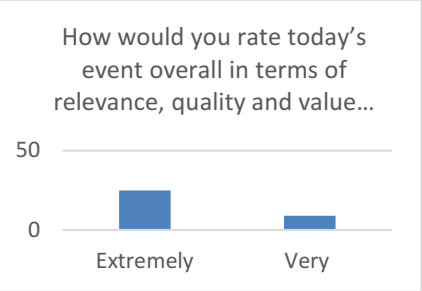
The network continues to thrive with more colleagues completing training last September.

Divisional Hubs were set up in November 2025 with varied success. Their aim is to bring together champions working in similar areas to strengthen peer support, local knowledge and learning. Attendance for health care assistants and nurses has been challenging due to clinical pressures in some areas, but work is ongoing to identify ways to overcome this including consideration of meeting times, engaging managers to consider options to support attendance and providing a virtual meeting option.

Earlier this month a Champions Event was held providing an opportunity for learning from both external and internal speakers, a chance to network and to celebrate the work of all champions. The feedback received was positive.




## 11. Education and Learning

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

## 12. Conclusion

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

The FTSU Guardian, supported by the network of champions, continues to maintain engagement with colleagues across the organisation to raise the FTSU profile, support staff who have raised concerns, record and follow-up cases raised. Identifying outcomes and triangulating data with other sources for example, what his being raised locally, sickness, recruitment and retention rates, numbers of grievances and formal investigations, information for occupational health and exit interviews can all help to provide a broader picture than FTSU alone. Work to further embed this approach will continue with support from colleagues across the organisation.

Monthly FTSU blogs continue to be posted to all staff to provide ongoing visibility and ensure colleagues are up to date on service development. Champions will continue to have a visual presence on the wards and departments of both the Countess and Ellesmere Port hospitals, ensuring colleagues within their own teams are well informed and supported should they wish to raise concerns.

The FTSU Action Plan with continue to be the driver for ongoing development and improvement.

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

## 13. Recommendation

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

Countess of Chester Hospital NHS Foundation Trust

## Committee Chair's Report

5th November 2026 at 9.30 –12.00 in the Women & Children's Building Seminar Room

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| **Committee** | Quality & Safety (Q&S) Committee |
| **Chair** | Prof A Hassell, Committee Chair |

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

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

- **Urgent and Emergency Care (UEC):** The Committee remained concerned about sustained operational pressure within UEC. The sustained (12% year on year) increase in demand, as well as continuing flow issues, have contributed to some ambulance delays, below target 12-hour and 4-hour performance, reduced Infection, Prevention & Control (IPC) and acute assessment compliance and corridor care. The Committee is assured that every effort is being put into addressing this within Emergency Department (ED) but that greater system support is also needed.
- **Blood transfusion training:** Compliance with mandatory blood transfusion training (circa 80%) remained below the required level, notably within clinical areas with the greatest use of blood products. The Committee was not yet assured that the existing trajectory would deliver timely and sustained improvement. Continued Divisional oversight and prioritisation of staff release for competency assessment and renewal to be implemented.
- **Venous thromboembolism:** At 85%, performance remained below the 95% national standard for completion of VTE risk assessments, while administration of prophylaxis within 14 hours remained well below target. More robust oversight of hospital-acquired thrombosis and associated lapses in care has now been established with regular updates to Q&S Committee via Quality Governance Group (QGG).
- **Electronic Patient Record (EPR) Team capacity.** Committee was concerned at the increasing number of competing priorities for EPR upgrades and the team's capacity to achieve them in a timely manner, given capacity constraints. Competing requirements included palliative care, maternity, ophthalmology, ED improvement and discharge work. The associated organisational risk would be considered through the Finance & Performance Committee.

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

- **UEC improvement programme:** The Committee received assurance regarding the extensive improvement work under way within UEC. This included senior clinical review, strengthened sepsis leadership, revised workforce deployment, improved Urgent Treatment Centre coordination and work to improve the reliability of assessment and rounding data. The Committee recognised the considerable commitment and energy of the clinical teams, although outcomes continued to be affected by demand, congestion and wider system pressures.

- **Cancer harm reviews:** The Committee received significant assurance regarding improvements in the cancer harm review process. The backlog had reduced to 13 outstanding reviews (the longest, from March 2026); 139 reviews had been completed during the reporting period, and the number of 104-day breaches had reduced from 61 to 44 over the previous 12 months. Specialty-level themes were being identified through the review process and used to inform improvement activity.
- **Palliative and end-of-life care:** Significant progress had been made against the priorities arising from the 2025 review. Mandatory training, clinical oversight arrangements, performance dashboards and psychological support for staff had been introduced. The service's Care Quality Commission (CQC) position had improved from Requires Improvement to Good, with further work focused particularly on advance care planning, Delivery of 7-day specialist palliative care service would require additional 3 WTE.
- **Patient experience:** The Committee welcomed encouraging patient-experience results across maternity, UEC and the national inpatient survey. Preliminary maternity feedback showed that 97% of respondents felt treated with respect and dignity during labour, 96% had confidence and trust in staff and 100% felt involved in decisions about their care. Type 1 A&E results showed that 93% of respondents felt treated with respect and 91% had confidence and trust in doctors and nurses, while 89% of Type 3 respondents reported a positive overall experience. The national inpatient survey also demonstrated broad improvement, particularly in relation to kindness, compassion, respect and dignity.
- **Ward 51 patient story:** A patient story provided strong assurance regarding compassionate end-of-life care, effective ward leadership and the professionalism of staff on Ward 51. The family's feedback recognised the kindness, empathy and dignity demonstrated by staff while caring for their relative and managing a busy and complex clinical environment.

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

- **Maternity rapid review:** The Committee was advised that a virtual regional rapid review of maternity quality arrangements was planned for November. The Trust would use the review to demonstrate the improvements made and learning embedded following previous external scrutiny.
- **Mental-health provision:** Some continuing concerns remained regarding mental; health patients presenting at ED, with mental health triage and rounding performance challenged. Concerns also remained regarding specialist support and treatment planning for inpatients with complex and challenging behaviours. This is particularly relevant to some Non Criteria to Reside (NCTR) patients.
- **Glaucoma services:** A quarterly glaucoma report would be received through the QGG and presented to the Committee. An automated validation tool was due to go live, supported by further work to triangulate data quality, waiting-list validation and booking processes before fuller assurance could be provided.
- **Hybrid theatre:** The proposed hybrid theatre remained dependent upon the outcome of a capital bid associated with redevelopment of the former Women and Children's site. In the interim, the risk score associated with the absence of a hybrid theatre had reduced following the introduction of lightweight protective equipment, with the remaining concern considered primarily reputational rather than a direct patient-safety risk.

- **Palliative-care capacity:** The ambition to provide a seven-day palliative-care service and fully implement the care-plan and patient-outcome programme remained dependent upon additional workforce funding and digital prioritisation. An establishment review had identified a workforce deficit within the existing five-day service.
- **Maternity workforce and theatre capacity:** The Committee noted continuing maternity workforce pressures, including the investment required to meet Birthrate Plus requirements. Elective caesarean-section capacity was being maintained, although additional activity could displace planned gynaecology work.

**Risks discussed and new risks identified**

- No new risks identified.

**PUBLIC – Board of Directors**
**24th November 2026**

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| **Report** | **Agenda Item 13.** | **Quarter 2 Maternity and Neonatal Trust Board Safety Report** | | | | | | |
| **Purpose of the Report** | Decision | | Ratification | | Assurance | **X** | Information | |
| **Accountable Executive** | Sue Pemberton<br><br>Nigel Scawn | | | Director of Nursing and Quality / Deputy Chief Executive<br>Medical Director | | | | |
| **Author(s)** | Natasha Macdonald<br>Sara Brigham<br>Liz Kewin | | | Director of Midwifery<br>Associate Medical Director<br>Divisional Director | | | | |
| **Board Assurance Framework** | BAF 1 Quality<br>BAF 2 Safety<br>BAF 3 Operational<br>BAF 4 People<br>BAF 5 Finance<br>BAF 6 Capital<br>BAF 7 Digital<br>BAF 8 Governance<br>BAF 9 Partnerships<br>BAF 10 Research<br>BAF 11 Transformation | | | **X**<br>**X**<br>**X** | BAF 1 – Failure to maintain quality may negatively impact patient and family experience<br>BAF 2 – Gaps in safety and harm prevention can compromise patient outcomes.<br>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<br>People and Culture<br>Purposeful Leadership<br>Adding Value<br>Partnerships<br>Population Health | | | | | | | **X**<br>**X**<br>**X** |
| **CQC Domains** | Safe<br>Effective<br>Caring<br>Responsive<br>Well led | | | | | | | **X**<br>**X**<br>**X**<br>**X**<br>**X** |
| **Previous considerations** | Quality and Safety Committee 5th November 2026 | | | | | | | |
| **Executive summary** | This report provides assurance regarding the quality, safety and performance of maternity and neonatal services for Quarter 2 2026/27.<br><br>This is the first quarterly report presented using the NHS England Maternity and Neonatal Trust Board Safety Reporting Template, replacing the previous detailed narrative report. The accompanying presentation provides a standardised overview of clinical outcomes, incidents and learning, workforce, training, service-user experience and progress against national maternity and neonatal safety priorities.<br><br>Governance and safety surveillance remain established, with learning from incidents, reviews and complaints informing improvement. The | | | | | | | |

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| | presentation reports 99% compliance with Saving Babies' Lives Care Bundle v3.2 for Quarter 2, alongside specific exceptions and improvement activity. Service-user feedback has led to the introduction of proactive postnatal telephone calls, and work is under way to improve engagement with underrepresented communities.<br><br>Progress against the Maternity Incentive Scheme (MIS) Year 8 remains on track. All Safety Actions A, C, D, E and F are currently assessed as met.<br><br>Areas requiring continued oversight include induction of labour delays, maternity triage performance and reporting, workforce capacity and implementation of the Maternal Care Bundle. Delivery of some improvements remains dependent on digital developments, regional pathways and wider system support.<br><br>The accompanying presentation details performance, improvement actions and identified risks, including areas where continued executive oversight and support are required. Whilst established governance arrangements provide assurance on safety oversight, further evidence of sustained improvement is required in the identified priority areas. |
| **Recommendations** | The Board of Directors is asked to<br>• Note the Quarter 2 Maternity and Neonatal Trust Board Safety Report.<br>• Receive assurance regarding the established governance, safety surveillance and improvement arrangements.<br>• Recognise the areas where further evidence of sustained improvement is required, particularly induction of labour, maternity triage, workforce capacity, training compliance and Maternal Care Bundle implementation.<br>• Note the identified risks, mitigation plans and executive support required to deliver improvements. |

| **Corporate Impact Assessment** | |
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| **Statutory/regulatory requirements** | Supports oversight of the NHS Resolution MIS Year 8 safety actions, Saving Babies' Lives Care Bundle, the Maternal Care Bundle and the NHS England Maternity and Neonatal 10 Point Plan. |
| **Risk** | Principal risks include induction of labour delays, maternity triage data and performance, workforce capacity, and digital and system dependencies affecting Maternal Care Bundle delivery. Actions and escalation requirements are detailed in the presentation. |
| **Equality & Diversity** | Service-user feedback and MNVP engagement inform improvement. Work is progressing to strengthen representation of Gypsy, Roma and Traveller families, people experiencing deprivation and families whose first language is not English |
| **Communication** | Findings and actions are reviewed through maternity and neonatal governance, PAIB, Safety Champions and Committee reporting. |

# Perinatal Services Quarterly Update Quarter 2 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 Committee oversight through provision of ward-to-board intelligence and highlights current and emerging risks requiring action or assurance. Quarter 2 covers the period 1 July to 30 September 2026. Where relevant, significant developments arising after the reporting period are included and clearly identified to provide the Committee with an updated assurance 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 has 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 within this Committee agenda 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 updates during this reporting period include:

- Monthly oversight of progress against all six Safety Actions.
- Completion and validation of supporting evidence requirements.
- Continued collaboration between Maternity, Neonatal and Quality Governance teams to support delivery of national safety requirements.
- Completion of elective caesarean section capacity and demand

At the time of reporting, all Safety Actions are currently assessed as met.

### Elective Caesarean Section Capacity and Demand Review

As part of the Maternity Incentive Scheme Year 8 requirements, a multidisciplinary review of elective caesarean section capacity and demand was completed on 1 October

2026 and received by the Quality and Safety Committee. The review assessed the whole pathway, including theatre capacity, workforce and operational resilience.

**Key assurance**

- Current provision is assessed as adequate with identified pressures. The service provides two full day elective caesarean lists each week, with estimated routine capacity of approximately 385 procedures per year, compared with 404 elective caesarean births undertaken during 2025/26.
- Demand is exceeding routine capacity and additional operating lists have been required. While current pressures are being managed safely, continued reliance on ad hoc additional capacity is not considered sustainable and presents an ongoing operational risk.
- A SMART improvement plan is in place, focused on theatre efficiency and utilisation, improved list planning, earlier booking and consideration of planned additional capacity to provide a more sustainable response to demand.
- Progress will be monitored through established maternity governance arrangements and PAIB, with a further capacity and demand review scheduled for April 2027.

**Board assurance:** Current pressures are being managed safely through additional capacity and multidisciplinary oversight. The identified longer term capacity risk is recognised, with a defined improvement plan and governance oversight in place.

**Birthrate Plus workforce establishment**

The Trust has completed its Birthrate Plus workforce review, which identified a 5.45 WTE gap between the funded midwifery establishment and the Birthrate Plus workforce requirement. The Board is aware of the requirement to achieve a fully funded establishment aligned to the Birthrate Plus recommendation.

A costed business case has been developed in response to the identified gap. The recommended option seeks £285k recurrent investment for an additional 6 WTE midwives, reflecting the Birthrate Plus requirement alongside subsequent growth in maternity activity. A proposed phased approach to implementation has been developed; however, the final phasing and associated investment remain subject to approval.

Subject to approval, this provides a clear route to achieving alignment with the Birthrate Plus workforce requirement within the required implementation timeframe. Progress will continue to be monitored through established governance arrangements and reported to Board.

**Maternity and Neonatal 10 Point Plan: Internal Resource Deployment and Specialist Workforce Resilience**

A full review of internal resource deployment and specialist workforce resilience across maternity and neonatal services has been undertaken and reviewed and received in full by the Perinatal Improvement Board. The review considered opportunities to safely redirect staff in specialist, education, governance, quality improvement and management roles to strengthen frontline service delivery where required. It also considered the

resilience of specialist services, including bereavement and infant feeding, and the education, training and competency arrangements required to ensure that safe and effective care can continue when specialist practitioners are not immediately available. The wider impact of redeployment on service delivery, specialist functions, education, governance, staff workload and national requirements was also considered. The review identified existing controls alongside areas requiring further strengthening, with improvement actions in place to enhance specialist resilience and competency assurance. The Trust Board is asked to receive and note the review, take assurance from the arrangements described and endorse the ongoing improvement actions in support of compliance with Requirement 6.7 of the Maternity and Neonatal 10 Point Plan.

**Health inequalities**

The Trust has received its PEADP baseline data pack, which provides an initial assessment of equity across maternity outcomes, workforce and organisational practice. The data includes analysis by ethnicity across key maternity measures including gestational age at booking, mode of delivery, preterm birth and postpartum haemorrhage.

The baseline provides important intelligence to inform improvement priorities. For July to December 2025, 63.6% of Black women booked by 10 weeks compared with 69.8% of White women. The data also shows variation in mode of birth, with 44.4% of births to Black women recorded as emergency caesarean births compared with 19.9% for White women. These findings require further exploration and should be interpreted with appropriate caution due to the relatively small numbers in some ethnic groups and associated statistical uncertainty.

The Trust will use this baseline alongside the Maternity and Neonatal Equalities Dashboard, local intelligence and service user insight to review relevant metrics, identify variation in outcomes and determine priority areas for improvement. Analysis will be further strengthened to consider deprivation alongside ethnicity, recognising that the current PEADP baseline primarily provides ethnicity based analysis. Improvement priorities will have defined measures, named ownership and timescales, enabling the Trust to monitor whether interventions are resulting in improved and more equitable outcomes over time.

This approach aligns with the PEADP framework, which requires services to identify racial and ethnic inequalities through data, routinely examine outcome measures by ethnicity, use intelligence to determine improvement priorities and evaluate whether changes result in more equitable outcomes.

Progress against the identified health inequalities metrics, improvement actions and evidence of impact will be monitored through the Perinatal Improvement Board, with material variation, deterioration or lack of improvement escalated through the established Board assurance route.

## 3. Conclusion

The Quarter 2 report provides assurance that established governance, safety surveillance and learning arrangements continue to support oversight of maternity and

neonatal services. Progress towards MIS Year 8 remains on track, although targeted improvement in training compliance is required. Further evidence of sustained improvement is needed in induction of labour delays, maternity triage performance and reporting, workforce capacity and implementation of the Maternal Care Bundle, including resolution of digital and wider system dependencies.

The elective caesarean section review assesses current provision as adequate with identified pressures. Demand exceeds estimated routine capacity, and reliance on ad hoc additional lists places pressure on staffing, patient flow and other elective activity. A defined improvement plan is in place to strengthen efficiency, list planning and sustainable capacity, with oversight through PAIB and a further annual review in April 2027. Overall, assurance relates to the arrangements for managing risks and progressing improvements; it does not remove the need for continued Committee scrutiny of delivery and outcomes.

## 4. Recommendations

The Board of Directors is asked to:

- Note the Quarter 2 Maternity and Neonatal Trust Board Safety Report.
- Receive assurance regarding the established governance, safety surveillance and improvement arrangements.
- Recognise the areas where further evidence of sustained improvement is required, particularly induction of labour, maternity triage, workforce capacity, training compliance and Maternal Care Bundle implementation.
- Note the identified risks, mitigation plans and executive support required to deliver improvements.

# Maternity & Neonatal Trust Board Safety Report

NHS England

## Presented by Perinatal Leadership team

Natasha Macdonald Director of Midwifery
Dr S Brigham Associate Medical Director

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# Executive summary

| Safety | Quality and learning | Workforce | Risks and mitigations |
|---|---|---|---|

| | RAG | Key Message. |
|---|---|---|
| **Safety** | | Stable safety position, supported by robust governance and high compliance with key maternity safety standards. Saving Babies' Lives compliance was 99% in Quarter 2. |
| **Quality & Learning** | | The PSIRF Perinatal Plan is embedded. Learning is routinely shared with patient facing teams, with staff encouraged to report incidents and participate in learning reviews. |
| **Workforce** | | Overall workforce position remains supported by good training compliance, but targeted improvement is required in specific professional groups and QIS training. Workforce sustainability remains under continued oversight |
| **Equity** | | Service user voice is embedded through MNVP representation and quarterly governance routes. Current triangulation has not identified a consistent local inequality signal, although data quality limitations remain. |
| **Governance & oversight** | | Strong governance arrangements provide ward to Board oversight of incidents, complaints, learning, risks and national maternity safety requirements through established governance routes |

What is going well:
The safety position remains stable, supported by established governance and learning processes. Saving Babies' Lives compliance was 99% in Quarter 2, and delivery against the six MIS Year 8 Safety Actions remains on track.

What is of concern:
Maternal Care Bundle delivery remains dependent on digital development, regional guidance and system pathways. Targeted training recovery is required in identified professional group

Emerging risks:
Key risks relate to workforce sustainability, maternity triage performance, reliable Birthrate Plus Live Acuity Tool completion, and delivery of MEWS within the electronic patient record.

Improving/deteriorating trends
Saving Babies' Lives compliance remains high and Maternal Care Bundle implementation is progressing. Workforce, training and digital exceptions remain under active oversight.

Key system actions underway:
Progress MCB implementation, including regional guidance and system pathways; deliver EPR developments for MEWS and reporting; maintain targeted training recovery plans; and continue oversight of workforce and capacity risk

## Board assurance statement:

The Board can be assured that effective perinatal safety systems are in place and that the overall safety position remains stable. Strong governance and high compliance with key maternity safety standards provide assurance. Further evidence of sustained improvement is required in relation to workforce sustainability, targeted training exceptions, maternity triage and delivery of the Maternal Care Bundle, including digital and system dependencies.



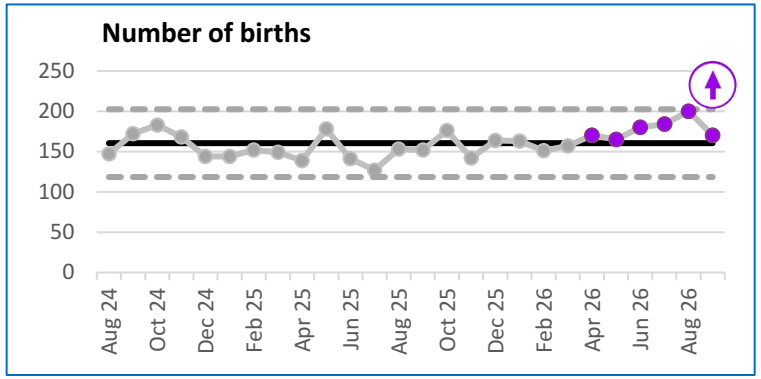
## Actions required from Board:

Receive assurance on established perinatal safety governance and oversight arrangements, noting the areas requiring continued improvement and executive support, particularly workforce capacity, maternity triage and digital development.

# Trust performance against national safety ambitions

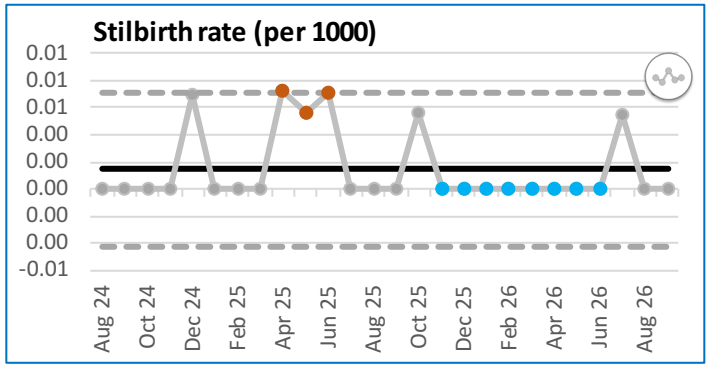
**Latest month** 01/09/26
**Number of births** **170**

Significant increase



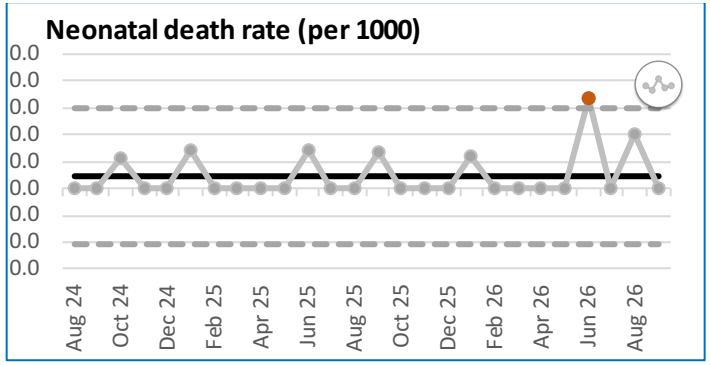

**Latest month** 01/09/26
**Still birth rate/1000** **0.0**

No significant change



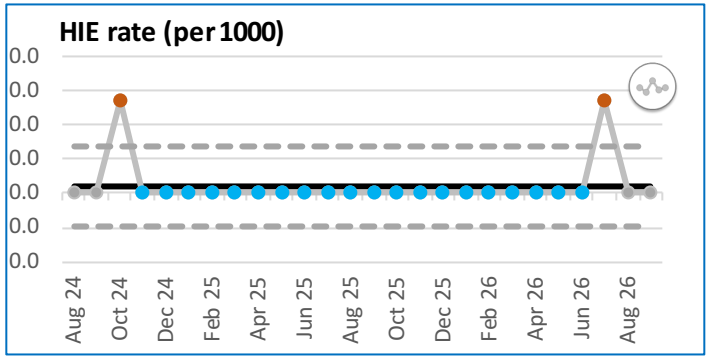

**Latest month** 01/09/26
**Neonatal Death rate/1000** **0.0**

No significant change




**Latest month** 01/09/26
**HIE rate/1000** **0.0**

No significant change

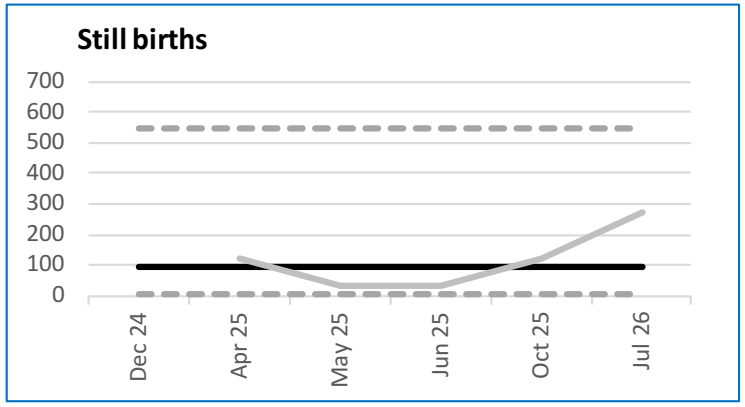


# Trust performance against national safety ambitions

**Date of last stillbirth** 01/07/26

**Average days between stillbirths** **90.9**

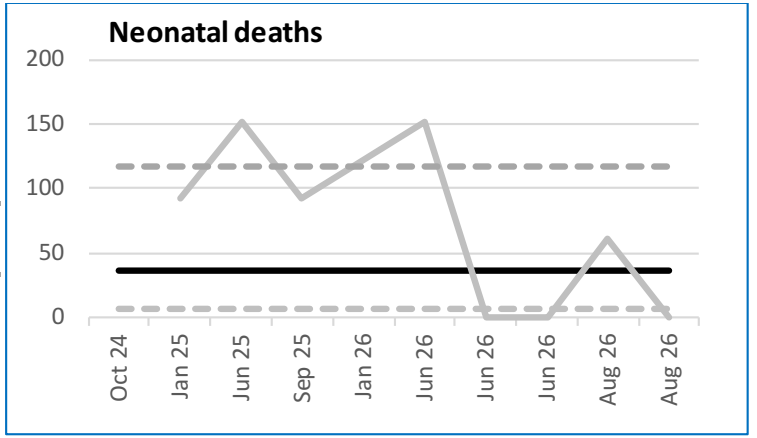
No significant change




**Date of last neonatal death** 01/08/26

**Average days between deaths** **36.7**

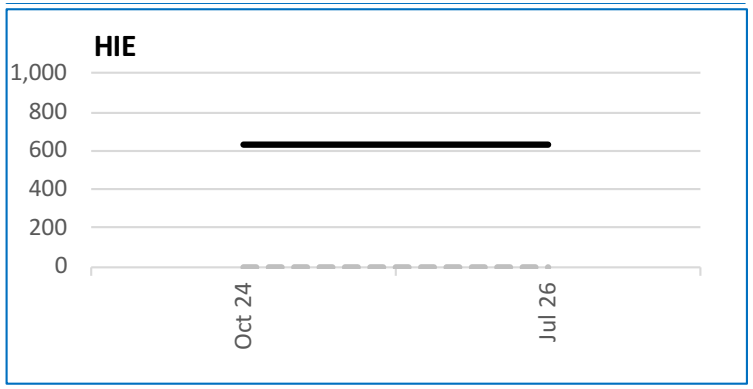
No significant change




**Date of last HIE** 01/07/26

**Average days between HIE** **636.8**

No significant change










| Metric | Period | Value | Variation | Assurance | Target | Benchmark |
|---|---|---|---|---|---|---|
| Women Delivered | Sep-26 | 170 | | | | |
| Term Admission Rate | Sep-26 | 4.1% | | | 4.8% | |
| Neonatal Admissions of Term Babies | Sep-26 | 7 | | | 7 | |
| Live Births | Sep-26 | 170 | | | | |

# 10 Point Plan for maternity and neonatal services

| Action required | Progress | Action | Responsible (role) | By when |
|---|---|---|---|---|
| 1. Listening to women and their families by rolling out Martha's Rule | Implemented within Neonatal Services. Maternity implementation remains in progress. | Complete maternity and neonatal gap analysis and implementation plan. Define audit, reporting and escalation arrangements and monitor through PAIB and Quality and Safety Committee. | DOM | Nov 2026 |
| 2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit data that are acted upon at board level | Established governance reviews outcomes, experience, complaints, incidents, audit and MNVP feedback. A single monthly triangulated report is not yet fully embedded. | Implement a monthly maternity and neonatal quality report bringing together clinical outcomes, audit, experience, complaints, incidents, MNVP intelligence and inequalities, with actions and impact tracked. | HOP | Nov 2026 |
| 3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care | **Compliant.** Joint Board accountability is established, and Director of Midwifery and Clinical Director participation is evidenced. | Maintain established arrangements and ensure governance documentation explicitly reflects attendance arrangements. | DOM | Oct 26 |
| 4. 'Amos into action' staff listening exercise | Awaiting national response. | | | |
| 5. Addressing inequalities in maternity and neonatal outcomes | PEADP participation and six-monthly inequalities review are compliant. Maternal Care Bundle implementation remains partially compliant. Actions for each element are progressing. | Continue inequalities oversight. Finalise and approve Maternal Care Bundle implementation plan with milestones, measures and quarterly reporting towards March 2027 delivery. | Gov business partner | Nov 2026 |

# 10 Point Plan for maternity and neonatal services

| Action required | Progress | Action | Responsible (role) | By when |
|---|---|---|---|---|
| 6. Ensuring 24/7 safety and responsiveness of maternity and neonatal services | Most requirements compliant. Gaps remain in Birthrate Plus establishment and formal specialist workforce resilience review. | Workforce business case for the **5.45 WTE** midwifery gap.<br>A full review of internal resource deployment and specialist workforce resilience across maternity and neonatal services has been completed. | HOM<br>HOP | Nov 26 |
| 7.Trusts to review their homebirth services | **Compliant.** Required review completed. No significant risks requiring regional escalation were identified. | Maintain oversight and assurance that homebirth services remain safe and high quality. | | Oct 26 |
| 8. Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach | **Compliant.** PSIRF, complaints oversight, duty of candour and family engagement processes are established. | Maintain thematic review, learning and Board oversight. Continue embedding trauma informed practice and consistent family debrief arrangements. | | Oct 26 |
| 9. Deliver safe and effective triage in maternity services (already committed by Government) | Benchmarking audit completed. Performance reporting and improvement plan require further alignment with the National Maternity Triage Specification. | Implement monthly triage dashboard covering waiting, assessment and review times, delays, redeployment, outcomes and inequalities.<br>Approve and commence improvement plan with monitored trajectory to implementation. | HOM | Mar 27 |
| 10. Post death care (already committed by Government) | **Compliant.** Board assurance completed with continuing oversight of national post death care actions and recommendations. | Maintain regular Board oversight and monitoring of national recommendations and improvement actions. | | Jul 26 |

# Reported incidents and thematic learning from investigations

## Reported incidents from SPEN,PMRT/MNSI/MOSS/PSIRF findings / National reports

| Incident type | Incident | What actions have been implemented | Family view / DoC | External Reviewer |
|---|---|---|---|---|
| **MOSS** | Drill | IOL QI project identified and full action plan created | N/A | ICB |
| **PMRT** | 31/40 Intrauterine Death | ▪ Review of local 'Management of Polyhydramnios' Guideline<br>▪ Scheduling of growth scans discussed at regional level<br>▪ Review of terminology within 'Fetal growth surveillance' guideline | DOC completed<br><br>Family views sought – No questions for the PMRT. They provided good feedback for care received | External Obstetrician and External Midwife on PMRT review panel – Consensus on identified learning and gradings of care |
| **MNSI** | Coincidental Maternal Death occurred 35 days following a second trimester miscarriage at 17 weeks. The patient had a diagnosis of liver cancer with metastases | ▪ No learning identified | No feedback received | MBRRACE referral |

| Theme | What learning and actions have been prioritised | Outcome / Learning /Actions/ Improvements | What impact have earlier actions had | What support do you need from executive board |
|---|---|---|---|---|
| Escalation and recognition of deterioration | MEOWS/MEWS | ▪ Incorporated in PROMPT and fetal surveillance mandatory study days<br>▪ Digital MEOWS scores<br>▪ Launch of Maternity Early Warning Score (MEWS) as per MCB | Improved escalation and recognition | Nil |

# Coroners' reports

## Outstanding report due

| Date listed | Summary |
|---|---|
| None reported during Quarter 2 | |
| | |
| | |

## Regulation 28 report issued

| Action required | Progress | Responsible (role) | By when |
|---|---|---|---|
| None reported during Quarter 2 | | | |
| | | | |
| | | | |

# NHS Resolution Scorecard

Quarterly triangulation of claims, complaints and patient safety incidents is used to identify recurring themes, inform improvement priorities and provide assurance on learning and risk reduction. Overall assurance: Claims, complaints and incident intelligence demonstrate recurring themes around recognition and escalation, communication and timeliness of care. These themes are informing current maternity improvement priorities and risk mitigation.

<table>
<tr><th colspan="2">Key themes from 10-year claims analysis</th><th>Themes identified from Complaints (current)</th></tr>
<tr><td>Obstetrics:<br>Contributing factors<br>• Failure or delay in recognising deterioration or complications<br>• Delay in treatment<br>• Failure to act on clinical findings or abnormal test results</td><td>The themes from low value clinical negligence claims include:<br>• Emergency and elective caesarean birth complications<br>• Delay in treating infection<br>• Care concerns associated with intrapartum or neonatal death<br>• Failure or delay in responding to abnormal cardiotocography<br>• Failure or delay in recognising retained products of conception</td><td>• Delay in treatment (analgesia)<br>• Emotional trauma<br>• Communication and information giving<br>• Staff attitude</td></tr>
<tr><th colspan="2">Themes identified from Maternity & Neonatal Patient Safety Incidents</th><th>Themes identified from other sources (e.g. staff feedback, family feedback, FSU etc)</th></tr>
<tr><td>• Postpartum haemorrhage<br>• Obstetric anal sphincter injury<br>• Shoulder dystocia<br>• Delayed induction of labour</td><td>• Term admissions to NNU<br>• OASI<br>• Shoulder dystocia<br>• Delayed IOL</td><td>• Staff feedback - concerned re: safe staffing<br>• Patients like the new environment, receive good care</td></tr>
</table>

| Improvement actions from identified themes | Outstanding risks & mitigations |
|---|---|
| • Medicine rounds reintroduced to strengthen medicines safety<br>• Patient experience rounds introduced to identify and respond to concerns<br>• Risk assessment processes throughout pregnancy reinforced<br>• IOL (patient flow) – QI project commenced<br>• Full Birthrate+ assessment completed June 2026, recruiting to shortfall (5.45 WTE) | • **Maternal Early Warning Score:** electronic patient record development remains outstanding, with implementation monitored through the Maternal Care Bundle plan.<br>• **Induction of labour:** delays remain an improvement priority, with the 90-day improvement plan in place and enhanced oversight of prolonged delays. |

# Perinatal Improvement Plan



Progress against national and local perinatal improvement priorities, including actions arising from reviews, learning and the Patient Safety Incident Response Framework (PSIRF).

| Escalations | Support required | Progress from previous escalations |
|---|---|---|
| Maternity triage: Further improvement | Continued digital and data support to develop a reliable monthly maternity triage dashboard and strengthen routine performance reporting. | National maternity triage benchmarking audit completed and reviewed through Trust governance. Improvement plan developed, with implementation and enhanced dashboard reporting now the focus. |
| Induction of Labour: Prolonged delays, particularly awaiting artificial rupture of membranes, remain an improvement priority. | Continued operational, workforce and data support to deliver the 90-day Induction of Labour Improvement Plan and address identified capacity constraints. | 90-day improvement plan implemented, with strengthened oversight, escalation and senior review. Performance is monitored through delays over 12 hours, over 24 hours and delays awaiting artificial rupture of membranes. |
| Maternity workforce: Birthrate Plus establishment requirements to support safe delivery of maternity care | Executive Team consideration of the costed workforce paper and agreement of the approach to addressing the identified establishment gap.<br>. | Birthrate Plus review completed. A 5.45 WTE establishment gap has been identified. A costed workforce paper and proposed phased approach have been developed for Executive consideration. Final phasing and investment remain subject to approval, with progress monitored through established governance and reported to Board |

# Performance Metrics

Service Suspensions

Number of times services were suspended

| | Month | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jan | Feb | March | April | May | June | July | Aug | Sep | | | |
| Obstetric unit | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | | | |
| Midwifery led unit | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | | | |
| Homebirth service | 0 | 1 | 0 | 0 | 0 | 3 | 0 | 1 | 0 | | | |
| Neonatal unit (internal) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | |
| Neonatal unit (external) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | |

## Women experiencing delays to induction >6hrs

Number of women whose commencement of induction of labour (IOL) is delayed >6 hours from point of admission for induction (from home or ward)

| | Month | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jan | Feb | March | April | May | June | July | Aug | Sep | | | |
| Delays to induction >6hrs | No data available | | | 8 | 13 | 7 | 19 | 14 | 8 | | | |

## Women experiencing delays to elective caesarean section >24hrs

Number of women scheduled for an elective caesarean section who had this delayed by more than 24hrs

| | Month | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jan | Feb | March | April | May | June | July | Aug | Sep | | | |
| Delays to elective caesarean section>24hrs | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | | | |

# Home births in the last quarter

| No. home births/ BBA (births before arrival) | No. birthing at home against medical advice | No. of births at home where there is a multi-disciplinary plan in place | No. transferred into acute unit | No. of transfers with a delay |
|---|---|---|---|---|
| 3 | 0 | 0 | 1 | 0 |

## Learning and action taken from incident review and audits

| Learning | Action | Progress on actions / impact |
|---|---|---|
| Seven women booked for home birth during the period. Three home births took place, and one woman required transfer by ambulance to the acute unit. No delayed transfers were identified. Service availability was affected on one occasion due to inpatient acuity. | Home birth activity, transfers and service availability continue to be monitored. Learning is informing ongoing review of the home birth pathway and operational guidance. | All women booked for home birth were receiving midwifery led continuity of care at the point of booking. |

| | Approved by | Date approved |
|---|---|---|
| Operational guideline inclusive of midwifery, obstetrics, neonates and ED Multidisciplinary home birth operational guideline | Yes | 2025 |
| Guidance for women choosing to birth outside clinical recommendations | In progress | In progress, due December 2026 |

# Triage



| Metric | Month 1 | Month 2 | Month 3 |
|---|---|---|---|
| 1. Proportion of women for whom expected timeframes are met for initial assessment and for clinical review, based on their category of urgency. | 86% | 90% | 93% |
| 2. Number of improvement actions implemented where issues are identified, including through service user feedback, performance data, incidents, audits, complaints or staff feedback | 0 | 0 | 1 |
| 3. Frequency of staff being redeployed to other maternity care areas within the unit from maternity triage:<br>% of shifts affected by re-deployment | Not recorded | Not recorded | Not recorded |

Performance against initial assessment and clinical review timeframes has improved across Quarter 2. However, routine reporting of staff redeployment from triage is not yet established, representing an outstanding assurance gap. Implementation of the Manager of the Day role and associated documentation will support improved monitoring

| Improvement actions | Progress | Impact | Responsible |
|---|---|---|---|
| Implement a Manager of the Day (MOD) role with operational oversight of the entire maternity service | Manager of the day to commence 2nd November 2026 | The MOD will provide visible leadership across all maternity areas, maintain situational awareness of staffing, capacity and patient flow, and coordinate escalation where required. All staffing redeployments will be authorised through the MOD and documented contemporaneously on the Manager of the Day paperwork and within the e-roster system | Claire Davies |
| Establish a multidisciplinary working group to oversee delivery of the Amos review recommendations | An initial meeting has been held between the Midwifery Matron and MATU Lead to review all Amos recommendations and assurance requirements. This meeting identified the key workstreams, considered the stakeholders required to support implementation, and began determining how evidence and information will be gathered to demonstrate compliance | Membership will include representatives from Midwifery, Obstetrics, Operations and the Digital Team. The group will develop and monitor a detailed action plan, ensuring that all recommendations and assurance requirements identified within the Amos report are either implemented or actively progressed with clear ownership, timescales and evidence of completion. | Helen Chapman |

# Training compliance

Maternity Incentive Scheme checkpoint 1 requirements met. Overall compliance remains high across most core training requirements, with targeted improvement required in identified staff groups and Quality Improvement Skills training.

MIS Checkpoint Date 1: 31 July 2026 **met** Next MIS Checkpoint Date 2: 30 November 2026

| | Midwives | Obstetricians | | MSWs | Anaesthetists | | Neonatal medical | | Neonatal Nursing (inc. ANNP) |
|---|---|---|---|---|---|---|---|---|---|
| | | Consultants | Resident | | Consultants | Resident | Consultants | Other | |
| **Obstetric emergency training (PROMPT)** | 117<br>98% | 13<br>100% | 16<br>76% | 31<br>100% | 23<br>83% | 20<br>86% | | | |
| **Fetal monitoring and surveillance** | 117<br>100% | 13<br>100% | 13<br>100% | | | | | | |
| **Neonatal resus training (including assessment)** | 117<br>99% | | | | | | 13<br>100% | 24<br>100% | 23<br>100% |
| **Mandatory & Stat training** | 92% | 86% | Held by host trust | 93% | 89% | Held by host trust | 86% | Held by host trust | 87% |
| **% QIS** | | | | | | | | | 62% |

| | Date & location of last simulation | Themes/learning identified & actions taken |
|---|---|---|
| **Hospital** | 16.09.2026 IOL suite. | • Multidisciplinary simulation completed. Learning identified around emergency response, structured handover and transfer to maternity theatre, with actions agreed. |
| **Community** | 09.09.2026<br>Longhouse Conference Room A. | • Multidisciplinary simulation completed. Learning identified around community emergency response, home birth equipment and emergency transfer arrangements, with actions agreed |

# Staffing Vacancy rates

| Staff group | Vacancy rate (%) |
|---|---|
| Midwifery | 3.58%<br>(Band 5 & 6) |
| Maternity Support workers | 19.35%<br>(Band 2 & 3) |
| Obstetric consultants<br>Resident doctors | 0.26%<br>0% |
| Neonatal Nurses | 31%<br>(Band 5 & 6) |
| ANNP | 0% |
| Neonatology consultants<br>Resident doctors | 0%<br>0% |
| Obstetric anaesthetists<br>Resident doctors | 0%<br>0% |

| Risks | Mitigations | Escalations |
|---|---|---|
| Midwifery Staffing<br>• Early career workforce<br>• Skill mix reduced | • Recruited band 6 midwives<br>• Robust preceptorship<br>• Pastoral support | |
| Maternity Support Workers<br>• Recruitment process, unable to shortlist from120 applications | • Readvertise the post | |

# Safety Champions feedback

| Feedback raised by staff | Action and progress |
|---|---|
| Digital systems and their impact on safe maternity care remain a concern, particularly system interoperability and the pace of improvement. | Digital concerns continue to be monitored through established governance arrangements, with staff contributing to improvement work and identification of system issues. |

| Feedback raised by service users | Action and progress |
|---|---|
| Feedback Service user feedback highlights positive experiences of bereavement, neonatal and perinatal mental health care, alongside opportunities to strengthen postnatal support, communication and consistency. | Feedback is informing improvement priorities. Proactive postnatal telephone contact has been introduced following the Perinatal Mental Health listening event, with further engagement work progressing through the MNVP. |

| Additional safety champions intelligence | Action and progress |
|---|---|
| Continued focus is required on psychological safety, staff confidence to raise concerns and visible leadership. | Safety huddles, Freedom to Speak Up and Just Culture approaches are embedded within the cultural improvement plan. Executive and senior clinical walk rounds continue. |

| Escalations | | Support required | Progress from previous escalations |
|---|---|---|---|
| Digital systems and their potential impact on safe maternity care remain an area requiring continued oversight. | | Continued senior leadership and digital support to progress system improvements and maintain visibility of maternity digital risks. | Staff remain engaged in improvement work and digital issues continue to be monitored through established governance arrangements |

# Themes and progress with Perinatal Cultural Improvement Plan

| Theme | Progress | Support requirements |
|---|---|---|
| Psychological safety and speaking up | Safety huddles, Freedom to Speak Up and Just Culture approaches are embedded within the improvement plan. Staff confidence to raise concerns remains an area requiring continued focus and monitoring | Continued senior leadership focus on psychological safety and ensuring staff have confidence to raise and challenge concerns. |
| Visible leadership and learning culture | Executive and senior clinical walk rounds continue. Improvement work is strengthening how learning and feedback from incidents, PMRT, mortality and morbidity reviews and SWARM reviews are consistently shared with staff and translated into practice | Sustained leadership visibility and consistent evidence that learning is shared, acted upon and embedded |
| Parent, family and service user voice | MNVP and parent involvement is being strengthened, with a focus on co-design and clearer evidence of how lived experience leads to service improvement. | Continued co-production, with measurable evidence of change through “You Said, We Did” and family feedback. |

# Insights from service users and Maternity & Neonatal Voices Partnership Co-production

**Bereavement Care**

The MNVP's ongoing bereavement group continues to be a valued source of peer support and feedback. Families speak highly of the compassionate care provided by the bereavement team and their experiences of the Lavender Suite.

Discussions have highlighted how profoundly grief can affect physical recovery, with families describing difficulties managing basic self-care, including eating, taking medication and looking after themselves following loss.

Families experiencing subsequent pregnancies have praised maternity triage and fetal Medicine staff for recognising their anxieties and providing additional reassurance without judgement.

**Perinatal Mental Health Listening Event – July 2026**

The MNVP and the Trust held a dedicated Perinatal Mental Health listening event, gathering feedback across the antenatal, birth and postnatal journey.

Families were extremely positive about the eight-week antenatal mental health course, particularly the trusted relationships, peer support and confidence it provided.

A key theme was the reduction in structured support following birth. Families requested proactive postnatal contact rather than having to recognise difficulties and seek support themselves. Families also proposed a structured postnatal peer-support programme.

*Proactive postnatal telephone calls have now been introduced in response to feedback, supporting earlier contact and continuity of care.*

**Other Key Service User Insights**

**Communication and consistency:** Feedback identified conflicting information during complex antenatal admissions, particularly around care plans and discharge decisions.

**Neonatal experience:** Parents praised the neonatal team for regular telephone updates when unable to visit, inclusion of siblings and excellent breastfeeding and expressing support, including after discharge.

**Equity and engagement:** An MNVP review identified underrepresentation of some communities, particularly Gypsy, Roma and Traveller families, those experiencing deprivation and those whose first language is not English. *To address this, work is progressing to strengthen community relationships, the feedback survey has been translated into most common languages, and a drop-in listening session is being held at Tomorrow's Women.*

# Saving Babies Lives v3.2 - 99% compliance for Q2

| | Compliance / progress / action |
|---|---|
| EI 1: Smoking in pregnancy | **100% compliance**, Full assurance. Required thresholds achieved. Improvement action in place to strengthen quit rates and local guidance. |
| EI 2: Fetal growth | **100% compliance**, Full assurance. All audited standards achieved. |
| EI 3: Reduced fetal movement | **100% compliance**, Full assurance. Required thresholds achieved.<br>. |
| EI 4: Fetal monitoring | **100% compliance**, Full assurance. Training, competency and intrapartum risk assessment requirements achieved. |
| EI 5: Pre-term births | **96% compliance**, Full assurance. Required interventions meet or exceed thresholds. |
| EI 6: diabetes in pregnancy | **100% compliance**, Full assurance. Required interventions meet or exceed thresholds. |

| | |
|---|---|
| **What is going well** | A high level of compliance was demonstrated across all six elements giving an overall SBL compliance of 99% for Quarter 2.<br>No immediate patient safety concerns identified, and no formal action plans required. |
| Areas for continued improvement | • Reduced fetal movements: ultrasound completion is monitored within 72 hours due to local capacity, rather than the 'next working day' standard on the regional guideline.<br>• Brain Injury: The rolling 12-month mean for babies born below 32 weeks' gestation was 15% (2 of 13 babies affected), exceeding the threshold of <7%. All cases continue to be monitored and reviewed through established neonatal and maternity governance processes. |
| Key exceptions | • Uterine artery Doppler assessment: **97%**, following one missed assessment.<br>• Resident doctor symphysis fundal height competency: **77%**, with overall training compliance remaining above target.<br>• Fresh Eyes fetal monitoring review: **86%**, with improvement focused on documentation and peer review consistency. |

# The Maternal Care Bundle



## Implementation Progress

| Intervention Elements | Description | Element Progress Status (Self assessment) | % of Interventions Fully Implemented (Self assessment) | Element Progress Status (Trust Board Validated) | % of Interventions Fully Implemented (Trust Board Validated) | Escalation required for board review* |
|---|---|---|---|---|---|---|
| Element 1 | Venous thromboembolism (VTE) | Not implemented | 0% | | 0% | Yes |
| Element 2 | Pre-hospital and acute care | Not implemented | 0% | | 0% | Yes |
| Element 3 | Epilepsy in pregnancy | Not implemented | 0% | | 0% | Yes |
| Element 4 | Maternal mental health | Not implemented | 0% | | 0% | No |
| Element 5 | Obstetric haemorrhage | Fully implemented | 100% | | 0% | Yes |
| All Elements | TOTAL | Partially implemented | 21% | | 0% | |

*If yes, please refer to 'Board summary - action plans' worksheet for details.

| | |
|---|---|
| **What is going well** | • Implementation is progressing, with some elements dependent on digital, regional and system developments. NHS Resolution has clarified that full implementation of all Maternal Care Bundle requirements by March 2027 is not itself a Maternity Incentive Scheme Year 8 requirement, provided appropriate planning, Board oversight, escalation and risk management arrangements are demonstrated.<br>• Element 5, obstetric haemorrhage, is fully implemented.<br>• Digital developments are progressing to support audit, reporting and compliance monitoring.<br>• Maternal Early Warning Score developments are progressing within the electronic patient record.<br>• Screening questions for maternal mental health are embedded within the electronic patient record. |
| **What is of concern** | • Elements 1 to 4 remain in implementation, with delivery dependent on a combination of digital developments, regional guidance and system pathways.<br>• Digital dependencies remain for maternal mental health and implementation of the Maternal Early Warning Score.<br>• Regional/system dependencies remain for venous thromboembolism, pre-hospital and acute care, epilepsy in pregnancy and early pregnancy prescribing pathways.<br>• Associated risks and external dependencies require continued oversight and escalation. |
| **What are the top contributors for under/over-achievement** | • Regional guidance: Updated Maternal Medicine Network guidance is required to support implementation of venous thromboembolism, pre-hospital and acute care, and epilepsy in pregnancy elements.<br>• System pathways: Integrated Care Board support is required to progress early pregnancy low molecular weight heparin prescribing pathways across primary care and non-maternity services.<br>• Trust-wide delivery: Digital development, electronic patient record changes, business intelligence reporting and workforce training are required to support implementation of the Maternal Care Bundle |

# 11. Progress to achieve NHS Resolution, Maternity Incentive Scheme Year 8, six safety actions

| | Assessment of compliance (met/partially met/not met ) | Is there clear evidence to support compliance | Gaps requiring action |
|---|---|---|---|
| **A – Workforce and Capacity** | MET | Yes – PAIB Perinatal Assurance and Improvement Board & Board reports | |
| **B - Training** | On track | Yes – PAIB & Board reports | Targeted improvement required in specified obstetric and anaesthetic training compliance. |
| **C - Learning from reviews and investigations** | MET | Yes – PAIB & Board reports | |
| **D - Service User Voice and Equity** | MET | Yes – PAIB & Board reports | |
| **E - Care Bundles** | MET | Yes – PAIB & Board reports | Maternal Care Bundle implementation plan presented within this paper, with key dependencies identified and escalated. |
| **F - Board Oversight, Governance, Culture and Leadership** | MET | Yes – Quarterly Board reports | |

| | |
|---|---|
| What is going well | Five Safety Actions are currently assessed as met. Safety Action B remains on target, with targeted improvement required in specified obstetric and anaesthetic staff groups. |
| What is of concern | Maternal Care Bundle implementation, digital dependencies and targeted training compliance remain areas for continued oversight and improvement |
| What are the top contributors for under/over-achievement | Named clinical leads, established governance arrangements and regular reporting support delivery and assurance across all six safety actions. |

# Data measures for perinatal quality oversight tool

| Metric | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Findings of review of all perinatal deaths using the real time data monitoring tool | A/B/B | - | - | - | - | - | C/A | - | - | | | | |
| Findings of review of all cases eligible for referral to MNSI | ✓ | - | - | - | - | - | - | - | - | | | | historic case |
| The number of patient safety incidents logged and what actions are being taken | 57 | 56 | 79 | 74 | 113 | 92 | 114 | 101 | 81 | | | | |
| Service user voice feedback - themes | Support | Experience | Cultural inclusion | Family involvement | Communication | Postnatal support | Mental health | Equity / Engagement | Triage | | | | |
| Staff feedback from frontline champion and walk-abouts - themes | Staffing | Communication | Speaking up | Leadership visibility | Workforce | Learning culture | Digital systems | Staffing | Digital | | | | |
| MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust | Nil | Nil | Nil | Nil | Nil | Nil | Nil | Nil | Nil | | | | |
| Coroner Reg 28 made directly to Trust | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| Progress in achievement of MIS Safety actions | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | |
| Proportion of midwives responding with ‘Agree’ or ‘Strongly Agree’ on whether they would recommend their trust as a place to work or receive treatment | Reported annually52.5% of Women and Children’s Division respondents agreed or strongly agreed that they would recommend the Trust as a place to work, while 58.2% were positive that they would be happy with the standard of care provided if a friend or relative required treatment. | | | | | | | | | | | | |
| Proportion of speciality trainees in Obstetrics & Gynaecology responding with ‘Excellent’ or ‘Good’ on how they would rate the quality of clinical supervision out of hours | Very good 26.9%<br>Good 54.2% | | | | | | | | | | | | |

**PUBLIC – Board of Directors**
**24th November 2026**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Report** | **Agenda Item 14.** | **Quarter 2 2026-2027 Mortality Surveillance Report (learning from deaths)** | | | | | | |
| **Purpose of the Report** | Decision | | Ratification | | Assurance | **X** | Information | |
| **Accountable Executive** | Dr Nigel Scawn | | | Medical Director | | | | |
| **Author(s)** | Dr Ian Benton | | | Deputy Medical Director | | | | |
| **Board Assurance Framework** | BAF 1 Quality<br>BAF 2 Safety<br>BAF 3 Operational<br>BAF 4 People<br>BAF 5 Finance<br>BAF 6 Capital<br>BAF 7 Digital<br>BAF 8 Governance<br>BAF 9 Partnerships<br>BAF 10 Research<br>BAF 11 Transformation | | | **X**<br><br><br><br><br><br><br>**X** | | | | |
| **Strategic goals** | Patient and Family Experience<br>People and Culture<br>Purposeful Leadership<br>Adding Value<br>Partnerships<br>Population Health | | | | | | | |
| **CQC Domains** | Safe<br>Effective<br>Caring<br>Responsive<br>Well led | | | | | | | **X**<br><br><br><br>**X** |
| **Previous considerations** | Quarter 1 Report July 2026 | | | | | | | |
| **Executive summary** | The purpose of this report is to provide ongoing assurance as to the Trusts structures, processes and oversight of mortality.<br><br>This report confirms that Mortality Indicators consistently remain within 'as expected' range<br>• SHMI for June 25 – May 26 is **89.8** ('as expected' range)<br>• HSMR for August 25 – July 26 is **100.71** ('as expected' range)<br><br>The Medical Examiner's Office have adapted their escalation processes to include a threshold requiring a governance review (reported via Datix) to allow an expedient case review, and those where learning / reflecting on cases would be best served to be discussed at departmental morbidity and Mortality Meetings.<br><br>11 cases have been escalated via Incident reporting for review in the last quarter. | | | | | | | |

| | |
|---|---|
| | Changes have also been implemented to align the oversight and learning from Coroners Inquests, mortality reviews and harm events (where the patient has died).<br><br>This report covers all adult deaths occurring within the hospital setting and a summary of women's, neonatal and paediatric mortality reviews completed. |
| **Recommendations** | The Board is assured by the contents of this paper and that learning from mortality and morbidity is improving across the organisation within the learning and safety meeting structures / groups reaching multiprofessional audiences. |

| **Corporate Impact Assessment** | |
|---|---|
| **Statutory/regulatory requirements** | Legal and regulatory compliance |
| **Risk** | Quality and safety. |
| **Equality & Diversity** | Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics |
| **Communication** | Public Board |

# Mortality Dashboard Quarter 2 2026-7

## Mortality Review

- 278 patients died (inpatient) in the Trust between 1st July 2026 – 30th September 2026.
- 100% were scrutinised by the Medical Examiner's Office
- 11 patients were identified by the ME's for further mortality/governance review. All are progressing with PSIRF oversight.
- 15 patients for departmental review for aspects of learning
- There were 2 reported deaths under LeDeR criteria

## Mortality Rate (SHMI / HSMR)

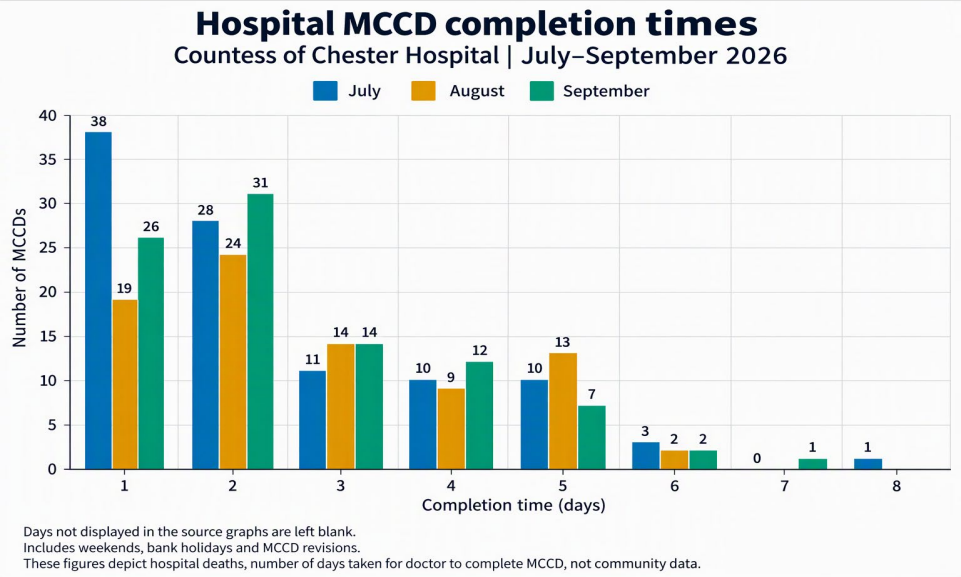
- SHMI for June 25 – May 26 is **89.8** ('as expected' range)
- HSMR for August 25 – July 26 is **100.71** ('as expected' range)
- All mortality measures have been within expected range for the last 9 quarter reporting periods.

| Medical Examiners Activity | | | | | |
|---|---|---|---|---|---|
| Month | Total Adult (inpatient) Deaths | Escalated (governance/datix) | Mortality review requests (learning) | HM Coroner referral | Deaths that occur in patients with a Learning Disability |
| July 2026 | 101 | 7 | 5 | 18 | 2 |
| August 2026 | 80 | 1 | 7 | 11 | 0 |
| September 2026 | 97 | 3 | 3 | 16 | 0 |

## Medical Examiners Updates

Since legislation came into effect on 9.9.24 the Medical Examiners continue to review 100% of all hospital and community based deaths.
The office is staffed to 1 WTE Medical Examiner, also providing on call cover over a weekend to accommodate faith deaths.
Following feedback and a review of ME practices there has been further refinement to their guidance regarding thresholds for categories of escalation to both Secondary and Primary care.
Where they feel there have been possible lapses in care that has led to a harm event they are now reported via datix. For learning and reflection these will be highlighted on a weekly basis.
Where aspects relate to pre-hospital care eg decisions to admit, transfer documentation, Advance care plans and preferred place of care, these will be fed back to the primary care teams, rather than to hospital escalation.
In response to an increasing trend to escalate deaths where they have died in hospital whilst being medical optimised for discharge, these are reported and forwarded to the Integrated discharge team.

The issuing of a Medical Cause of Death (MCCD) and the scrutiny of the medical record is undertaken swiftly in the majority of cases.
Data below is the performance following notification of hospital death to completion of ME process.



# Indicator trends

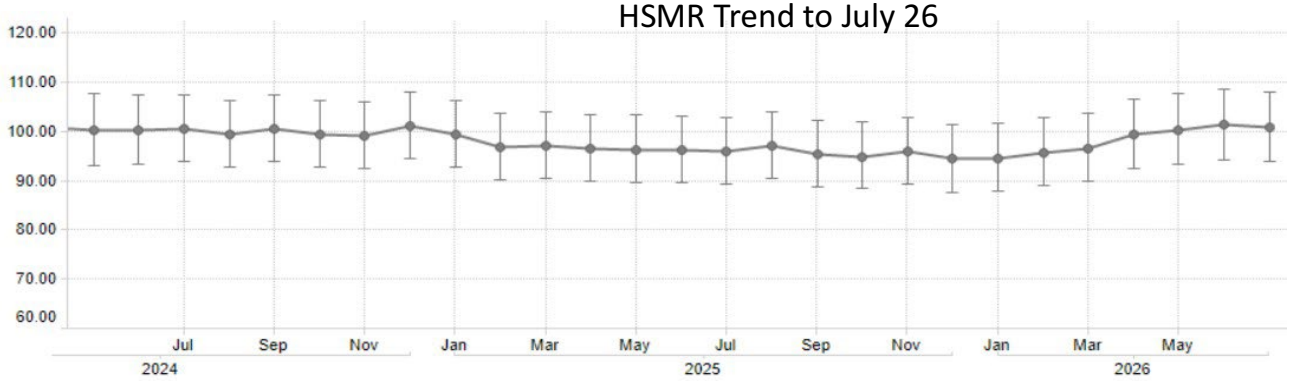
Countess of Chester Hospital NHS Foundation Trust

Data type: HED SHMI & HED HSMR

SHMI Trend to June 26




HSMR Trend to July 26



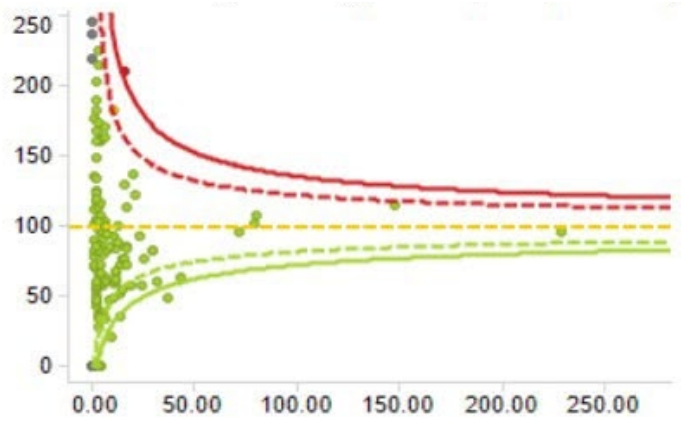

Both the rolling HSMR and SHMI trends show the last 24 data periods reporting within the expected range.

# Statistical outliers – diagnosis aggregate level

Countess of Chester Hospital NHS Foundation Trust

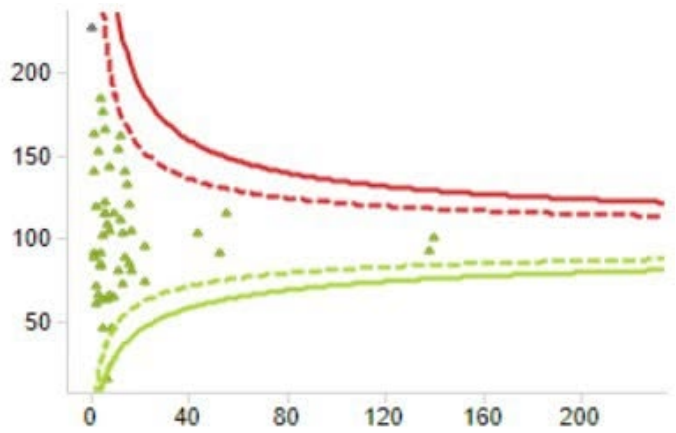
Data type: HED SHMI & HED HSMR

SHMI funnel plot for Jul25-Jun26




There is one 'amber' statistical outlier at diagnosis group level – cardiac arrest and ventricular fibrillation. There is one 'red' – cancer of bronchus; lung

HSMR funnel plot for Aug25 - Jul26




There are no statistical outliers at diagnosis group level

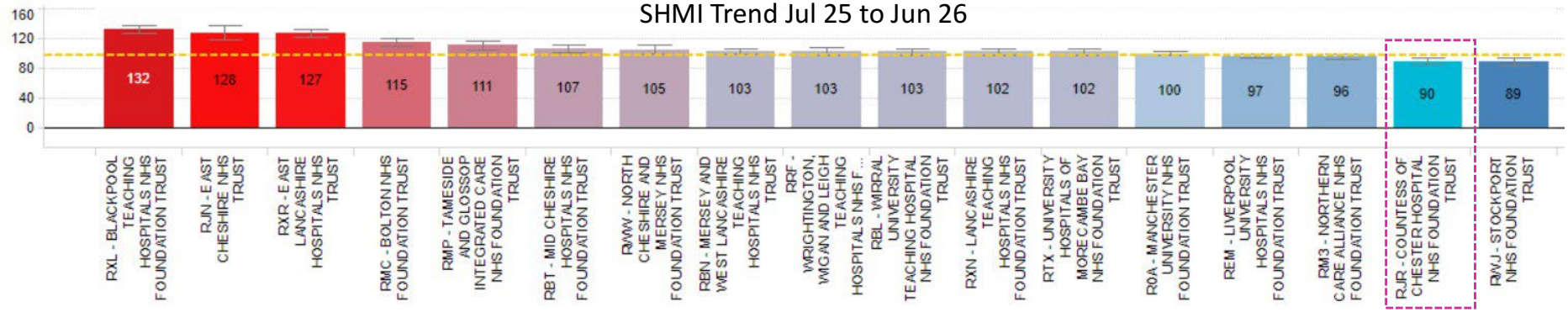
99.8% Control Upper Limit  95% Control Upper Limit

# Peer comparison

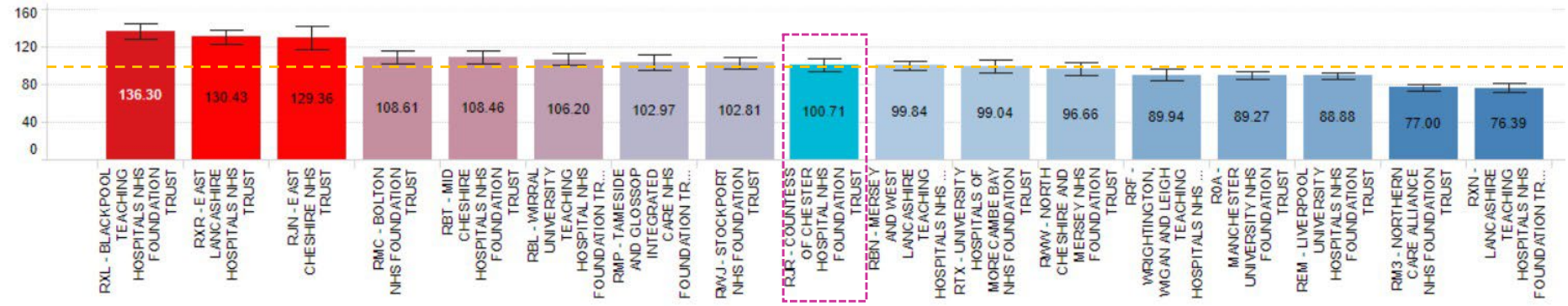
Countess of Chester Hospital NHS Foundation Trust

Data type: HED SHMI & HED HSMR

SHMI Trend Jul 25 to Jun 26




HSMR Trend Aug 25 to Jul 26

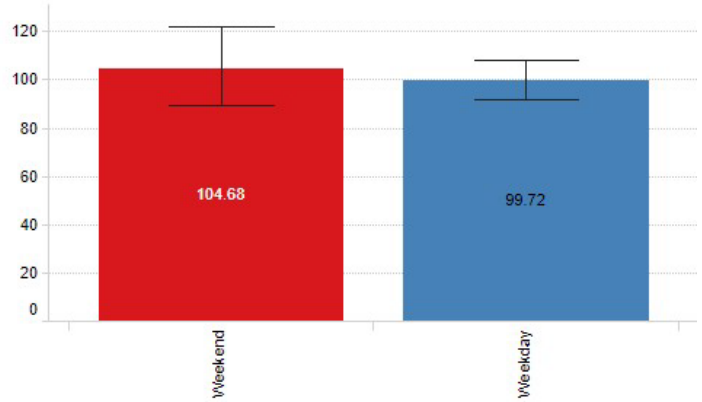


# Weekday/Weekend

Countess of Chester Hospital NHS Foundation Trust

Data type: HED HSMR

## HSMR Weekend and Weekday Aug25-Jul26




Weekend mortality is within range 104.68

Weekday mortality is within range 99.72

| Weekday/Weekend Admission | HSMR | Number of provider spells with palliative care coding | Number of super-spells | Number of super-spells (%) | Number of observed deaths | HSMR 95% Upper CI | HSMR 95% Lower CI | Expected number of deaths | Expected rate (%) | Obs.- Exp | Comorbidity score per super-spell | Crude rate (%) | Palliative care per 1,000 super-spells |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Weekday | 99.72 | 458 | 21554 | 88.82% | 624 | 107.86 | 92.05 | 625.77 | 2.90% | -1.77 | 8.44 | 2.90% | 21 |
| Weekend | 104.68 | 110 | 2714 | 11.18% | 164 | 121.99 | 89.27 | 156.67 | 5.77% | 7.33 | 10.37 | 6.04% | 41 |
| Grand total | 100.71 | 568 | 24268 | 100.00% | 788 | 108.00 | 93.80 | 782.43 | 3.22% | 5.57 | 8.65 | 3.25% | 23 |

## Perinatal Deaths

This report provides Quarter Two 2026/2027 summary of women's, neonatal and paediatric mortality reviews completed. Cases were reviewed using the Perinatal Mortality Review Tool (PMRT) where applicable, and learning has been agreed through multi-disciplinary review processes. Learning is shared to improve the quality and safety of care and to prevent recurrence.

Cases Reviewed in Quarter Two

**Intrauterine deaths reviewed:** 1

**Neonatal deaths reviewed:** 0

**Maternal Death:** 1 (coincidental death)

Initial learning response were completed, learning identified and actions agreed. Eligible cases are then reviewed using the Perinatal Mortality Review Tool (PMRT) and any care issues identified incorporated into quality improvement work programmes.

## Notes / Glossary

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

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

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

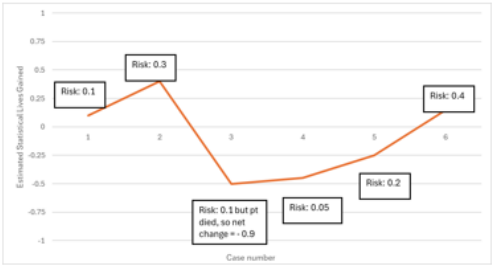
**Summary Hospital-level Mortality Indicator (SHMI) v Hospital Standardisation Mortality Ration (HMSR)**

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

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

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

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




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

**PUBLIC – Board of Directors**
**24th November 2026**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Report** | **Agenda Item 16.** | **Non-elective Pressure & Impact on Finance and Performance** | | | | | | |
| **Purpose of the Report** | Decision | | Ratification | | Assurance | | Information | **x** |
| **Accountable Executive** | Daniel Nash | | | Director of Transformation & Productivity | | | | |
| **Author(s)** | Daniel Nash & Tom Jackson | | | Director of Transformation & Productivity, Divisional Director of Operations Urgent Care | | | | |
| **Board Assurance Framework** | BAF 1 Quality<br>BAF 2 Safety<br>BAF 3 Operational<br>BAF 4 People<br>BAF 5 Finance<br>BAF 6 Capital<br>BAF 7 Digital<br>BAF 8 Governance<br>BAF 9 Partnerships<br>BAF 10 Research<br>BAF 11 Transformation | **X**<br>**X**<br><br><br><br>**X**<br><br><br><br><br>**X** | | | | | | |
| **Strategic goals** | Patient and Family Experience<br>People and Culture<br>Purposeful Leadership<br>Adding Value<br>Partnerships<br>Population Health | | | | | | | **X**<br><br>**X**<br>**X** |
| **CQC Domains** | Safe<br>Effective<br>Caring<br>Responsive<br>Well led | | | | | | | **X**<br>**X**<br><br>**X**<br>**X** |
| **Previous considerations** | Not applicable | | | | | | | |
| **Executive summary** | The purpose of this report is to demonstrate the impact of attendance growth and increasing NCTR volumes on the trust performance against UEC key performance indicators, and its ability to transact on savings following evidenced improvements. The paper compares data from September 2024-August 2025 to September 2025- August 2026 to enable a month-on-month comparison of demand across a range of metrics.<br><br>The paper demonstrates through the data how increases in demand across our urgent and emergency care pathways have created an additional pressure of 48 beds per day. The additional 48 beds are accounted for through an increase of 7 in our NCTR patient cohorts in our inpatient beds, and increased admissions demand of 41 beds per day. | | | | | | | |

| | |
|---|---|
| | This pressure is masking improvements across pathways, which have led to a reduction of 0.78 days in our average length of stay. This reduction equates to a reduction of 42 beds in demand profile, with other improvements in pathways fully mitigating the 48 bed pressure, as evidenced through our UEC KPI's (4 Hour, 12 hour and ambulance handover performance).<br><br>If the improvements delivered were transactable it would equate to a £6m saving opportunity across temporary escalation spaces (TES) and core beds. This saving is mainly through a reduction in pay spend, which would equate to circa 105 WTE. If a decision was made to realise performance benefit over savings the paper also outlines the forecast improvement across the 3 UEC KPI's whilst acknowledging the R value of ED occupancy on each metric.<br><br>The additional income generated through increased demand equates to £2m in year and £4m recurrently leaving a residual net financial pressure of £4m in year and £2m recurrently, however it is worth noting that since the paper was completed the organization has seen a sustained increase in demand across September and October above the volumes seen in the first 5 months of this financial year. |
| **Recommendations** | The Board of Directors is asked to **note** the information included within the paper |

| **Corporate Impact Assessment** | |
|---|---|
| **Statutory/regulatory requirements** | Not applicable |
| **Risk** | Not applicable |
| **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 agenda pack |

## Non-Elective Admissions Impacting Finance and NHS Standards

**Rising inpatient demands from factors outside of the organisation's immediate and direct control masking improvements in inpatient LoS and resulting in the inability to achieve NHS quality standards and financial savings.**

## 1. Introduction

Following discussions between the Divisional Director of Urgent Care and the Director of Transformation regarding the inability to transact improvements due to factors beyond the control of The Countess of Chester it was agreed that a paper would be produced to demonstrate:

- The specific challenges faced at COCH and the scale of impact
- Demonstrate the impact on UEC finances and operational performance
- Articulate work undertaken internally to improve length of stay

To undertake this analysis the Business Intelligence (BI) team undertook a year-to-year comparison (2024/25 against 2025/26) across a range of specific KPI's, which is included in Appendix A, the cohort of patients exclude paediatrics from these core comparisons outlines in section 2. The initial year-on-year data review only included completed datasets for each month so commences September 2024 and runs through to August 2026 to enable comparison to the same month the preceding year.

## 2. Inpatient Demand and Capacity

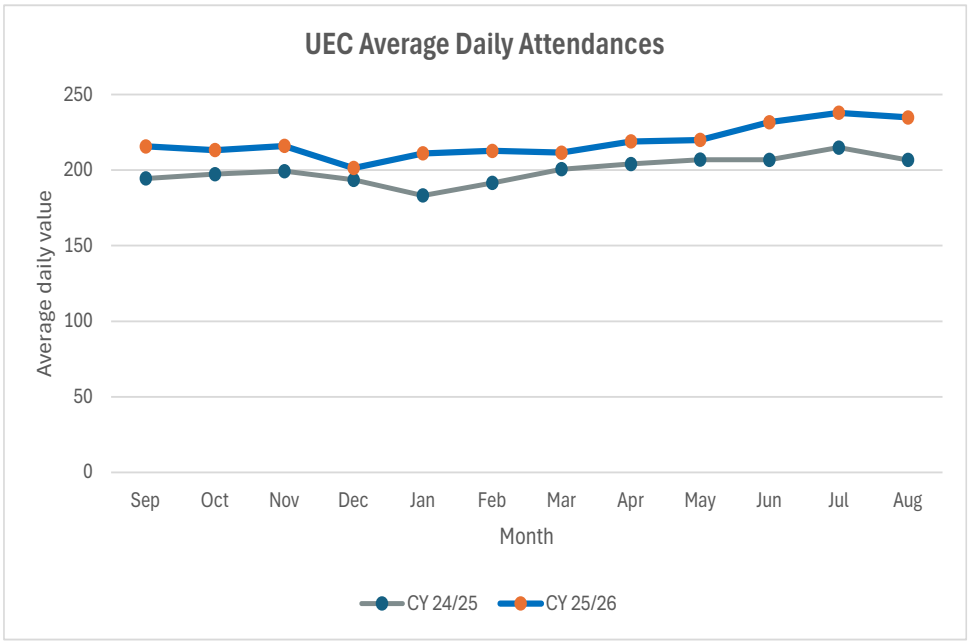
### 2.1. Non-Elective Admission Pressure

To articulate the inpatient non-elective pressure the trust faced, data for daily attendances, daily UEC admissions and total daily emergency admissions were reviewed.

The data clearly demonstrated a growth across all 3 metrics when compared to the same month the preceding year as demonstrated below:

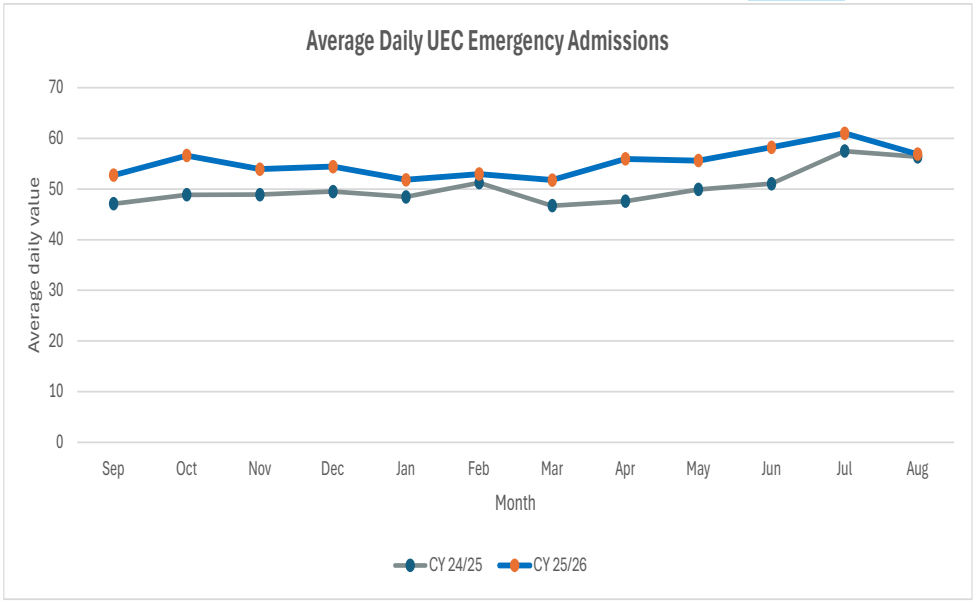
UEC Average Daily Attendances

| | CY 24/25 | CY 25/26 | % Change |
|---|---|---|---|
| Sep | 194 | 216 | 11% |
| Oct | 197 | 213 | 8% |
| Nov | 199 | 216 | 8% |
| Dec | 194 | 201 | 4% |
| Jan | 183 | 211 | 15% |
| Feb | 191 | 213 | 11% |
| Mar | 201 | 211 | 5% |
| Apr | 204 | 219 | 7% |
| May | 207 | 220 | 6% |
| Jun | 207 | 232 | 12% |
| Jul | 215 | 238 | 11% |
| Aug | 207 | 235 | 14% |



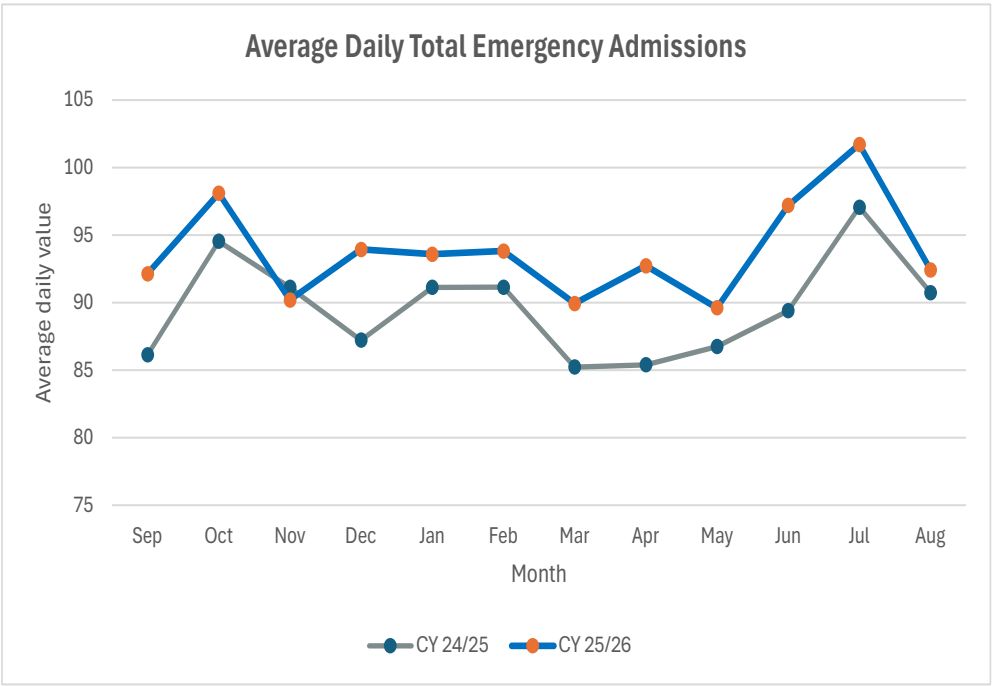
Average Daily UEC Emergency Admissions

| | CY 24/25 | CY 25/26 | % Change |
|---|---|---|---|
| Sep | 47 | 53 | 12% |
| Oct | 49 | 57 | 16% |
| Nov | 49 | 54 | 10% |
| Dec | 49 | 54 | 10% |
| Jan | 48 | 52 | 7% |
| Feb | 51 | 53 | 3% |
| Mar | 47 | 52 | 11% |
| Apr | 48 | 56 | 18% |
| May | 50 | 56 | 11% |
| Jun | 51 | 58 | 14% |
| Jul | 57 | 61 | 6% |
| Aug | 56 | 57 | 1% |




Average Daily Total Emergency Admissions

| | CY 24/25 | CY 25/26 | % Change |
|---|---|---|---|
| Sep | 86 | 92 | 7% |
| Oct | 95 | 98 | 4% |
| Nov | 91 | 90 | -1% |
| Dec | 87 | 94 | 8% |
| Jan | 91 | 94 | 3% |
| Feb | 91 | 94 | 3% |
| Mar | 85 | 90 | 6% |
| Apr | 85 | 93 | 9% |
| May | 87 | 90 | 3% |
| Jun | 89 | 97 | 9% |
| Jul | 97 | 102 | 5% |
| Aug | 91 | 92 | 2% |




To understand the impact of the increase in admissions a review of length of stay (LoS) was undertaken to calculate the cumulative bed impact of the increased admissions.

To calculate the additional bed pressure, it is required to multiply the additional daily emergency admissions by the average LoS per month as per the table below:

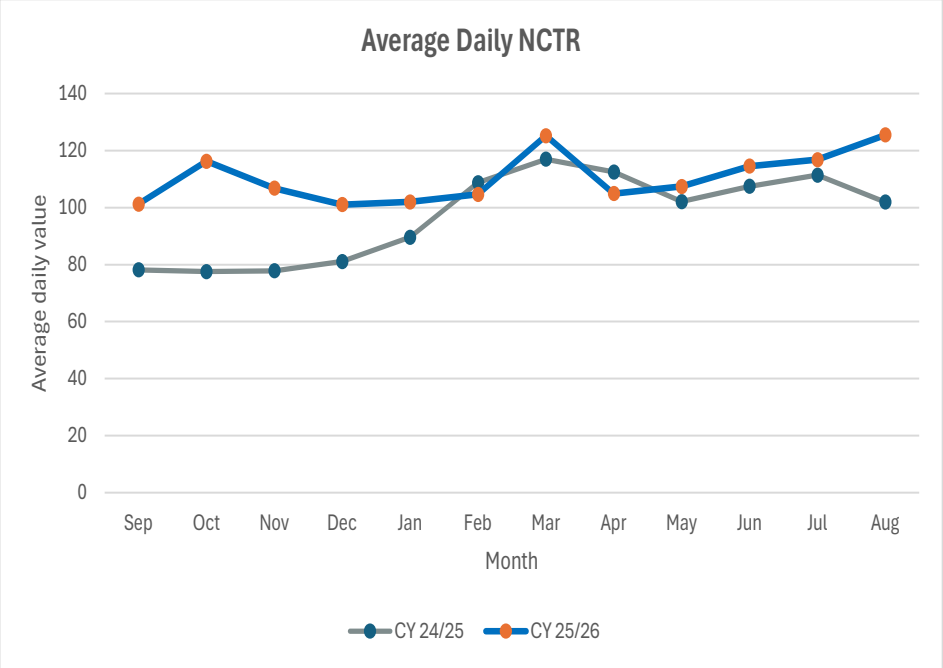
| | Additional Admissions | LoS (Days) | Bed Pressure |
|---|---|---|---|
| **Sep** | 6.0 | 8.91 | 53 |
| **Oct** | 3.5 | 8.34 | 30 |
| **Nov** | -0.9 | 8.17 | -8 |
| **Dec** | 6.7 | 9.01 | 60 |
| **Jan** | 2.5 | 9.38 | 23 |
| **Feb** | 2.7 | 9.45 | 25 |
| **Mar** | 4.7 | 8.72 | 41 |
| **Apr** | 7.3 | 8.94 | 66 |
| **May** | 2.9 | 8.29 | 24 |
| **Jun** | 7.8 | 8.21 | 64 |
| **Jul** | 4.6 | 7.98 | 37 |
| **Aug** | 1.7 | 8.14 | 14 |

As the table clearly demonstrates apart from November 2025 COCH has experienced significant daily additional demand through increase rates of emergency admissions, with an average of 37x additional bed days required daily to manage the increases in admissions. It is important to note that the non-elective admission rate for patients through SDEC remains static at 30% and static for ED at 23%.

## 2.2. No Criteria to Reside Inpatient Pressure

The NCTR data below (data only includes COCH site NCTR position and not EPH) and clearly enables conclusions to be drawn around the impact of NCTR on our bed capacity:

| | CY 24/25 | CY 25/26 | Nett Position | % Change |
|---|---|---|---|---|
| Sep | 78 | 101 | 23 | 30% |
| Oct | 78 | 116 | 39 | 50% |
| Nov | 78 | 107 | 29 | 37% |
| Dec | 81 | 101 | 20 | 25% |
| Jan | 90 | 102 | 12 | 14% |
| Feb | 109 | 105 | -4 | -4% |
| Mar | 117 | 125 | 8 | 7% |
| Apr | 113 | 105 | -8 | -7% |
| May | 102 | 107 | 5 | 5% |
| Jun | 107 | 115 | 7 | 7% |
| Jul | 111 | 117 | 5 | 5% |
| Aug | 102 | 125 | 24 | 23% |




COCH has seen growth across 10 the previous 12 months when comparing to the same month the previous year. The data shows and average increase of 13 beds filled with NCTR patients at COCH per day over the past 12 months

## 2.3. Increasing Bed Capacity to Support Flow

When facing challenges of the scale above the organisation responded by increasing the capacity of beds available across our core and escalation capacity (including corridor care in extremis) to enable decongestion of our ED department and to create flow across the trust. The below dataset show the initial response to the challenges undertaken by the trust, the ceiling of our capacity, the extension of escalation capacity remaining open beyond normal 'winter pressure' timescales and the reduction in escalation capacity since the start of the 2026/27 financial year:

Average Core Daily Beds

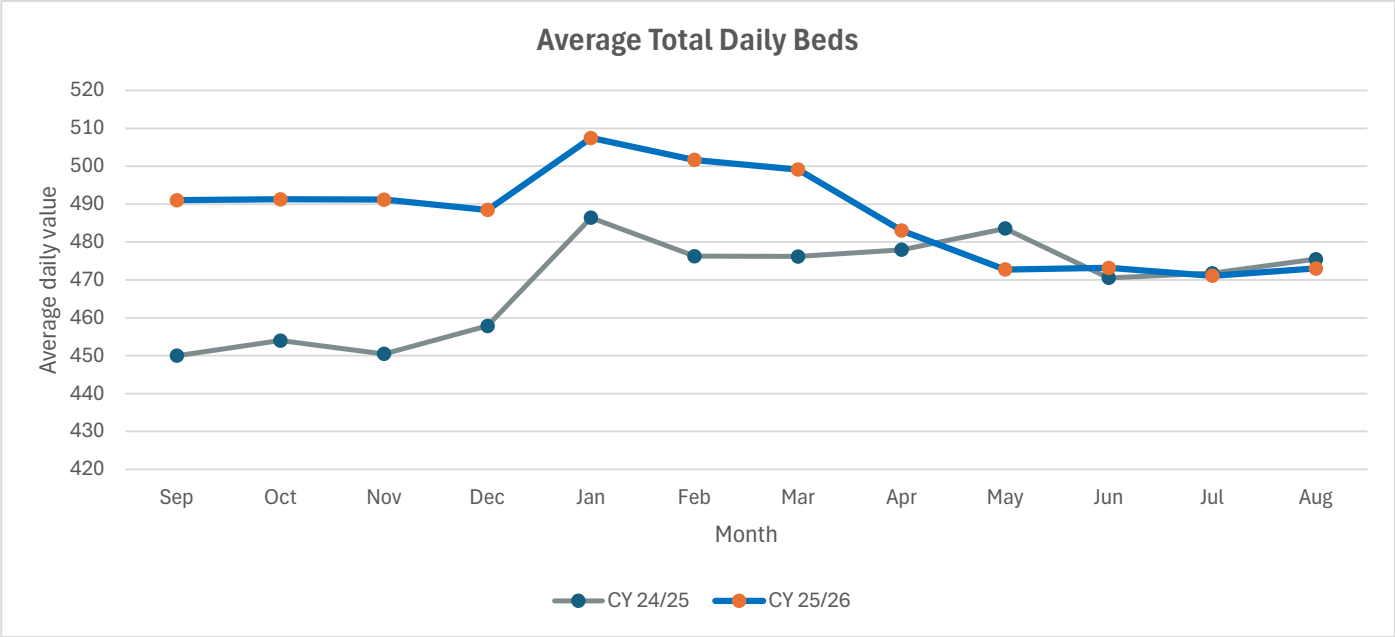
| | CY 24/25 | CY 25/26 | % Change |
|---|---|---|---|
| Sep | 438 | 452 | 3% |
| Oct | 438 | 458 | 5% |
| Nov | 439 | 459 | 4% |
| Dec | 444 | 454 | 2% |
| Jan | 451 | 451 | 0% |
| Feb | 451 | 448 | -1% |
| Mar | 450 | 449 | 0% |
| Apr | 446 | 449 | 1% |
| May | 451 | 449 | 0% |
| Jun | 450 | 449 | 0% |
| Jul | 450 | 449 | 0% |
| Aug | 447 | 449 | 0% |

Average Escalation Daily Beds

| | CY 24/25 | CY 25/26 | % Change |
|---|---|---|---|
| Sep | 12 | 32 | 168% |
| Oct | 16 | 28 | 75% |
| Nov | 12 | 27 | 130% |
| Dec | 14 | 26 | 85% |
| Jan | 30 | 37 | 25% |
| Feb | 22 | 32 | 45% |
| Mar | 21 | 32 | 49% |
| Apr | 26 | 27 | 4% |
| May | 27 | 23 | -16% |
| Jun | 18 | 24 | 34% |
| Jul | 19 | 22 | 16% |
| Aug | 25 | 24 | -5% |

Average Total Daily Beds (core, escalation, temp escalation/corridor care)

| | CY 24/25 | CY 25/26 | % Change | Beds Open | Corridor |
|---|---|---|---|---|---|
| Sep | 450 | 491 | 9% | 485 | 6 |
| Oct | 454 | 491 | 8% | 486 | 6 |
| Nov | 450 | 491 | 9% | 485 | 6 |
| Dec | 458 | 488 | 7% | 480 | 8 |
| Jan | 486 | 507 | 4% | 488 | 19 |
| Feb | 476 | 502 | 5% | 481 | 21 |
| Mar | 476 | 499 | 5% | 481 | 18 |
| Apr | 478 | 483 | 1% | 476 | 7 |
| May | 484 | 473 | -2% | 472 | 1 |
| Jun | 471 | 473 | 1% | 473 | 0 |
| Jul | 472 | 471 | 0% | 471 | 0 |
| Aug | 475 | 473 | -1% | 473 | 0 |




COCH's total bed base increased from its 2024 Autumn baseline of 454, to 480, this further increased in January-March 2026 to an average of 503. This has since reduced to an average of 472 beds, this remains 18x open beds higher than the initial Autumn 2024 baseline. This demonstrates the efforts made by the trust to mitigate the challenges presented by both pressures faced at the front door and the increase in patients no longer actively receiving acute care in our bed base.

The table below bring together the 3 areas of focus discussed above and shows the net bed pressure faced daily despite the efforts of the organisation in increasing our capacity to meet the needs of our patients:

| | Admissions | NC2R | LoS | Bed Pressure | Core Beds | Esc Beds | Total Beds (inc. Esc) | Net Position |
|---|---|---|---|---|---|---|---|---|
| Sep | 6.0 | 23 | 8.91 | 77 | 14 | 20 | 35 | 42 |
| Oct | 3.5 | 39 | 8.34 | 68 | 20 | 12 | 32 | 37 |
| Nov | -0.9 | 29 | 8.17 | 21 | 20 | 15 | 35 | -14 |
| Dec | 6.7 | 20 | 9.01 | 80 | 10 | 12 | 23 | 58 |
| Jan | 2.5 | 12 | 9.38 | 35 | 0 | 7 | 7 | 28 |
| Feb | 2.7 | -4 | 9.45 | 21 | -2 | 10 | 8 | 14 |
| Mar | 4.7 | 8 | 8.72 | 49 | -1 | 11 | 9 | 40 |
| Apr | 7.3 | -8 | 8.94 | 58 | 2 | 1 | 3 | 55 |
| May | 2.9 | 5 | 8.29 | 29 | -2 | -4 | -6 | 35 |
| Jun | 7.8 | 7 | 8.21 | 71 | -1 | 6 | 5 | 66 |
| Jul | 4.6 | 5 | 7.98 | 42 | 0 | 3 | 3 | 40 |
| Aug | 1.7 | 24 | 8.14 | 37 | 2 | -1 | 1 | 37 |

The table shows that apart from in November 2025 where the reduced demand in admissions and increase in bed capacity within the trust led to a net bed demand decrease there has been a consistent aggregate rise in the bed pressures over the last 12-months. The table demonstrates that as we de-escalated out of our winter escalation, we witnessed a sustained demand increase in admissions. When the increases in admissions slowed in August 2026, concurrently COCH saw an increase in the highest increase in NC2R (24x) in comparison to August 2025.

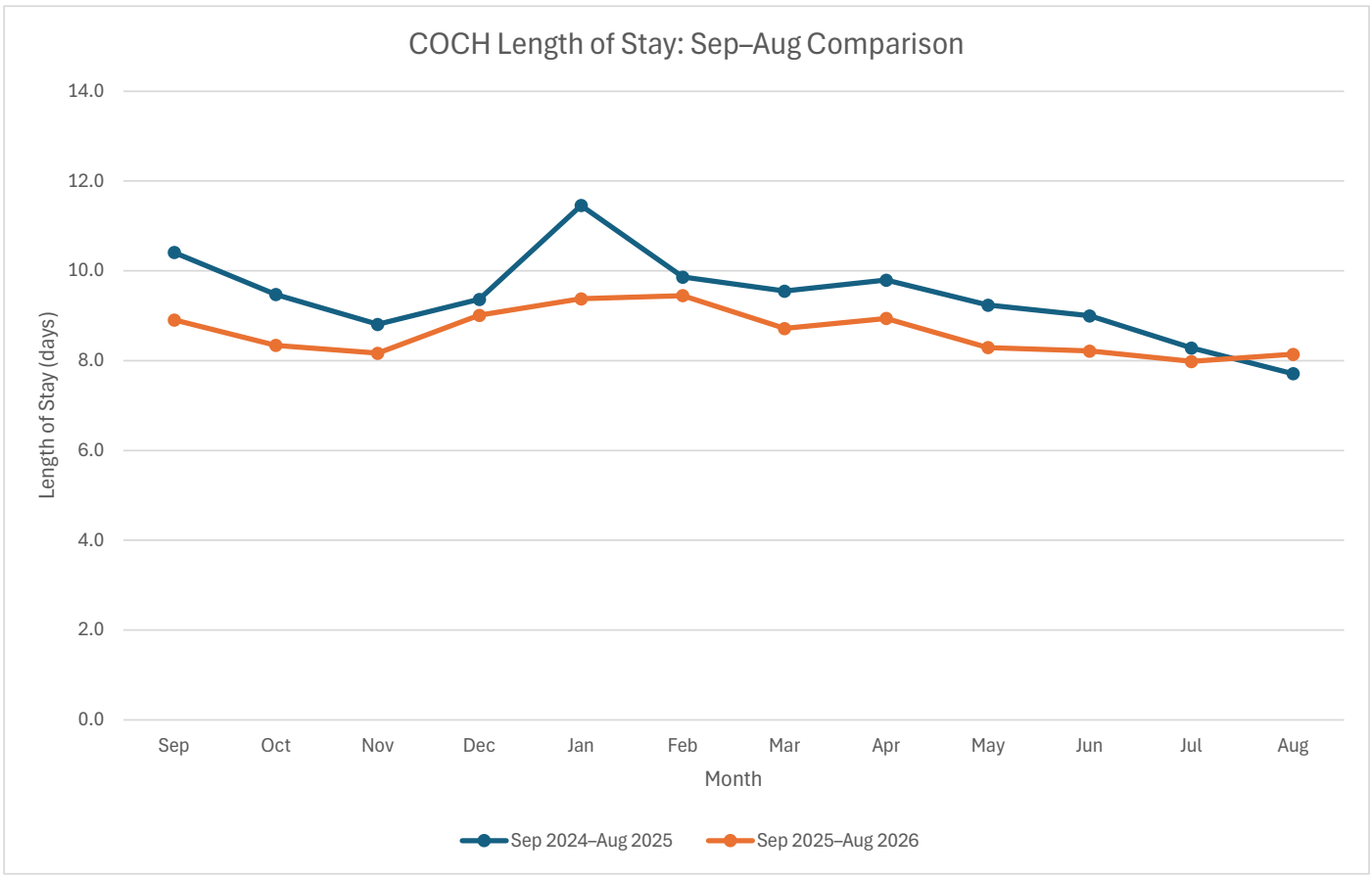
The above data also enables a different framing to challenges faced within the organisation, in the last 12-months we have had an average net pressure of 36 beds per day, this is net of the average 12 more bed being open and occupied over that period.

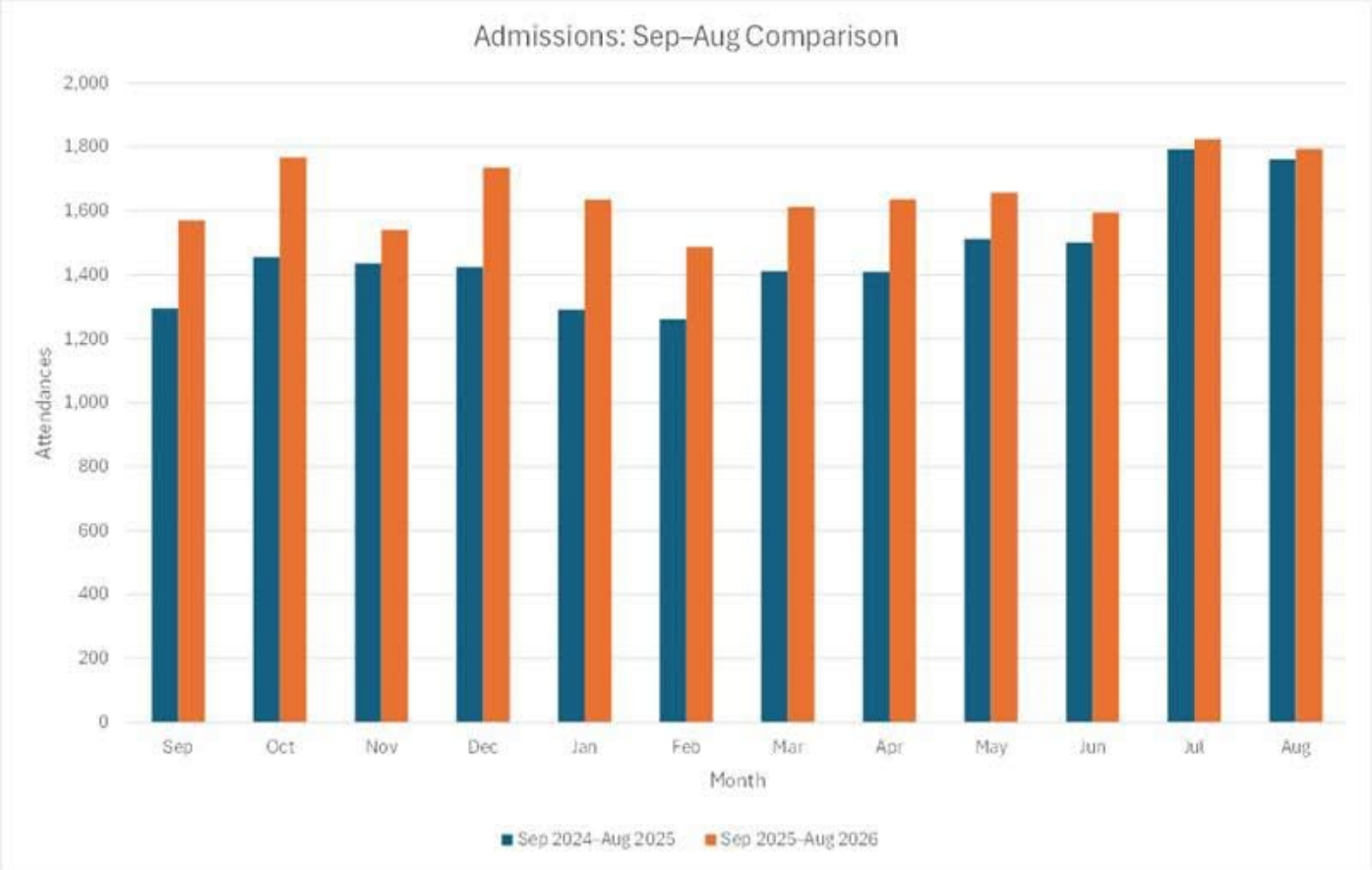
However, if we focus strictly on this financial year (April 2026 onwards) and do not include winter pressure months the bed pressure is 48x with 1/7 of this being driven by additional NCTR patients and 6/7 driven by increased admissions.

### 2.4. Length of Stay Improvements

When reviewing the data it became apparent that as an organisation, we are facing a significant increase in demand at the front door whilst simultaneously seeing more NCTR patients residing in our bed base, however we were still able to deliver performance improvements in our UEC KPI's despite this pressure supporting a hypothesis that we must be delivering improvements beyond increasing our bed base to support this delivery.

When reviewing COCH's length of stay (LoS) it was clear that a reduction in our LoS was supporting the trust in delivering its performance. The table and graph below overlay our LoS across the same time period as used previously in the paper to enable consistent analysis:


COCH Length of Stay: Sep–Aug Comparison
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Length of Stay (days)
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Month
Sep 2024–Aug 2025
Sep 2025–Aug 2026


Admissions: Sep–Aug Comparison
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
Attendances
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Month
Sep 2024-Aug 2025
Sep 2025-Aug 2026

| Month | Attendance Sep 2024–Aug 2025 | Attendance Sep 2025–Aug 2026 | LoS Sep 2024–Aug 2025 | LoS Sep 2025–Aug 2026 |
|---|---|---|---|---|
| Sep | 1,295 | 1,570 | 10.41 | 8.91 |
| Oct | 1,455 | 1,767 | 9.47 | 8.34 |
| Nov | 1,436 | 1,541 | 8.81 | 8.17 |
| Dec | 1,424 | 1,736 | 9.37 | 9.01 |
| Jan | 1,291 | 1,635 | 11.46 | 9.38 |
| Feb | 1,261 | 1,487 | 9.86 | 9.45 |
| Mar | 1,411 | 1,612 | 9.55 | 8.72 |
| Apr | 1,409 | 1,636 | 9.79 | 8.94 |
| May | 1,511 | 1,656 | 9.24 | 8.29 |
| Jun | 1,501 | 1,594 | 9.00 | 8.21 |
| Jul | 1,793 | 1,824 | 8.28 | 7.98 |
| Aug | 1,762 | 1,569 | 7.71 | 8.14 |

The table and charts above demonstrate the increase in admissions and reduction in mean LoS across our inpatients at COCH[1], the only month not demonstrating a decrease in LoS is August 2026. As noted earlier in this paper we did see the lowest pressure in admissions in August, however we also saw the largest spike in NCTR volumes post implementation on the new criteria.

To calculate the bed saving opportunity we analysed the dataset above using Model Health System methodology to calculate bed saving opportunity and daily beds saved, the outputs of this work are in the table below below:

| | Sep 2024–Aug 2025 | Sep 2025–Aug 2026 | Difference |
|---|---|---|---|
| **Total Admissions** | 17549 | 19627 | 2078 |
| **Mean LoS** | 9.41 | 8.63 | -0.78 |
| | | **Bed Day Saving** | 15309.06 |
| | | **Beds Per Day** | 41.94 |

This clearly shows the improvements delivered over the past 12 months and whilst not demonstrating the totality of all improvements made across the organisation, it does outline how LoS improvements have mitigated COCH's front door and NCTR pressure by 42 beds on average per day. This means that 86% of the 48x daily bed pressure over the 12-months is mitigated but also provides evidence of why COCH has been unable to reduce its escalation usage to similar levels to the previous year.

The split of average LoS, by their criteria to reside LoS and no criteria to reside

| | **Sept 2024 vs. August 2025** | **Sept 2025 vs. August 2026** |
|---|---|---|
| NC2R LoS | 4.2 Days | 4.3 Days |

[1] Point of clarification the difference between the admissions data in bed demand dataset and LoS data in August is related to when the data was captured and admitted patients from August remaining in our bed base when this data was collected.

| | | |
|---|---|---|
| C2R LoS | 8.4 | 7.7 |

The above data has been pulled from model hospital data, this excludes an inpatient LoS <24-hours. But highlights the indicative of the reduction in the acute period of an inpatients LoS, by 0.7 days.

## 3. Interventions:

The data for a reduction in mean length-of-stay (LoS) has been split by their criteria and no criteria to reside elements. The data indicates there has been a reduction of 0.7 days for patients in their inpatient LoS when they are deemed to require an acute hospital bed.

There are biases that can occur within the data:

- If you are admitting more patients due to an increased bed base, then it is commonly the short-stay patients (1–2-day LoS) who are now admitted, when previously they may have been discharged from ED. This bias will have limited impact due to the same number of beds being available to the organisation during the two periods.
- When separating an individual patient's pathways between criteria to reside vs. no-criteria to reside, the data can be changed through increased data quality and capture during this time. This is deemed to have had limited impact.

The Trust has adopted a whole-pathway approach to reducing average Criteria to Reside (CTR) length of stay, recognising that sustainable improvement depends on ensuring a comprehensive assessment at the point of decision of inpatient admission, timely clinical decisions throughout the patient's LoS, maintaining patients' functional independence and resolving discharge barriers earlier.

It is difficult to proportion weighting to the interventions that have led to the reduction in C2R LoS, however, the below section provides details salient interventions that have been accelerated or instigated in the last 12-months.

### 3.1. Effective Ward and Board Rounds (Autumn 2025)

Consistent multidisciplinary ward and board rounds across the 17-core inpatient bed base are central to the improvement approach. An effective board and ward rounds provide a structured daily review of each patient's clinical criteria for discharge, expected date of discharge, outstanding diagnostics, therapy requirements and barriers to leaving hospital. These processes are reinforced through daily Trust-wide discharge reviews, executive oversight, twice-weekly long-length-of-stay reviews and integrated escalation of complex delays.

The Trust has complemented this with the co-location of medically optimised patients, where operationally appropriate. COCH current has 52x NC2R patients collocated in 3-specific areas. This enables senior medical teams during ward and board rounds to focus on patients requiring active investigation, treatment escalation and post-take decision-making, rather than having their attention diluted by patients whose principal requirements are discharge coordination or onward care.

Co-location of NC2R does not remove clinical oversight. Medically optimised patients continue to receive structured multidisciplinary review, with a focus on discharge actions and escalation. The model therefore creates two clearer operational priorities: rapid senior decision-making for acute patients and focused discharge progression for patients who no longer require acute hospital care.

### 3.2. Rapid Improvement Events to drive ward improvement (Spring 2026)

Speciality specific Rapid Improvement Events have been used as a mechanism for translating the wider length-of-stay strategy into specialty-level changes. These events have been led clinically by the senior nursing and medical teams, and utilised local intelligence in combination with benchmarking data. Respiratory and Diabetes/Endocrinology reviews have examined on-ward ways of working, sources of delay and opportunities to reduce unwarranted clinical variation. The example of respiratory is detailed below.

Respiratory identified that medical attendance at morning board rounds was inconsistent, delaying agreement of clinical criteria for discharge, expected discharge dates, medication and other actions. It tested daily multidisciplinary board rounds involving medical, nursing, physiotherapy and pharmacy colleagues, supported by a 14:30 medical and nursing huddle. Patients suitable for discharge before 10:00 were identified at the previous afternoon's huddle, while same-day discharge opportunities were identified at the morning board round. Data highlighted improved timeliness of discharges off the ward and the number of week-day discharges.

The Respiratory RIE also recognised that many patients who have chronic respiratory conditions will manage in non-respiratory wards for part or all their inpatient stay. This can delay access to specialist expertise, create variation in supported-discharge decisions and extend length of stay. The service has therefore strengthened consultant and specialist nurse in-reach into ED and other wards, supported by proactive case-finding.

### 3.3. Hot Clinic Access (Spring 2026)

Hot Clinics are a rapid-access (commonly within a week), outpatient clinic, delivered by an independent practitioner from an inpatient specialty, overseen by the consultant team, they investigate patients acute or worsening symptoms to avoid an immediate hospital admission or reduce a patient's length-of-stay.

There is not a national mandate for every trust to operate 'hot clinics', however, national guidance is clear that they are increasingly a component of delivering effective Same Day Emergency Care.

Since Spring 2026, hot clinics have been implemented across, respiratory, diabetes, gastroenterology, and cardiology[2]. This allows for improved rate of discharge by Acute Medicine prior to admission to a core inpatient ward, after the Acute Medical Unit.

### 3.4. Inpatient Therapy and Community Rapid and Reablement Oversight (Winter 2026)

Targeted therapy work has been implemented to reduce delays and shorten hospital length of stay:

- Senior therapy oversight through daily review of P1 patients enables earlier identification and escalation of discharge barriers, supporting timely decisions and improving patient flow. Alongside scrutiny of long-stay patients, with mandatory weekly Long Length of Stay meetings, with the review threshold reduced from 21 to 14 days and strengthened multi-agency involvement.
- Standardised escalation processes and mandatory MDT attendance across all acute wards have improved accountability and multidisciplinary decision-making, ensuring delays are identified and resolved more quickly.

[2] Rapid Access Chest Pain clinic waiting time reduced from 12-weeks to 1-week.

- Improved therapy workforce resilience has been achieved through temporary backfill arrangements for up to eight registered therapy staff, maintaining consistent assessment, intervention and discharge planning capacity.

Community response Hubs and Hospital at Home change:

- Community Response Hub activity increased substantially during 2026, with monthly visits rising from 3,508 in January to 6,704 in August. By summer 2026, the service is delivering approximately 6,800 care calls per month, almost doubling activity compared with the start of the year and significantly strengthening support for hospital discharges.
- CRH improvement has been enabled through the integration of community services across the West Cheshire Health Collaborative into a single P1 model, streamlined referral processes supported by daily multidisciplinary triage, integrated palliative care provision, and the establishment of three locality-based teams combining nursing and therapy expertise.
- Hospital at Home has enhanced patient flow through increased senior clinical in-reach to SDEC, Acute Medicine and Frailty services, increasing step-down activity from around 10% to 15-20% of caseload. Expanded therapy support, greater outpatient IV capacity and the introduction of new pathways for cancer patients and suspected spinal cord compression have enabled earlier discharge and additional admission avoidance for patients who would often otherwise require prolonged hospital stays.

### 3.5. Frailty Pathway (Spring 2026)

SDEC and frailty pathways provide alternatives to admission through earlier assessment, specialist review, Hospital at Home and Frailty Virtual Ward support. However, they also provide the opportunity to ensure patients have a clear clinical assessment at the point of admission.

Frailty SDEC, Monday to Friday service, was reinstated following a period of being compromised due to being utilised as an escalation capacity. Since April 2026 this unit sees an average of >9- patients per day, with a 38% admission rate, and provides a comprehensive geriatric assessment for these patients, including physiotherapy and pharmacy review at the point of admission.

Front-door therapy capacity has increased from 5.8 WTE to 10.8 WTE supporting seven-day therapy across ED and SDEC. Earlier functional assessment, mobilisation and discharge planning are critical to reducing hospital-acquired deconditioning and reducing overall inpatient LoS.

### 3.6. Next Phase of Interventions

Several of the interventions remain in their infancy. These include:

- Therapy front-door resource is not yet fully in place, and will provide significant additional support from October 2026 and as we move into winter 2026/27.
- Hot clinic utilisation is still sporadic and requires changes to process to enable easier access, greater awareness and increased number of specialties.
- Acute medical consultant support is enhanced from September 2026 and furthermore from November 2026, this will enable a reduction in time for senior review for patients yet to be admitted to the hospital, the correct specialty medic revieing the patient, and freeing up a clinical resource to enable increased specialty specific weekend working.
- There are further enhancements to the principle of colocation of medically fit patients to support effective ward and board rounds on acute wards. A revised iteration aims to reduce

medical interventions on this ward, ensure patients are discharged pre-midday and reduce hospital acquired deconditioning.

## 4. Financial Implications

In the present NHS environment, there is a high level of scrutiny to drive productivity and reduce the cost base, it is important to articulate the opportunity cost that is being prevented from transaction within this financial year due to the pressures that COCH does not have complete control over.

### 4.1. Inpatient Capacity Costs

Utilising the dataset since 1st of April 2026, COCH has seen a net increase demand of 48 beds per day, despite this COCH has delivered a marginal improvement across 4 and 12 hour UEC KPI's. To calculate the opportunity cost, the costs of both escalation capacity and core bed capacity has been calculated.

The model would prioritise closing escalation capacity first before looking at what the cost saving opportunity within our core bed base was. Finance and BI confirmed we averaged 24 escalation beds open per month since April 1st at a full year effect cost of £3.3m. The secondary part of the model was to calculate reducing core bed capacity by 24 beds, the calculation and costs associated are included in the table below:

| | | WTE | Cost |
|---|---|---|---|
| Medical Costs (24 Bed Ward) | Consultant | 0.71 | £ 123,447.57 |
| | Registrar | 1.64 | £ 173,663.14 |
| | SHO | 4.11 | £ 343,718.57 |
| Nursing & Non-Pay Costs (24 Bed Ward) | Registered Nurses | 15.90 | |
| | Health Care Support Workers | 26.60 | £ 2,043,390.64 |
| Escalation (current escalation including med staffing and non-pay costs) FYE | Registered Nurses | 28.55 | |
| | Health Care Support Workers | 27.94 | £ 3,284,323.00 |
| Total | | 105.45 | £ 5,968,542.93 |

### 4.2. Additional Income – NEL Admissions & NEL ED Attendances

The figures above have been developed in collaboration with finance and do reflect what it is felt are true costs associated with the additional demand we are managing.

However when considering the cost saving opportunity from the additional activity it is important to consider the additional income being generated through the increased attendance to our UEC and then subsequent admissions. The table below articulates the in year benefit with marginal rates applied, and what the recurrent impact from next financial year once these figures have been incorporated into our baseline activity. The figures below are estimates of the full year effect numbers if we continue to face pressures at our current rate through the first 5 months of this financial year:

**Estimated Income of Non Elective and ED Growth above planned levels - 2026/27**

| | | | | |
|---|---|---|---|---|
| | 2026/27 Impact - Marginal Rate Applied | | Recurrent Impact - no marginal rate | |
| Non Elective Activity | £ | 1,746,589 | £ | 3,030,884.00 |
| ED Attendances | £ | 175,893 | £ | 879,471.00 |
| Total | £ | 1,922,482 | £ | 3,910,355.00 |

When taking into account the figures from the 2 tables above related to costs and income, it is clear that whilst some of the additional costs are mitigated through additional income as expected there remains a gap as outlined below leaving an in year opportunity gap of £4m, and a residual recurrent opportunity gap of £2m :

### 4.3. Non-Income Backed Costs

**True Opportunity Cost**

| | | | | |
|---|---|---|---|---|
| | | | True Opportunity Cost | |
| Cost of 48 Bed Pressure | £ | 5,968,542.93 | | |
| In Year 2026/27 Estimated Income | £ | 1,922,482.00 | £ | 4,046,060.93 |
| Recurrent 2027/28 Estimated Income | £ | 3,910,355.00 | £ | 2,058,187.93 |

Improvement work continues to take place across the UEC and inpatient footprint and considering the evidenced improvements in our LoS and sustained performance and marginal improvement in UEC KPI's it is felt that this is evidence of the masked opportunity cost of our improvements due to pressures beyond the trusts control.

It is worth noting that in November 2025 NHSE released a productivity opportunity pack based off national cost collection submissions and from that pack we included £4.4m in saving opportunities within this year's CIP target, with an additional £1.6m within divisional CIP programmes, therefore the inability to transact against the improvements we are delivering is causing pressure on CIP delivery and progress.

## 5. Performance Implications

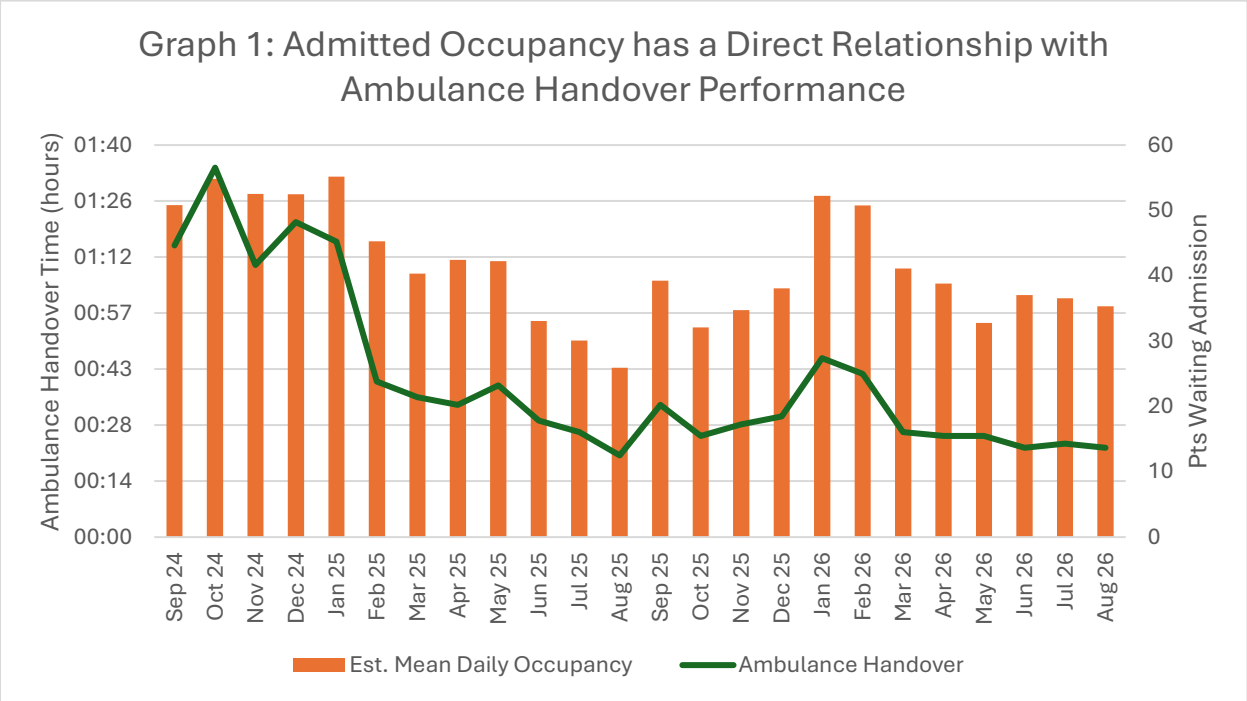
The increased bed pressure masks improvements in LoS across the organisation, this lost financial opportunity can also be articulated as a lost opportunity to support UEC performance indicators.

Type 1 ED occupancy is directly proportional to the number of patients awaiting inpatient admission. By reviewing the correlation between occupancy levels and UEC indicators, you can

subsequently estimate the performance impact that improved flow would have meant for Urgent and Emergency Care.

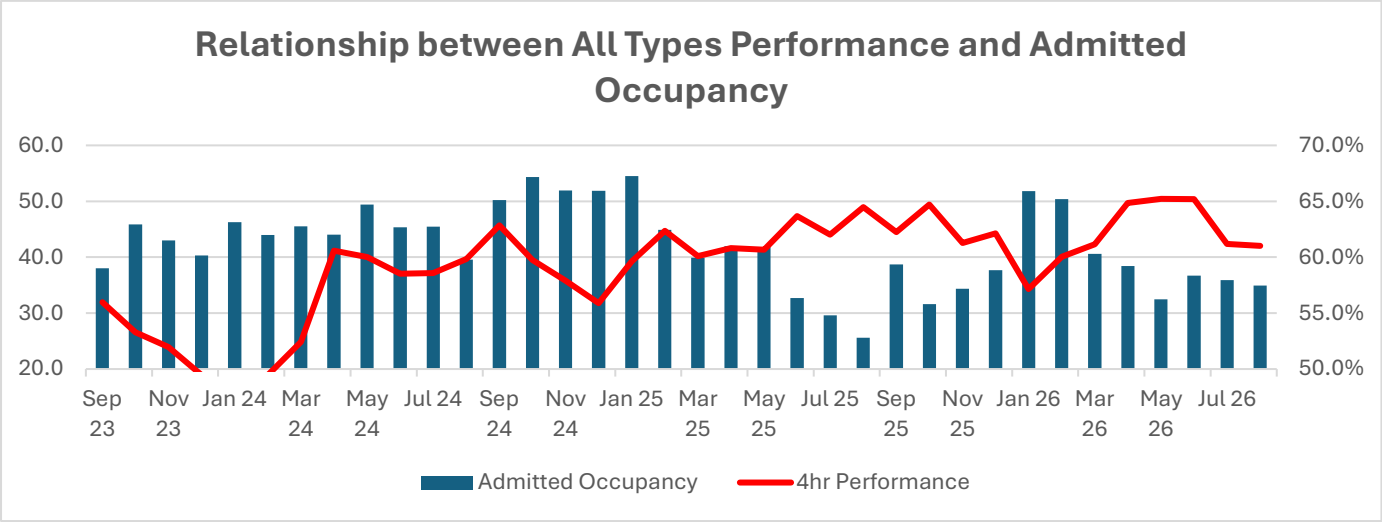
## 5.1. Ambulance Handover Performance:

The relationship is strong (r=0.88) between admitted occupancy, and the ambulance handover times other factors include attendances and available staffing within the Emergency Department. This correlation indicates an additional 1x patient waiting admission is associated with a 2-minute increase in average ambulance times. If all other things remain equal then, in absence of additional admitted pressure, COCH would have moved to and maintained a 15-minute time to average handover over the last 12-months. (Graph 1), with occupancy associated with 74% of the variation seen in ambulance handover delays.



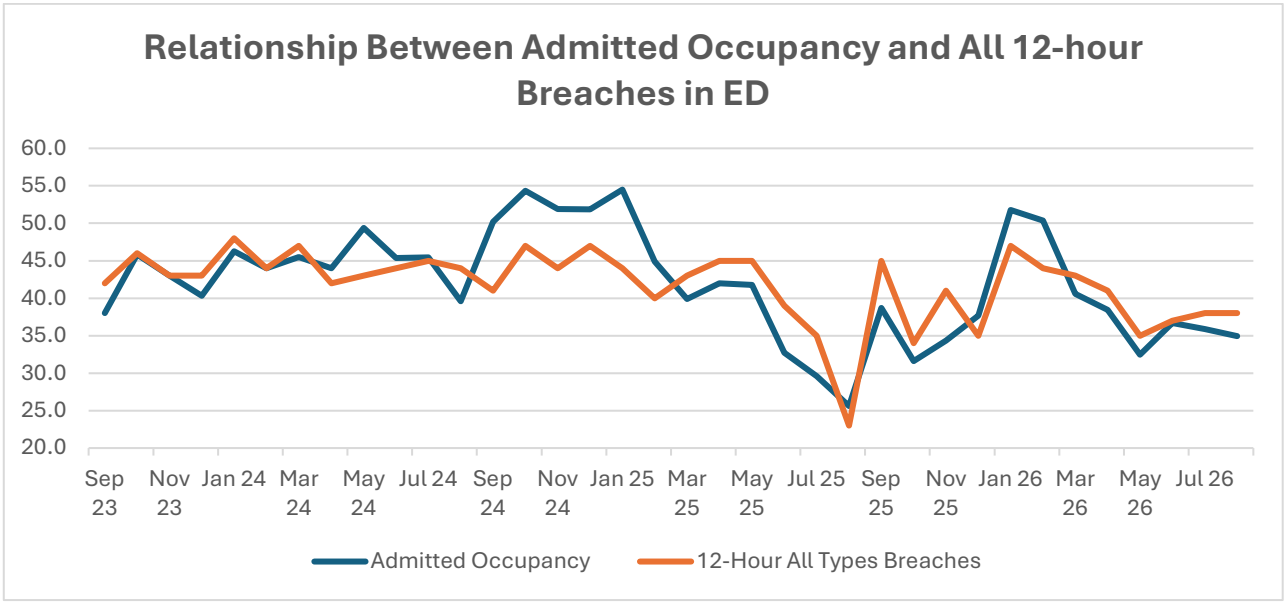

## 5.2. 4-hour Performance

Over the last 3-years the correlation is moderate between ED occupancy and 4- hour performance (r=-0.67), with 41% of the variation in 4-hour performance connected to admitted occupancy levels. Other factors would include staffing levels and ED attendances. For every 10-less admitted patients in the Type 1 ED there would be a performance improvement of 3.2% ED 4-hour Performance.




## 5.3. 12-Hour LoS Performance

Over the last 3-years the correlation is strong between ED occupancy and 12-hour performance (r=0.77), with 65% of the variation in 12-hour performance connected to admitted occupancy levels in the emergency department. 10x less admitted patients in the ED are associated with 6x less 12-hour breaches.



### 5.4. Performance Summary

The above information highlights the relationship between admitted occupancy levels and ED performance metrics, and theoretical changes. This highlights firstly the importance of decongesting ED through an established bed base and reduction in inpatient LoS, and that the 4-hour standard can be credibly impacted outside of admitted occupancy levels. Comparing M1-M5 25/26 vs. 26/27 Despite additional patients arriving at the ED/UTC, ED 4-hour standard has improved by 3% in the first 5-months of the year compared.

The impact on occupancy levels on ED performance is clear from local data and documented nationally. The impact on reductions in admitted occupancy on ED performance would operate on a bell-curve, e.g. when the department is busy or has good capacity the impact to performance on further improvements would be limited. However, it would be reasonable to expect that the additional admitted pressure is leading to ambulance handovers being 29-mins instead of 15-mins, would reduce 12-hour breach performance to <5% and improve 4-hour performance to 70%.

## 6. Conclusion

The Countess of Chester has faced growth in non-elective demand over the last 12 months, with net bed pressure increasing by 36 beds per day and rising to 48 beds per day between April and August 2026. Despite these pressures, the Trust has delivered measurable improvements in Criteria to Reside length of stay, these improvements generated capacity equivalent to approximately 42 beds per day.

However, this additional capacity has been fully absorbed by increased admissions and discharge pressures, masking the benefits delivered. Had these pressures not materialised, the Trust would have been able to close escalation capacity and reduce core bed requirements, releasing £6 million of recurrent savings and materially improving CIP delivery.

The income generated from the additional demand offsets the costs by £1.9m in year and £3.9m recurrently, leave a net cost of £4m in year and £2m recurrently.

There has also been a performance opportunity cost. Analysis demonstrates a relationship between admitted occupancy and UEC performance. In the absence of the additional inpatient pressure, and other factors being equal, the Trust could reasonably have expected to sustain ambulance handovers at 15 minutes, reduce 12-hour breaches to below 5%, and improve ED 4-hour performance to approximately 70%.

In summary, the evidence demonstrates that COCH has delivered improvements in inpatient LoS. However, increasing demand and discharge pressures have prevented the organisation from realising the full benefit of this improvement, resulting in a lost opportunity to either release almost £6 million in recurrent savings or achieve materially better urgent and emergency care performance. However, the additional demand is resulting in additional income which then leads to a question of how best to utilise the income to support the organisation:

It is clear than inaction by partners is resulting in COCH facing pressures across admitting and discharge pathways which is resulting in financial pressures and an inability to transact financial benefit from the productivity improvements evidenced within this paper. Executives are asked to consider how to utilise the evidence base within this paper to drive narrative and decisions at a local and regional level, acknowledging the non-income backed £4m in year pressure and recurrent £2m that these pressures generate.

Countess of Chester Hospital NHS Foundation Trust

# Committee Chair's Report
# 24th September 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 alerts, noting the Board is sighted on operational, finance and people performance and risks.

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

- Winter plan 2026/27 reviewed and approved.
- Operational performance report including significant challenges in UEC with increased attendances impacting on patient flow, 4 hour performance and 12 hour breaches. RTT performance continues to improve and is above plan. Wait list size is being closely monitored as this remains higher than plan, with targeted validation and focus on pathways below 18 weeks. FDS and 62 day cancer performance is good, with the 31 day standard just below target noting increased breaches in skin and breast specialities. DM01 performance has challenges in some areas.
- Research update including findings from the external review of the Trust's research arrangements. This covered structure and capacity; governance oversight, assurance and regulation; corporate and administrative support; consideration of establishing a strategic research committee; system and university positioning and ambition; funding pathways and opportunities.
- Transformation, productivity and CIP update demonstrating significant recurrent gap and in year gap. Increased scrutiny and support with recovery plans developed, including understanding and removing barriers, clarity on milestones, risk appetite and holding to account. Project management software now established and request for support in engaging with this.
- GMC survey results presented by Director of Medical Education. 2026 indicator results were within IQR with overall theme of improvement. Detailed breakdowns by speciality identified some strong areas and some areas for action. GMC identified area of concern is emergency medicine (improved but still remains intensive support). Significant improvement noted in obs and gynae moving from intensive support to no concerns. Three areas remain under observation.
- Quality and harms report providing an overview of Trust wide incident reporting, themes and learning; complaints and concerns; new patient experience framework progress and next steps; infection rates and infection prevention; workstream updates from the Discharge, UEC and Admission Avoidance Programme.
- Financial performance report providing overall Trust position with challenges as outlined in Divisional and CIP updates.
- People update provided trust wide overview on metrics; staff survey to launch next week; and progress being made on implementation of WorkPal.

- NOF Q1 report provided to OMB, setting out the metrics, Trust scores and positioning, noting work planned to review a number of the metrics to further understand the context and underpinning data.

**Divisional updates**

- Planned care overview of quality, workforce, operational and financial performance. Incident reporting levels majority low or no harm including falls, pressure ulcers and medication errors; increase in complaints and concerns with themes of delays and access, communications, and quality; mandatory training compliance and targeted actions being taken (including safeguarding); Finance position on track at month 5 with continued challenges and risk in delivering CIP; active discussions taking place to address resident doctor vacancies; activity against plan shows a small underachievement with significant recovery demonstrated from previous month (varies across specialities); improved RTT performance with continued focus.
- TICC overview of quality, workforce, operational and financial performance. Actions taken to improve therapies response time includes recruitment; outpatient therapies activity on plan but recovery actions for some therapies; virtual ward and community response activity continues; expanded tier 2 dermatology services go live end September; finance performance on plan notwithstanding need to progress CIP plans through to transacted; continued incident reporting with majority no or low harm; patient experience scores remain positive; falls and pressure ulcers continue to be reviewed; mandatory training compliance has deteriorated; continued challenges in long term sickness absence; appraisal compliance needs improvement; collaborative working and move to 24 hour nursing MOU from October 2026.
- Women and Children's overview of quality, workforce, operational and financial performance. Incident reporting with majority low and no harm, and review of incidents where harm is identified; number of incidents remain open; reportable deaths including a coincidental maternal death; improved timeliness and closure of complaints and concerns; focus remains on mandatory training compliance; sickness absence levels are high and work ongoing with support from HR; RTT monitored and plans in place including increased capacity; continuing improvement in breast and gynae cancer FDS; births and bookings continue to increase; finance performance on track but risks in drugs cost pressures and ensuring transacted CIP; deep dive on delays in induction of labour, the challenges and the actions for improvement; discussion on birth rate plus and importance of considering the gaps and opportunities for 2027/28 planning.
- Diagnostics and Clinical Support Services overview of quality, workforce, operational and financial performance. Incident reporting with the majority low and no harm with review of incidents where harm is identified; five retrospective HTARIs submitted following an audit of historic incidents; Phlebotomy issues including sickness and vacancies awaiting withdrawal from ward service as this transitions; new risk scored at 16 relating to CWMS telepath system which will be unsupported as we transfer the systems to LIMS circa 2028; NHSE funding confirmed for CT/MR with Interventional Radiology (IR) business case to be presented to OMB in October; finance forecast is showing a £1m adverse variance largely due to CIP gap; pathology south hub business case requested with detailed review required supported by clinical workforce.

- Urgent Care overview of quality, workforce, operational and financial performance. Incident reporting with the majority low and no harm with review of incidents where harm is identified; falls and pressure ulcer reviews continue; complaints and concerns response in month; JAG 5 year on-site review completed and actions progressing to meet 6 month deadline; RTT trajectory to eliminate 40 week breaches by end October; significant challenges in UEC 4 hour performance and 12 hour breaches and priorities agreed to continue the focus on improvement; CDU estate changes following receipt of external funding (planned completion Feb 2027); improvements in e'discharge and continued work on dictation backlog; financial position continues to be closely managed along with the in-year £2m CIP gap and recovery plan; workforce risks on sickness absence and mandatory training.

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

- Received CEO report with a range of national, regional and local updates.
- Thirlwall Inquiry recommendations presented to OMB and next steps in responding to these including a multidisciplinary group undertaking a baseline assessment by end September.
- Laboratory Information Management System programme is being progressed across the Cheshire and Merseyside (C&M) Pathology network, with provisional time line for go-live at the first site in November 2027. COCH is part of this programme along with other providers in C&M.
- Business cases approved for vascular centre business plan; and on-site waste processing.
- Trust strategy and clinical strategy reflections shared in context of external environment, national and regional changes, with a plan to review these in detail at the next Trust clinical leads day (December 2026).

**Risks discussed and new risks identified**

- Received the significant risk report with risks with a residual score of 15 or above, noting the risks and actions being taken are also triangulated through the Divisional risk and performance reports.
- Risk was also discussed in relation to the Winter Plan; LIMS project risks recognising programme scale and complexity;

Countess of Chester Hospital NHS Foundation Trust

# Committee Chair's Report
## 22nd October 2026

| | |
|---|---|
| **Committee** | Operational Management Board |
| **Chair** | Deputy Chief Executive, Mrs Sue Pemberton |

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

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

- There were no alerts that the Board are not already sighted on through performance reports and broader updates.

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

- Operational performance report including UEC performance and the ongoing challenges, including context of significant increase in attendances and use of the corridor; positive cancer performance; improvement in DM01 across modalities notwithstanding specialty challenges; close review of increasing waiting list continues.
- Quality and safety update with continued levels of incident reporting of which 94% are low or no harm with 7 severe and 2 catastrophic; 12 STEIS reportable incidents year to date; incident themes, PSIIs, and learning; deteriorating compliance in risk assessment completion; complaints and concerns; improvement in friends and family test response rates; infection prevention and control cases;
- Highlight reports from UEC and admission avoidance programme including discussions with Primary care networks, RAT extension to ambulance attends and SDEC, review of UTC admission criteria, increasing GP out of hours slots,and discharge workstreams.
- Financial performance at month 6 reported as on plan supported by non recurrent measures above what was planned; CIP performance remains a significant risk, including Divisional recovery plan profiles and delivery; Run rate reductions also need to correlate to transacted CIP.
- People update included being off plan on workforce reductions; continued focus on sickness absence processes, support and return to work; improvement to mandatory training overall but key areas and subjects require attention; anti-racism framework; compassionate leadership programme; e-roster implementation.

**Divisional updates**

- Women and Children's Division: Update on incidents with the majority low or no harm and 1 catastrophic and 2 severe; No Neonatal deaths or still births; 44 incidence open over 28 days; 4 complains; 38 concerns open and 44 closed in month; compliments received; AMOS 10 point plan positive feedback; learning and themes; good overall compliance with mandatory training; improved sickness absence and appraisal rates; GMC survey action plan in place; RTT position improving and in line with plan, further work progressing to ensure compliance;

PIFU targets being achieved; financial position currently overspent but forecasting a balanced position for year and with additional income expected in Month 7; CIP delivery; and a spotlight on the paediatric diabetes nursing service.

- Diagnostics and Clinical Support Services Division: Update on incidents allow and no harm in month; 1 complaint raised in month and low volume of concerns; phlebotomy service changes from December; risk updates including financial performance, mortuary staffing and proposed system MR service provision changes; DM01 improvements, reduced performance in turnaround time being analysed, radiology live dashboard to be launched; pathology and pharmacy KPIs including improvements in medicines reconciliation; Month 6 financial overspend and adverse forecast with recovery plans needed for CIP by end October; capital bids; compliance with mandatory training and appraisals; reduced staff turnover; focus on long term sickness.
- Therapies and Integrated Community Care: Therapies KPIs; work and impact of the front door team (including reduced length of stay) which is now embedding in ED; opportunity to review documentation and digital solutions; income over performance year to date; increase in virtual ward bed occupancy in month; performance against community response metrics and community wait times; financial performance and CIP on plan; incidents all low or no harm; positive patient experience feedback; strong performance against quality and safety KPIs; strengthened MDT at Ellesmere Port Hospital including social care; moderate risks focussed on staffing challenges; focus on appraisal rates and mandatory training; sickness levels in some services and support for staff.
- Urgent Care Division: Incident reporting with majority low or no harm; falls and pressure ulcers; complaints and concerns with focus needed on timely responses; positive elective performance; continued challenges in non-elective including 4 hour performance and 12 hour breaches; UEC improvement priorities; adverse financial position driven by undelivered CIP with recovery plans in place (moderate to high risk actions); focus on sickness absence and mandatory training; continued high risks regarding waiting times and medical patients outside of bed base, and new moderate risk regarding specific drug supply shortages.
- Planned Care Division: Incident reporting with majority low and no harm and 1 severe in month; quality and safety KPIs including falls and pressure ulcers; improving VTE compliance with further actions needed; continued focus on mandatory training and appraisal; financial position overspend largely driven by CIP and activity underperformance with recovery plans in place at speciality level.

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

- Digital and data strategy presented and discussed prior to formal approval processes.
- Presentation on non elective pressures demonstrating the increased demand on services, and the productivity gains which have been masked by this in the performance metrics. Discussion included the admission avoidance and deflection work, as well as the potential options for community response needed in the wider system.
- Full GMC report circulated with update on action plans expected at next OMB meeting.

| Risks discussed and new risks identified |
| --- |
| • Received and reviewed the significant risk and Divisional risk report including escalations and updates from the October Risk Management Committee meeting. Escalations included UEC pressures, ophthalmology follow up appointments, general surgery on-call model, cyber security, fire safety, and compliance with the medical devices outcome registry. Discussion took place around the impact of violence and aggression across UEC and in particular the wards and escalation, with support needed for staff and an imminent discussion to take place at the violence and aggression steering group. |

**PUBLIC – Board of Directors**
**24th November 2026**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Report** | **Agenda Item 18.** | **NHS Oversight Framework (NOF)** | | | | | | |
| **Purpose of the Report** | Decision | | Ratification | | Assurance | | Information | **X** |
| **Accountable Executive** | Jason Bradley | | | Chief Digital and Data Officer | | | | |
| **Author(s)** | Denise Wood | | | Associate Director of Data & Analytics | | | | |
| **Board Assurance Framework** | BAF 1 Quality<br>BAF 2 Safety<br>BAF 3 Operational<br>BAF 4 People<br>BAF 5 Finance<br>BAF 6 Capital<br>BAF 7 Digital<br>BAF 8 Governance<br>BAF 9 Partnerships<br>BAF 10 Research<br>BAF 11 Transformation | | | **X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X** | Relevant across all BAF risks. | | | |
| **Strategic goals** | Patient and Family Experience<br>People and Culture<br>Purposeful Leadership<br>Adding Value<br>Partnerships<br>Population Health | | | | | | | **X**<br>**X**<br>**X**<br>**X**<br>**X**<br>**X** |
| **CQC Domains** | Safe<br>Effective<br>Caring<br>Responsive<br>Well led | | | | | | | **X**<br>**X**<br>**X**<br>**X**<br>**X** |
| **Previous considerations** | Executive Directors Group (EDG) November 2026<br>Operational Management Board (OMB) October 2026. | | | | | | | |
| **Executive summary** | The purpose of this report is to provide an update on the NHS Oversight Framework revised set of metrics for 2026/7 and segmentation for COCH.<br><br>Quarter 1 (Q1) 2026/27 was published by NHS England on 11th September 2026, with Q2 due in early December. The latest local performance data is included in each Integrated Performance Report (IPR), with local Q2 data in the September 2026 IPR.<br><br>Some measures remain static as they are annual measures: staff survey (new survey underway as at Nov 2026), inpatient satisfaction for 2025 published in August 2026.<br><br>The Trust has been ranked 95/134 for Q1 2026/27, segment 3, compared to 133 /134 for Q1 2025/26, segment 4. The majority of providers are in segment 3 following adjustment downwards for those in segments 1 and 2 with a financial override. | | | | | | | |

| | |
|---|---|
| | Strong performance continues in “access to services” for 18 weeks, diagnostics, and cancer waiting times. Challenges remain with community waiting times and emergency department performance for 4 hour and 12 hour targets.<br><br>Experience of care is positive for CQC inpatient satisfaction, with lower scores in staff survey advocacy rate and “no criteria to reside” percentages.<br><br>Effectiveness of care shows continued strong performance for the mortality indicator, and positive for the new indicator for smoking cessation. Delayed inductions and readmission rates score lower.<br><br>For patient safety the new metric for clinical audit scores at level 1, and MRSA at level 2. The C-difficile indicator is affected by a change definition that now includes the number of specimens tested (seen as comparatively high) as well as the rate of infection, which remains comparatively low.<br><br>People and workforce score well for sickness absence, flu vaccinations and temporary staffing, but are impacted by lower scores for staff survey indicators.<br><br>Finance and productivity metrics score strongly aside from the known planned deficit. |
| **Recommendations** | The Board of Directors is asked to note the latest NHS Oversight Framework (NOF) data which was published in September 2025. |

| **Corporate Impact Assessment** | |
|---|---|
| **Statutory/regulatory requirements** | Contributes to regulatory and legislative compliance. |
| **Risk** | This paper correlates with a number of the Trust strategic risks as recognised in the Board Assurance Framework and High Risk Register. |
| **Equality & Diversity** | Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics |
| **Communication** | Not confidential |

# NOF metrics — Q1 2026/7 and Q2 update

## November 2026

# Segment 3 Ranking 95/134

## Adjusted segment



Provider value

Q1 2026/27

**3 NOF Score**

Q1 2026/27

## Financial override

Provider value

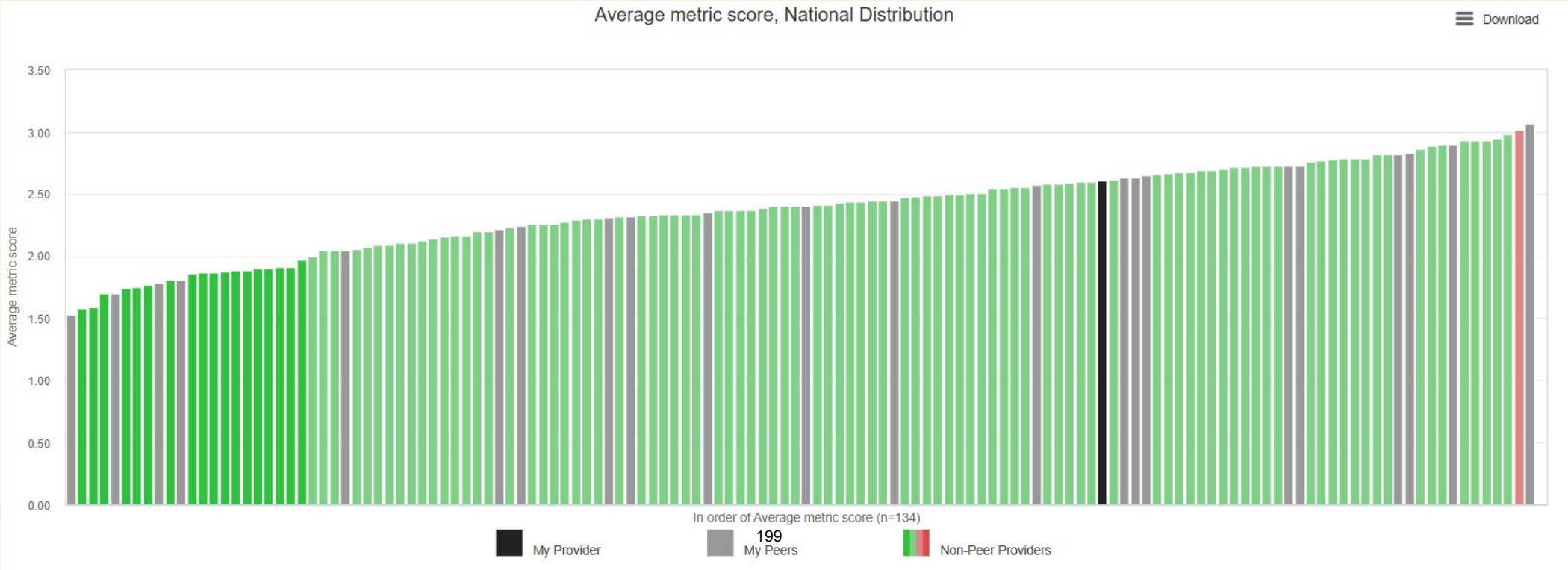
**Yes**

| Segment Q1 | No of trusts (Q4) |
|---|---|
| Seg 1 | 18 (21) |
| Seg 2 | 14 (10) |
| Seg 3 | 83 (69) |
| Seg 4 | 19 (34) |

# Oversight framework summary – average metric score

| Average score CoCH 2.61 |
|---|
| Seg 3 range c. 2.26 - 2.77 (c. 116) |
| Seg 4 range c. 2.78-3.07 |

| Headlines | Data period | Provider value | | Chart |
|---|---|---|---|---|
| Adjusted segment | Q1 2026/27 | 3 | NOF Score | |
| Average metric score | Q1 2026/27 | 2.61 | NOF Score | |
| Unadjusted segment | Q1 2026/27 | 3 | NOF Score | |



# Oversight framework summary – C&M

| Ranking | Organisation Name | Avg Score |
|---|---|---|
| 1 | Liverpool Heart and Chest Hospital NHS Foundation Trust | 1.53 |
| 4 | Clatterbridge Cancer Centre NHS Foundation Trust | 1.7 |
| 9 | Alder Hey Children's NHS Foundation Trust | 1.78 |
| 20 | Walton Centre NHS Foundation Trust | 2.05 |
| 50 | Liverpool Women's NHS Foundation Trust | 2.31 |
| 51 | Mersey and West Lancashire Teaching Hospitals NHS Trust | 2.32 |
| 65 | Mid Cheshire Hospitals NHS Foundation Trust | 2.4 |
| 95 | Countess of Chester Hospital NHS Foundation Trust | 2.61 |
| 97 | North Cheshire and Mersey NHS Foundation Trust | 2.63 |
| 99 | Wirral University Teaching Hospital NHS Foundation Trust | 2.65 |
| 120 | East Cheshire NHS Trust | 2.82 |
| 126 | Liverpool University Hospitals NHS Foundation Trust | 2.9 |

# Oversight framework – detailed metrics (1)

**SCORED METRICS (Contributing to Segmentation)**

**Q1 RANKING 95 / 134 - SEGMENT 3**

| Metric | Type | 2025/26 Target or Threshold | Latest (local version) Time period | * | Latest (local version) Value | Q1 2026/27 Time period | * | Q1 2026/27 Value | Latest published Rank | Score 1 | Score 2 | Score 3 | Score 4 | Overall Domain Score | Overall Domain Segment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **ACCESS TO SERVICES DOMAIN** | | | | | | | | | | | | | | | |
| % patients waiting <18 weeks (absolute) | Acute | 60% | Sep-26 | ↑ | 69.67% | Jun-26 | ↓ | 67.78% | 49/129 | | 2.13 | | | 2.67 (2.24) | 3 (3) |
| % patients waiting >52 weeks | Acute | 1% | Sep-26 | ↑ | 0.34% | Jun-26 | ↑ | 0.70% | 45/129 | | 2.65 | | | | |
| % patients waiting >52 weeks (community) | Community | - | Sep-26 | ↑ | 11.84% | Jun-26 | ↑ | 14.55% | 65 / 79 | | | 3.52 | | | |
| % patients waiting less than 18 weeks for community care | Community | - | Sep-26 | ↑ | 35.13% | Jun-26 | | 42.19% | 70/ 79 | | | 3.52 | | | |
| % Diagnostic referrals waiting over 6 weeks | Acute | | Sep-26 | ↑ | 14.30% | Jun-26 | | 15.99% | 62/ 131 | | 2.41 | | | | |
| % urgent referrals for cancer diagnosed within 28 days | Acute | 80% | Jun 26 - Aug 26 | ↑ | 86.86% | Q1 2026/27 | ↓ | 84.45% | 13/116 | 1 | | | | | |
| % patients treated for cancer within 62 days | Acute | 80% | Jun 26 - Aug 26 | ↑ | 83.33% | Q1 2026/27 | ↓ | 82.92% | 9/ 116 | 1 | | | | | |
| % A&E patients seen within 4 hours | Acute | 78% | Jul 26 - Sep 26 | ↓ | 61.09% | Q1 2026/27 | ↓ | 65.10% | 114/123 | | | 3.83 | | | |
| % A&E attendances >12 hours | Acute | 0% | Jul 26 - Sep 26 | ↑ | 14.71% | Q1 2026/27 | ↑ | 20.53% | 120/122 | | | 3.95 | | | |
| **EXPERIENCE OF CARE DOMAIN** | | | | | | | | | | | | | | | |
| CQC inpatient satisfaction | Acute | | 2024 | ⇔ | 2 | 2024 | ↓ | 2 | | | 2 | | | 3.05 | 4 |
| NHS staff survey advocacy rate | All Trusts | | 2025 | ⇔ | 5.79 / 10 | 2025 | | 5.79 / 10 | 129/134 | | | 3.89 | | | |
| % of intermediate care beds occupied by patients without criteria to reside | Community | | Jun-26 | ⇔ | 35.13% | Jun-26 | | 35.13% | 34/ 50 | | | 3.25 | | | |
| **EFFECTIVENESS OF CARE AND POPULA TION HEALTH DOMAIN** | | | | | | | | | | | | | | | |
| Summary Hospital Level Mortality Indicator | Acute | As Expected | Jun-25 - May-26 | ⇔ | As Expected | Apr-25 - Mar-26 | ↑ | As Expected | S2 | | 2 | | | 2.82 | 4 |
| Rate of pregnant women with a delayed planned induction per 1,000 deliveries | Acute | - | Jul 26 - Sep 26 | ↑ | 81.5 per 1000 births | Q1 2026/27 | | 82.4 per 1000 births | 104 /134 | | | 3.62 | | | |
| 30 day readmission rate band | Acute/Community | - | 2025 | ⇔ | Band A1 | 2025 | | Band A1 (Sig higher than national Average) | 104 / 134 | | | | 4 | | |
| % of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service | Acute | | 01/10/2025 - 01/09/2026 | ↓ | 37.75% | Apr-26 | | 45.1% | 33 / 97 | 1.67 | | | | | |

# Oversight framework – detailed metrics (2)

**SCORED METRICS (Contributing to Segmentation)**

**Q1 RANKING 95 / 134 - SEGMENT 3**

| Metric | Type | 2025/26 Target or Threshold | Latest (local version) Time period | * | Value | Q1 2026/27 Time period | * | Value | Latest published Rank | Score 1 | Score 2 | Score 3 | Score 4 | Overall Domain Score | Overall Domain Segment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **PATIENT SAFETY DOMAIN** | | | | | | | | | | | | | | | |
| Breadth and depth of clinic audit outliers | Acute | | Q1 2026/27 | ⇨ | 1 (no alerts) | Q1 2026/27 | | 1 (no alerts) | | 1 | | | | 2.70 (3.06) | 3 (4) |
| Number of cases of MRSA in the last 12 months | Acute | 0 | Aug-25 - Sep-26 | ↑ | 2 | Jul-25 - Jun-26 | ↑ | 3 | 59/134 | | 2.64 | | | | |
| Rate of E-Coli | Acute | <1 | Aug-25 - Sep-26 | ↓ | 1.24 | Jul-25 - Jun-26 | ↓ | 0.98 | | | | 3 | | | |
| Rate of C-Difficile | Acute | <1 | Aug-25 - Sep-26 | ↓ | 0.97 | Jul-25 - Jun-26 | ↓ | 0.96 | | | | | 4 | | |
| Staff survey - raising concerns | Acute/Community | | 2025 | ⇨ | 5.81 | 2025 | ↓ | 5.81 | 129/ 134 | | | 3.89 | | | |
| **PEOPLE & WORKFORCE DOMAIN** | | | | | | | | | | | | | | | |
| Sickness absence rate | Acute/Community | - | Jul 26 - Sep 26 | ↓ | 5.70% | Q4 2025/26 | ↑ | 5.50% | 77/134 | | 2.46 | | | 2.79 (3.39) | 4 (4) |
| Staff survey - engagement score | Acute/Community | - | 2025 | ⇨ | 6.27/10 | 2025 | ↓ | 6.27/10 | 129/134 | | | 3.89 | | | |
| National education and training survey satisfaction rate | All Trusts | | 2025 | ⇨ | 74.38% | 2025 | | 74.38% | 89/134 | | | 3.28 | | | |
| NHS staff standards score | All Trusts | | 2025 | ⇨ | 7.18/10 | 2025 | | 7.18/10 | 131/134 | | | 3.93 | | | |
| Healthcare worker flu vaccination rate | All Trusts | | Sep 26 - Oct 26 | ↓ | 28.10% | Feb-26 | | 51.10% | 59/134 | | 2.15 | | | | |
| Temporary staffing cost relative band | All Trusts | | Q1 2026/27 | ⇨ | 1 | Q1 2026/27 | | 1 | | 1 | | | | | |
| **FINANCE, PRODUCTIVITY & INNOVATION DOMAIN** | | | | | | | | | | | | | | | |
| Combined finance score (planned vs variance) | All Trusts | | Sep-26 | ⇨ | 2 | Jun-26 | ↓ | 2 | | | 2 | | | 1.62 (2.36) | 1 (3) |
| Planned surplus/deficit | Acute/Community | Breakeven/ Surplus | Sep-26 | ⇨ | -5.70% | Jun-26 | ↑ | -5.70% | 125/134 | | | | 4 | | |
| Variance YTD to plan (NEW Sep 25) | Acute/Community | | Sep-26 | ⇨ | 0.00% | Jun-26 | ↑ | 0.00% | 52/134 | 1 | | | | | |
| Relative cost difference | All Trusts | 100% | 2025-26 | ↑ | 95.67 | 2025 | | 98.29 | 55/134 | 1 | | | | | |
| % of clinical trials set up within 90 days | All Trusts | | Q1 2026/27 | ⇨ | 100% | Q1 2026/27 | | 100% | 1/104 | 1 | | | | | |
| Data Quality Maturity Index | Acute/Comm/MH | | Jun-26 | ⇨ | 93% | Apr-26 | | 93% | 62/134 | | 2.48 | | | | |

*** arrow denotes improvement or deterioration from previous score**