TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 4 June 2025, 10.00am – 12:30pm
Trust Conference Room, Burtonwood Wing, Warrington Hospital

Agenda Item	Time	Agenda Item	Objective/ Desired Outcome	Process	Presenter
BM/25/06/30	10:00	Engagement Story – My Patient Story	*To note*	**Presentation**	Teddy Dean, Patient Jen McCartney, Head of Patient Experience and Inclusion
BM/25/06/31	10:15	Welcome, Apologies and Declarations of Interest	*To note*	*Verbal*	Chair
BM/25/06/32	10:17	Minutes and Action Log of the previous meeting held on • 2 April 2025	*For approval*	*Minutes*	Chair
BM/25/06/33	10:20	Matters Arising	*To note for assurance*	*Verbal*	Chair
BM/25/06/34	10:25	Chief Executive's Report • Financial Update	*For assurance*	*Report & Verbal*	Chief Executive
BM/25/06/35	10:35	Chair's Report	*For info/update*	*Verbal*	Chair
BM/25/06/36	10:45	Board Assurance Framework	*For approval*	*Report*	Company Secretary
Strategic aims:		QUALITY — We will always put our patients first, delivering safe and effective care and an excellent patient experience	PEOPLE — We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future	SUSTAINABILITY — We will work in partnership with others to achieve social and economic wellbeing in our communities	
BM/25/06/37	10:55	Integrated Performance Reports (IPR) and Assurance Committee Reports IPR Dashboard	*For assurance*	*Report*	All Executive Directors
(a)		**Quality Dashboard** **Including** Assurance Reports Strategic People Committee 08.04.25, 13.05.25	*For assurance*	*Report*	Chief Nurse Cliff Richards, Committee Chair
(b)		**People Dashboard** **Including** Assurance Reports Strategic People Committee/Committee in Common 16.04.25, 21.05.25	*For assurance*	*Report*	Chief People Officer Julie Jarman, Committee Chair

(c)		**Sustainability Dashboard -** *including Cash Support* **Including** Assurance Reports Finance and Sustainability Committee 28.04.25, 02.06.25 – to follow	*For assurance*	*Report & Presentation*	Chief Finance Officer John Somers, Committee Chair
d)		**Audit Committee** Assurance Report 24.04.25	*For assurance*	*Report*	Committee Chair. Mike O'Connor
Strategic aim:		Quality			
BM/25/06/38	**11:45**	Fragile Clinical Services Update	*To note for assurance*	**Report**	Chief Nurse /Executive Medical Director, Chief Operating Officer & Deputy Chief Executive
Strategic aim		People			
BM/25/06/39	**11:55**	Bimonthly Communications and Engagement Report	*To note for assurance*	**Report**	Director of Communications and Engagement
Strategic Aim		Sustainability			
BM/25/06/40	**12:05**	Bimonthly Strategy Highlight Report	*To note for assurance*	**Report**	Chief Strategy & Partnerships Officer

Governance					
BM/25/06/41	**12:15**	Compliance with Licence Annual Return – completion of G6 & Cos7	*For Approval*	**Report**	Company Secretary
BM/25/06/42	**12:20**	Review of Board Effectiveness – Survey Outputs	*To note for assurance*	**Report**	Company Secretary
BM/25/06/43	**12:25**	Changes to the Constitution	*To approve*	**Report**	Company Secretary

SUPPLEMENTARY PAPERS for noting (see Supplementary Pack)

To Note For Assurance					
BM/25/06/44		Infection Prevention and Control Update Q4	Quality Assurance Committee Date: 13 May 2025 Ref: **QAC/25/05/037** Outcome: Noted	*To note for assurance*	**Report**	Chief Nurse
BM/25/06/45		Patient Experience & Inclusion Sub Committee Bi-annual Report	Quality Assurance Committee Date: 13 May 2025 Ref: **QAC/25/04/013** Outcome: Noted	*To note for assurance*	**Report**	Chief Nurse

BM/25/06/46	Hospital Volunteer Annual Report	Strategic People Committee Date: 21 May 2025 Ref: **SPCIC/25/05/037** Outcome: Noted	*To note for assurance*	**Report**	Chief Nurse
BM/25/06/47	Guardian of Safe Working Report Q4	Strategic People Committee Date: 21 May 2025 Ref: **SPCIC/25/05/038** Outcome: Noted	*To note for assurance*	**Report**	Executive Medical Director
BM/25/06/48	Gender Pay Gap Annual Report	Strategic People Committee Date: 21 May 2025 Ref: **SPCIC/25/05/039ii** Outcome: Noted	*To note for assurance*	**Report**	Chief People Officer
BM/25/06/49	Digital Strategy Group Update	Finance & Sustainability Committee Date: 2 June 2025 Ref: **FSC/25/04/020** Outcome: Noted	*To note for assurance*	**Report**	Executive Medical Director
Closing					
BM/25/06/50	**12:30**	Review of the Meeting	To discuss	**Verbal**	Chair
BM/25/06/51		Any Other Business	To discuss	**Verbal**	Chair
Date and Time of next meeting – 10am, Wednesday 6 August 2025 – Lecture Theatre, Education Centre, Halton Hospital					

Supplementary papers are available to members of the public on request by email whh.foundation@nhs.net

Paediatric Emergency Department

My Patient Story by Teddy Dean

Working Together

Excellence

Inclusive

Kind

Embracing Change

Adventure led to injury

- On my older brother's bike which was far too big for me
- Riding without any safety equipment on a makeshift bike ramps
- Fell over my handlebars and knocked myself out
- Taken to Warrington Hospital – Paediatric ED

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

My time in Paediatric ED

Attended Paediatrics Emergency Department

Seen by Triage Nurse quite quickly

Assessed and given pain relief (gas and air) and allocated a cubicle

Confirmed broken collar bone

Discharged with a treatment plan, an appointment for the Fracture Clinic and I was sent home

What mattered to me

Lessons learned and next steps

➢ Good practice noted – Seeing the person in the patient

➢ Good communication had a positive impact

➢ Positive impact of MDT working

➢ Positive recognition for the team working well under pressure

➢ Include patient story in Shared Learning Forum session to aid teaching with regards to importance of communication

➢ Patient story to be shared with the Paediatric ED Team

➢ Patient story to be shared at Patient Experience and Inclusion Sub Committee

Conflicts of Interest

At any meeting where the subject matter leads a participant to believe that there could be a conflict of interest, this interest must be declared at the earliest convenient point in the meeting. This relates to their personal circumstances or anyone that they are of at the meeting.

- Chairs should begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the organisation's register(s) on completion of a Declaration of Interest Form.
- The Vice Chair (or other non-conflicted member) should Chair all or part of the meeting if the Chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the Chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

Interests fall into the following categories:

- **Financial interests:**
  Where an individual may get direct financial benefit[1] from the consequences of a decision they are involved in making.
- **Non-financial professional interests:**
  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- **Non-financial personal interests:**
  Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- **Indirect interests:**
  Where an individual has a close association[1] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

Warrington and Halton Teaching Hospitals NHS Foundation Trust **Minutes of the Trust Board Meeting – Meeting held in Public** **Wednesday 2 April 2025** **Trust Conference Room/Via MS Teams**	
Present	
Steve McGuirk (SMcG)	Chair
Cliff Richards (CR)	Non-Executive Director & Deputy Chair
Michael O'Connor (MOC)	Non-Executive Director & Senior Independent Director
Julie Jarman (JJ)	Non-Executive Director
John Somers (JS)	Non-Executive Director
Jayne Downey (JD)	Non-Executive Director
Nikhil Khashu (NK)	Chief Executive
Dan Moore (DM)	Chief Operating Officer and Deputy Chief Executive
Ali Kennah (AK)	Chief Nurse
Michelle Cloney (MC)	Chief People Officer
Paul Fitzsimmons (PF)	Executive Medical Director
Jane Hurst (JH)	Chief Finance Officer
Apologies	
Jan O'Driscoll	Partner Non-Executive Director
In Attendance	
Lucy Gardner (LG)	Chief Strategy and Partnerships Officer
Kate Henry (KH)	Director of Communications & Engagement
John Culshaw (JC)	Company Secretary
Jen McCartney (JMcC)	Head of Patient Experience and Inclusion (**BM/25/04/001**)
Janice Doward	Patient's Wife (**BM/25/04/001**)
Leah Johnston (LJ)	Patient's Daughter (**BM/25/04/001**)
Emily Kelso	Corporate Governance and Membership Manager (minutes)
Observing	
Sue Fitzpatrick	Lead Governor – Public Governor

Agenda Ref	Agenda Item
BM/25/04/001	**Engagement Story – Mark's Story** SN introduced the Engagement Story, told by the patient's daughter LJ which detailed the experience of her father who had been admitted to Trust following complications after a lung lobectomy. The key points taken from the presentation were as follows: • the exceptional care experienced in the intensive care unit • once moved onto the ward a number of issues with care and communication were experienced, these were explained in detail in the presentation slides

	• LJ emphasised the role their family had to play in ensuring their father's safety and care, including their mother, a retired nurse, who had to intervene multiple times • LJ shared their father's diary entries, which reflected his fear and depression during his stay on the ward. AK acknowledged the severity of the issues raised and expressed the Trusts commitment to addressing the communication and safety issues experienced on the Ward. Along with emphasising the importance of the Trust Board hearing the story directly from the patient's family to understand the impact. AK expressed their commitment to addressing the identified issues, emphasizing the need for systemic changes to improve quality of care on the ward in questions. It was confirmed that the story would be shared with the ward in order to drive improvements. JD reflected on Martha's Rule, that grants patients, families, carers, and staff the right to request a rapid review from a critical care outreach team if they have concerns about a patient's rapidly deteriorating condition. It was confirmed the Trust was committed to this rule. JD asked that following review by the Ward that assurance be provided on actions to improve practice at a future Quality Assurace Committee meeting, and an update provided to the Trust Board in 6 months' time. SMcG reflected on the boards response to the patent story, particularly the willingness to learn from mistakes to drive improvements to quality of care. **The Trust Board discussed and noted the Engagement story and agreed an update on actions be presented to QAC and reported up to Board in 6 months' time.**
BM/25/04/002	**Welcome, Apologies and Declarations of Interest** SMcG welcomed the Trust Board, attendees and observers to the meeting and apologies were noted as detailed above, there were no declarations of interest made. SMcG informed all in attendance that the meeting was to be recorded for minuting purposes using AI, in line with the Digital Acceptable Use Policy, there were no objections. **The Trust Board noted the apologies and declarations of interest.**
BM/25/04/003	**Minutes and Action Log of the previous meeting held on 5 February 2025** The minutes of the meeting held on 5 February 2025 were agreed as an accurate record. The Action Log was reviewed, completed actions were noted.

	The board again discussed the action around health inequalities and the importance of addressing within the organisation and the need to integrate this focus into their clinical vision and strategy. They emphasised the need for data-driven approaches and the importance of not letting this priority fall off the agenda.

The Trust Board approved the minutes of the meeting held on 5 February 2025 and noted the Action Log |
| **BM/25/04/004** | **Matters Arising**

The Trust Board noted that there were no matters arising. |
| **BM/25/04/005** | **Chief Executive's Report**

NK introduced the paper, which was taken as read, and highlighted the following key points:
• Over the next two years NHS England would be abolished, leading to approximately 9000 redundancies. Jim Mackey had been appointed as the new Chief Executive of NHS England.
• Integrated Care Boards (ICBs) had been instructed to reduce running costs by 50%.
• Martin Taylor had been appointed as interim Chair of Bridgewater.
• Cathy Elliott to start as Chief Executive of the ICB in June and was currently involved in handover meetings.
• Mandy Nagra had been appointed as Chief System Improvement Delivery Officer, starting on April 7th and was keen to meet to meet with NK and CFOs about delivering the financial plan going forward.
• The acquisition of Bridgewater Community Healthcare (BCH) FT by WHH had been approved agreed by both boards.
• The proposed name for new integrated partnership had been approved as - North Cheshire and Mersey Healthcare Partnership NHS FT
• Discussions were taking place on the impact of changes in NHS England and ICBs on future plans.
• CMAST were to consolidate to one entity, focusing on mental health, learning disabilities, and non-specialist services, with an aim to reduce administration costs
• The Trusts gynaecology super clinics had been recognised nationally for improving access to treatments.
• The staff survey had been presented and shared, with further details to be discussed later on the agenda
• In regard to infrastructure the Halton C Block roof updates had been approved.

JS raised concerns about the Level 3 CIPS in the plan, particularly regarding the infrastructure needed to support the £8.5 million schemes. It was noted that this would be discussed further at the FSC meeting in May. |

	The board discussed the need for clarity on the apparatus to deliver real cash on the ground. Concerns were expressed about relying on spreadsheets without understanding the actual implementation. The board discussed how redundancy pay for NHS England staff would be funded. NK explained that redundancy pay would come from the overall NHS budget. Jim Mackey would be making representations to the Treasury for additional funding. **The Trust Board noted the Chief Executive's Report**
BM/25/04/006	**Chair's Report** SMcG provided a verbal update on activities since the last board meeting, highlighting the following: • The Countess of Chester Hospital NHS Foundation Trust had announced the appointment of Neil Large as Interim Chair of its Board of Directors from 1 March 2025. It was noted that Cheshire Police are considering criminal charges against some former executives of the Countess of Chester. There were 10 core participants involved in the inquiry, highlighting the importance of accountability • The name for the organisation has been agreed, though there was still some concerns and background noise about the name choice. It was agreed to commit to the selected name to avoid prolonged debates. **The Trust Board noted the verbal update from the Chair.**
BM/25/04/007	**Board Assurance Framework (BAF)** JC introduced the report which provided the board with an update on each of the Trusts strategic risks. The key highlights from the report, were as follows • Following discussion at FSC Risks 1898, 145 and 125 were being bought together to form a new strategic risk 2273 around securing new funding and delivering the strategic vision. • Given this, risks 1898 and 145 had been closed and risk 125 deescalated to the Corporate Risk Register (CRR), these changes were supported by the FSC and executive leads • The description of risk 2253 had been updated to capture more detail on the risks associated with shared Board roles, as discussed in the February Board meeting. • There were no updates to risk ratings • No target risk ratings or risk appetites had changed **The Trust Board approved the changes and updates to the Strategic Risk Register and Board Assurance Framework**
BM/25/04/08	**Integrated Performance Report** NK introduced the agenda item which provided a summary of Trust performance. The executives presented a set of summary slides which

highlighted the indicators within the IPR that were both failing and had special cause variation of a concerning nature. In addition, there were there were 2 indicators that had special cause variation of a concerning nature and did not have a target, these are detailed below:

In addition, there were There were 2 indicators that have special cause variation of a concerning nature and do not have a target, there were:

- **16. Mortality ratio – HSMR (NEW)**
- **17. Mortality ratio – SHMI (NEW)**

PF explained that HSMR and SHMI rates were not outliers – green rating on HED data. However, there had been a rise in SHMI and HSMR due to coding changes in SDEC activity (low risk patients' exclusion from 'admitted patients' dataset due to a move to type 5 UEC activity coding).
This was being monitored via HED and reviewed through MRG. In addition, the use of Type 5 reporting was to be reviewed by the executive team.

AK presented on the two failing **Quality** indicators

- **22. Mixed Sex Accommodation Breaches (ITU) (NEW)**

The ongoing issue with mixed sex accommodation breaches were primarily in ITU (Intensive Therapy Unit) and were linked to patient flow and the layout of ITU. It was explained that the breaches would likely continue until patient flow improved

- **23. Sepsis - % screening for all emergency patients**

It was explained there were 3 main drivers for the deterioration in sepsis performance, there were
1. New Guidance: Changed the quoted start time to the point of arrival.
2. Blood Cultures: Challenges around aseptic collection of blood cultures.
3. Department Pressures: High volumes and pressures in the department.
AK explained the actions taken to improve which included; newly qualified nursing staff being introduced and trained, assessment trolleys with necessary equipment being introduced, discussions with IPC and microbiology to extend the role of taking blood cultures to non-HCA staff.

The board discussed the trends in sepsis performance, noting a volatile pattern. AK explained that the new standards had impacted the reported figures. It was further explained that capacity was an ongoing issue which would hopefully be resolved with an emphasis on training more staff to handle blood cultures properly.

AK assured board members that patients were being treated with broad-spectrum antibiotics initially, with adjustments made once blood culture results became available.

DM presented on the 2 failing **Access and Performance** indicators:

- **35. A&E Waiting times - % patients waiting under 4 hours from arrival to admission, transfer or discharge (NEW)**

- **76. A&E Waiting times - % patients waiting under 4 hours from arrival to admission, transfer or discharge (including WUTC) (NEW)**

Work was continuing via the UEC System Improvement Programme with system partners. A deep dive to triangulate attends vs performance was underway to be completed for April 2025. The Trusts ambulance handover times continued to be one of the best in Cheshire & Merseyside. There was continued focus on admission avoidance and alternatives to ED. The "Call before Convey" system initiative had been introduced in February 2025.

MC presented on the one failing Workforce

- **63. Supporting Attendance (NEW)**

MC explained the targeted approach to high areas of sickness reason, working with occupational health to provide a session on this. Compassionate stage 3 sickness absence had been introduced to fast-track cases where appropriate. The process was designed to be compassionate, avoiding formal hearings and focusing on quick resolution for staff with long-term sickness and no prospect of return. The process involved clear communication with the staff involved, ensuring they understand the situation and the steps being taken. MC confirmed the Trust had work with unions to ensure the process was fair and supportive.

A pattern of sickness absence increase had been identified nearing the end of the month, it was confirmed a review was underway.

JH provided an update on the one failing **Finance and Sustainability** indicator:

- **74. CIP – % delivery against plan (recurrent) (NEW)**

£11.8m CIP had been delivered recurrently against the target of £16.8m. Current Year Performance had improved from 14% in the previous year to 80% in the current financial year. Performance had worsened in the second half of the year due to back-loaded CIP targets and schemes not delivering as expected. The Trust relied more on non-recurrent savings towards the end of the year. £11.8m CIP had been delivered recurrently against the target of £16.8m.

The board discussed the importance of the delivery unit (established to support the delivery of the CIP programme, ensuring CIPs are recurrent and quality impact assessed) in maintaining performance. It was noted that there was a need to maintain performance from April onwards despite challenges like winter pressures.

The Board agreed the new metrics supported the need for better performance management and data integration. The board discussed the importance of triangulating data to understand the impact of changes across different areas.

The Trust Board noted the contents of the report.

QUALITY
BM/25/04/09	**Fragile Clinical Services Update**

	PF introduced the report which provided a status update on the Trust's oversight of Fragile Clinical Services. The following key highlights were taken from the report:
	• The services currently designated as fragile were Urology, Orthopaedics Fractured Neck of Femur, ENT and Cardiology and Cardiorespiratory Services
	• **The Chronic Pain Service:** was to be escalated to fragile services oversight following presentation as a Deep Dive to QAC in May 2025. Escalation was indicated following external service review commissioned by the EMD..
	• **Urology –** There had been a recent cluster of Urology Cancer incidents with harm. A deep dive cluster review of cases and action plan was to be presented at QAC April 2025
	• **Orthopaedics – Fractured Neck of Femur -** Prompt surgery remained an unresolved quality and performance issue. Emergent risk around Orthogeriatric review highlighted in the February report was now resolved
	• **Ear Nose and Throat Surgery -** Waiting list position had improved predominantly due to insourcing. Mitigations were in place for medical staffing challenges, improving consultant staffing – 3 consultants were now established in post, further fixed term consultant had joined in March. The service was becoming less fragile.
	• **Cardiology and Cardiorespiratory Services -** Cardiology pressures driven by consultant vacancies, consultant illness and a misalignment of activity in job plans resulting in excess capacity being directed towards cath-lab and elective work with a deficit in outpatient and inpatient capacity (Model Hospital data).
	Consideration was being given to any system risks in other services, with a focus on high-risk areas.
	The Trust Board: noted the current list of Fragile Services, associated clinical risk and high-level progress updates
BM/25/04/10	**Maternity & Neonatal Update**
	SMcG introduced AGJ to present the paper, he explained his concerns raised around the volume of papers required to be presented to the Board based on national guidance. These were:
	i. Monthly Maternity and Neonatal review
	ii. Cheshire & Merseyside Perinatal Mortality Review Tool (PMRT) Report Q3
	iii. Maternity Incentive 5-Year Update including Saving Babies Lives Care Bundle V3 Update
	iv. Midwifery Safe Staffing Report Q3
	v. Avoiding Term Admissions into Neonatal units (ATAIN) Q3
	vi. Transitional Care Audit
	vii. Maternity Survey

	Board members discussed in detail particularly the rationale behind the extensive paperwork and its effectiveness. Board members agreed they had confidence in the governance systems and processes in place particularly the monthly assurance reporting from the Director of Midwifery into the Quality Assurace Committee including deep dives where requested. In addition, oversight from JD as the boards Maternity Safety Champion. AGJ and JD reassured the board on the ongoing cultural work in maternity services, emphasising the importance of sustaining these efforts to ensure continuous improvement, they highlighted the positive feedback received from the regional maternity team. The board discussed opportunities around separate risk reporting for maternity services to provide more concise reporting into Trust Board. AK explained the compliance requested from MIS, and NICE guidance for year 7, which required direct reporting on progress into Trust Board, minutes had been requested to evidence which the Trust had complied with. **The Board of Directors noted the appended maternity reports as per national recommendations and agreed further work would take place around producing a concise summary report for Trust Board in addition to the effective governance systems and processes already in place.**
BM/25/04/11	**Compliance Update Q3** AK introduced the report which provided compliance updates for Quarter 3 of 2024/25. It was explained that items contained within the report had either been discussed at the Quality Compliance Oversight Group (QCOG), or at the Health and Safety Sub-Committee previously. The following key points were highlighted from the report: • CQC engagement meetings had taken place, positive feedback had been received on the quality of the Trusts responses to enquiries offering assurance on compliance. The Trusts consistent high performance around complaints was noted from the review. • The Trust had changed approach to the Single Assessment Framework from Q4, where a triangulation of evidence would be utilised to offer assurance on compliance, alongside Ward Accreditation, Quality metrics and other data sources. • The Trust received an Environmental Health Assessment in December 2024 achieving a rating of 4. An action plan has been completed and will be monitored by the Health and Safety Subcommittee to work towards a level 5 rating. **The Trust Board noted the report**
BM/25/04/12	**Quality Strategy 2025 – 27**

	AK introduced the paper which outlined the approach to the quality strategy and presented the quality priorities for 2025/26. The priorities were aligned with the Integrated Performance Report (IPR), reflecting known risks, complaints, and issues highlighted in various subcommittee papers. They also overlapped with the strategic quality priorities. The streamlined strategy aimed to simplify from the previous structure which had different levels, feedback from staff indicated this had been difficult to understand. The revised visual presentation of the "Our Quality Strategy on a Page" was noted to be effective, with content clearly displayed. Discussions with BCH colleagues highlighted the importance of integration of health inequalities within the strategy, which was considered timely and appropriate, linking with national priorities. **The Trust Board noted the paper and approved the approach to the Quality Strategy and the Quality Priorities.**
PEOPLE	
BM/25/04/13	**EDI Annual Report** **MC introduced the report which provided** a high-level analysis of the key findings the Equality, Diversity and Inclusion Annual Report for 2024/25. It was noted that the Trust (as a public sector organisation) was required to demonstrate how it is actively working to reduce health inequalities by promoting equality and working to eliminate discrimination, whilst maintaining a commitment to respect human rights. MC explained the SPC held the delegated authority on behalf of the Trust Board for the approval of all equality, diversity and inclusion reporting. The Equality, Diversity and Inclusion Annual Report (2024/25) was approved by the committee on 19 March 2025, and in line with national requirements the report was published on the Trust website by the 30 March 2025 deadline. **The Trust Board noted the Equality, Diversity and Inclusion Annual Report (2024/25), as approved by the Strategic People Committee**
BM/25/04/14	**Freedom To Speak Up Guardian Report** JH the Executive Lead for FTSU presented the report in the absence of the FSUG around the ongoing work to support staff in speaking up, highlighting the importance of triangulating this data with other sources to identify areas needing attention. The following key points were highlighted: - there had been an increase in disclosures increase in disclosures 66 compared to 21 for same period last year - the ongoing work to support staff in speaking up, including training and resources to ensure that staff feel safe and supported in raising concerns. It was highlighted that the Trusts FTSUG had a strong background as a mental health nurse and a particular strength in mediation.

	• A draft FTSU strategy for 2025 - 2027 had been circulated to the Executive and non-Executive Lead for FTSU and was provided in full as an appendix
	NK commented the increase in disclosers was a positive, providing evidence that staff felt safe and supported to speak up, a reflection of the cultural changes being seen across the Trust. The spike in October was following FTSUG month where the role of the FTSUG and FTSU Champions were being promoted heavily Trust wide.
	JJ commented on the importance of triangulating data from FTSUG report with performance data and the results from the staff survey. MC confirmed that triangulation was taking place and correlations had been identified.
	MC explained the work taking place with identified care groups, including some of those under fragile services oversight, to support sexual safety in the workplace in response to staff survey results and triangulation of FTSU disclosures. Awareness raising sessions had commenced to empower people with strategies to prevent, report and respond to incidents of sexual misconduct.
	The Trust Board noted the progress of Freedom to Speak Up.
BM/25/04/15	**National Staff Opinion Survey**
	MC introduced the paper which provided The National Staff Opinion Survey results indicated that the improved position from the previous year had been maintained,
	The survey highlighted two significant improvements, these were; Always Learning and Flexible Working. The report detailed areas requiring attention, including statistically significant variations.
	It was explained that the survey now included questions on sexual behaviour, misconduct, and harassment, with extensive work completed over the past year in collaboration with Bridgewater, including signing the Sexual Safety Charter.
	There was a positive correlation between the Freedom to Speak Up Guardian (FTSUG) and the Patient Safety Incident Framework (PRSIF), leading to quality improvements. Staff indicated they could see improvements, though work remained on confidence in lessons learned from reported incidents.
	Bullying and harassment were identified as key focus areas, with efforts to align responses with revised cultural priorities. There was a discrepancy between staff survey results and internal Datix data on employee relations. The northwest data showed correlations with WRES and WDES data, emphasising the importance of reporting and speaking up. Efforts were ongoing to improve ESR reporting on race and disability, and to address long-term sickness and presenteeism.

	Both sets of survey results (BCH and WHH) were reviewed by the newly formed Strategic People Committee in Common (SPCiC) to determine priorities and resource allocation.
	Further work to develop local action plans for improvement were currently underway led by the Culture, Engagement and Inclusion Team and HR Business Partners. Updates on localised action plans would be reported through the Trusts governance structure.
	The Trust Board noted the report.
	SUSTAINABILITY
BM/25/04/16	**Strategy Programme Highlight Report**
	LG introduced the Strategy Programme Highlight Report, providing a progress update on key strategic projects and initiatives which underpinned several of WHH's strategic (QPS) priorities. The report highlighted that the Living Well Online platform was now live, receiving 20,000 views in the first two days, indicating significant potential for further development.
	Work had commenced on the Runcorn Health and Education Hub, with an expected opening early next year. The hub would provide access to careers in work, health, and care through the college. The Full Business Case had been slightly delayed due to complexities in the commercial setup and recent changes in procurement. It was anticipated that the commercial case would be presented to the board in June.
	The report also noted that the CDC's paediatric respiratory and gynaecology pathways were scheduled to go live in May, with the new build concluding in May and the first patients expected in June. Additionally, funding had been identified to start work on the phased development estates plan.
	A tour of the CDC was proposed, a number of Board members agreed to take part in the tour during the lunch break.
	The Trust Board noted the report.
	For Approval
BM/25/04/18	**Performance Assurance Framework**
	JH introduced the report which proposed a number of updates to the Trusts The Performance Assurance Framework for the 2025/26 financial year, these were:
	• Amendment to the content and purpose of the Quality People and Sustainability (QPS) Review. • Updates to reflect changes to the organisation including team names and job titles.

	The Trust Board supported the amendments to the PAF as part of the annual refresh.
BM/25/04/19	**Integrated Performance Report Refresh** JH introduced the paper detailing proposed amendments to the IPR for 2025/26, covering Quality, Access and Performance, Workforce, and Finance. It was noted that the 2025/26 draft NHS Standard Contract and NHSE Oversight Framework had been reviewed to understand changes that might affect performance monitoring. The report provided an explanation of the indicators proposed for addition or removal. JH reflected on the training conducted during Board Development sessions to help Board members use the IPR effectively for performance assurance. It was noted that the report was now more concise and its presentation more effective in providing a snapshot of Trust performance, both at committee and Trust Board meetings. **The Trust Board noted the contents of the report and approved the proposed amendments to the IPR Dashboard for 2025/26.**
**GOVERNANCE**
BM/25/04/20	**Trust Board Cycle of Business** JC introduced the report explaining that in accordance with the Foundation Trust's Constitution, the Board were required to review the Cycles of Business on an annual basis. The proposed amended Cycle of Business was provided for review and approval. **The Trust Board approved the Trust Board Cycle of Business for 2025/26**

BM/25/04/21	**Committee Terms of reference and Cycles of Business**
	
	JC introduced the report explaining that in accordance with the Foundation Trust's Constitution, the Boards committees were required to review their Terms of Reference and Cycles of Business on an annual basis. Detailed in the report were the proposed changes which had been approved at respective committees and were being bought to the Board for formal ratification, these were;
	    I. Quality Assurace Committee
	   II. Finance & Sustainability Committee
	  III. Audit Committee
	  IV. Strategic People Committee in Common – agreed
	
	The Trust Board reviewed and approved the Committee Terms of Reference and Cycles of Business

**Supplementary Papers – To note for Assurance**

BM/25/04/22
BM/25/04/23
BM/25/04/24
BM/25/04/25
BM/25/04/26
BM/25/04/27
	Learning From Deaths Q3
	Learning From Experience Q3
	Infection Prevention and Control Update Q3
	Guardian of Safe Working Report Q3
	Digital Strategy Group Update
	Charitable Funds Committee
	    ○ **Governing Document**
	    ○ **Cycle of Business**

Closing	
BM/25/04/28	**Review of the Meeting** It was note that the meeting had run very slightly over time, however it had been important to allocatee some addition time to the patient story, from which actions would be taken forward and monitored by the Quality Assurace Committee. The Trust Board discussed and agreed the meeting had been effective meeting with good discussions and challenge on agenda items and links with strategic risks as per the BAF.
BM/25/04/29	**Any Other Business** No further business was raised. **Meeting ended at 12:37pm**
Date and Time of next meeting – 10am, Wednesday 4 June 2025 – Trust Conference Room Warrington	

TRUST BOARD

AGENDA REFERENCE	BM/25/06/32ii	SUBJECT:	ACTION LOG	DATE OF MEETING	4 June 2025

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status

2. ROLLING TRACKER OF OUTSTANDING ACTIONS

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/24/08/70	7.8.24	Health Inequalities	A separate session to be organised to discuss in more detail	**LG**			Board agreed the topic woul d be scheduled for a future Board Development Session as part of Integration work – Date to be confirmed during 2025/26	(green)

RAG Key

	Action overdue or no update provided		Update provided and action complete		Update provided but action incomplete

REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/25/06/34	
SUBJECT:	**Chief Executive's Report**	
DATE OF MEETING:	4 June 2025	
AUTHOR(S):	Nikhil Khashu, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	SO1 We will always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will be the best place to work with a diverse and engaged workforce that is fit for now and the future.	✓
	SO3 We will work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**All**	

LINK TO PUBLIC SECTOR EQUALITY DUTIES	*Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate*:		
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			

EXECUTIVE SUMMARY (*KEY ISSUES*):	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.		
PURPOSE: *(please select as appropriate)*	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to note the content of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Chief Executive's Report	AGENDA REF:	BM/25/06/34

1. BACKGROUND/CONTEXT

This report provides the Trust Board with an overview of a range of strategic and operational issues since the last meeting on 5 February 2025, some of which are not covered elsewhere on the agenda for this meeting.

2. KEY ELEMENTS

2.1 Trust News

I'm pleased to confirm my appointment as Chief Executive from 1 April 2025. The warm welcome from WHH and BCH staff greatly influenced my decision. Both organisations are filled with dedicated colleagues. I was impressed by the potential for growth and collaboration, as shown by the recent joint Clinical Summit, which highlighted our ability to foster practical improvements and a shared sense of purpose.

2.2 National News

The past two months have seen a continued focus on addressing core challenges within the NHS, particularly around workforce, patient access, and digital transformation.

Pay Awards Confirmed: In May, significant real-terms pay awards for 2025-26 were confirmed for NHS staff, backdated to April 1st. This includes an average 5.4% rise for resident doctors, 4% for consultants, specialists, and GPs, and 3.6% for Agenda for Change (AfC) staff. These increases are being funded through central budget efficiencies.

Urgent and Emergency Care: April saw continued high demand in A&E, with 2.3 million attendances. While ambulance response times for Category 2 calls showed some improvement, four-hour A&E waiting time performance remains below the 95% standard.

NHS App Expansion: A major expansion of the NHS App was announced in April, with 87% of hospitals now offering services through the app, exceeding the government's target. This aims to improve patient choice and flexibility in accessing healthcare and reduce missed appointments.

Cancer Care: Over three million additional appointments were delivered, and the NHS exceeded its faster diagnosis standard for cancer. Targeted breast cancer treatment was also approved for routine NHS use in April.

Planning Guidance 2025/26: The NHS's strategic direction continues to be guided by the 2025/26 Planning Guidance, emphasising three transformative shifts:

- **From Hospital to Community:** Strengthening community-based services.

- **From Sickness to Prevention:** Investing in proactive health initiatives.

- **From Analogue to Digital:** Accelerating digital transformation, including increased use of the NHS App, implementation of the Federated Data Platform, and Electronic Patient Records.

Digital Infrastructure: NHS England Digital announced changes to their Path to Live environments, consolidating and decommissioning older environments to improve efficiency and consistency in IT delivery.

Nursing Care Funding: From April 1st, 2025, there was a 7.7% increase in funding for care homes providing NHS-funded nursing care, aiming to support more individuals in the community and reduce pressure on hospitals.

New Cancer Treatment: April saw the rollout of a 5-minute 'super-jab' for 15 cancers, a significant step forward in cancer treatment.

GP Access: Initiatives were announced in April to improve patient access to GP practices through technology, including easier online registration.

Overall, April and May 2025 have been marked by a strong commitment to improving NHS performance and patient experience, underpinned by strategic investments in workforce, digital transformation, and efficiency drives, while continuing to address the persistent challenges of demand and waiting lists.

2.3 Regional Update

Warrington Borough Council - After a distinguished 47-year career across the academic, public, government, and private sectors, including 31 years in leadership roles within the borough and 20 years at Warrington Council, Professor Steven Broomhead MBE, Chief Executive Warrington Borough Council, announced his retirement, effective at the end of June 2025.

On behalf of the Trust, a heartfelt thank you is extended to Professor Broomhead for hard work, dedication, and service, which have significantly contributed to the advancement of Warrington and its communities

ICB - The Trust Board is asked to note that Mandy Nagra has been appointed as the Cheshire & Merseyside ICB Interim Director of Improvement.

2.4 Cheshire & Merseyside Provider Collaborative (CMPC) Leadership Board Meeting

The CMPC Leadership Board met on Friday 2nd May. This was the first single provider collaborative meeting for Cheshire and Merseyside. A meeting where all providers joined together, informally, to meet as the Cheshire and Merseyside Provider Collaborative (CMPC). This inaugural meeting discussed several system wide issues and included Trust CEOs being joined by Chairs.

The Leadership Board received an update on the work being progressed by the ICB with NHSE on the system's financial plan and additional provider and ICB actions required to reduce current system expenditure plans to the available financial envelope. A revised plan had been shared with NHSE with further discussions at a regional and national level expected. Additional scrutiny and intervention is expected, and further control and standardisation was relayed as necessary.

The Board was introduced to Mandy Nagra, who has been appointed as Cheshire and Merseyside System Improvement Director. Mandy commented on an amount of good work going on within C&M but also the need for this to be spread widely. This message was coupled with a wider expectation of more and continuous improvement, tough choices and delivery at

pace. It was noted that there is an opportunity for improvement in every organisation in the system.

Further areas of discussion related to a quarterly review of programme delivery and discussion on the work plans for each of the programmes in the year ahead. These deliverables and commitments are summarised in supporting information shared with meeting attendees.

Update papers were also provided on the following areas:

- System financial report
- System performance update

The Terms of Reference and Joint Working Agreement for the new Provider Collaborative are being developed and will be brought to the Trust Board for review and approval.

2.5 Overview of Trust Performance

Appendix 1 is a snapshot dashboard overviewing Trust performance across the domains of Quality, People and Sustainability for the last full month of complete reported datasets. In this case, this is month 1 – April 2025. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside the relevant Committee Assurance Reports.

2.6 MaDE for Easter

A Multi Agency Discharge Event (MaDE) took place from 14 to 23 April to enhance patient flow and safety by reducing hospital stays and increasing morning discharges. The event involved collaboration across Warrington and Halton Hospitals (WHH) and Bridgewater Community Healthcare (BCH), with partners like the North West Ambulance Service and local authorities. MaDE teams focussed on identifying and resolving barriers to discharge, supporting wards and Emergency Departments, and utilising community services to avoid unnecessary admissions. A central control team at Warrington Hospital coordinated efforts.

The event reported a 6.3% increase in discharges compared to 2024, with Ward A6 achieving a 244% increase, followed by Wards B18 and A9. Feedback from partners praised the collaborative, action-focused approach, emphasising reduced patient delays and improved recovery through inter-agency planning. The event's success highlighted teamwork's impact on patient outcomes.

2.7 Making a difference through supported internships

I celebrated with Lee Smith, a neurodiverse individual who secured a job as a domestic cleaner at Warrington Hospital after a supported internship with Warrington and Vale Royal College, Warrington Council, and DFN Project SEARCH. The program supports young people with additional needs through work placements and employability training, showcasing WHH and BCH's commitment to social and economic wellbeing.

2.8 The AI Dermatology Service – a true example of better care together

Bridgewater's AI Dermatology Service officially launched on Friday, 11 April, marking a significant milestone in collaborative healthcare delivery between Bridgewater Community Healthcare NHS Foundation Trust and Warrington and Halton Teaching Hospitals NHS Foundation Trust

The AI Dermatology Service is a pioneering initiative that leverages medical-grade artificial intelligence to identify both skin cancer and common benign skin conditions. This innovation enables patients to receive faster diagnoses and, in many cases, same-day treatment directly onsite.

The implementation of this AI technology is expected to reduce the number of unnecessary hospital appointments for patients with non-serious skin issues, thereby freeing up resources for more urgent cases. This aligns with broader NHS objectives to reduce patient waiting times and respond more effectively to increasing demand for dermatological services.

The service is located at the Warrington and Halton Diagnostics Centre, situated within the Halton Health Hub at Runcorn Shopping City. Notably, this is one of only a few government-funded Community Diagnostic Centres established in a shopping centre across the UK, and it is the first of its kind in Cheshire and Merseyside.

Following the successful launch, Bridgewater staff are now fully integrated into the state-of-the-art facilities at the Diagnostics Centre, delivering an improved patient experience. The benefits of this service are already evident for both patients and healthcare professionals.

2.9 International Nurses Day

The Trust celebrated International Nurses Day, on May 12 within the NHS, honouring the contributions of nurses to healthcare and society. Marking the birthday of Florence Nightingale, the founder of modern nursing, the day highlighted nurses' critical role in patient care, public health, and advancing medical practice. It served as an opportunity to recognise the dedication, compassion, and expertise of nurses, who form the largest workforce group, delivering care across hospitals, clinics, and communities.

2.10 Powered by purpose

The Trust also marked International Clinical Trials Day, on 20 May, commemorating the first randomised clinical trial conducted by James Lind in 1747, which investigated scurvy treatments. The day raises awareness of the critical role clinical trials play in advancing healthcare by developing new treatments, devices, and care methods.

2.11 Start of the year

The joint Start of the Year Conference for WHH and BCHT took place on 2 May, and brought together staff from diverse roles to reflect on 2024-25 and plan for 2025-26. The agenda focused on four key pillars: quality, people, performance, and finance.

Key Priorities for 2025-26:

- Quality: Focus on reducing pressure ulcers, falls, and violence against staff, while addressing health inequalities across all ages.
- Performance: Aim to meet the 78% four-hour urgent care target by March 2026, improve RTT performance by 5%, and ensure fewer than 1% of patients wait over 52 weeks.
- People: Reduce reliance on temporary staff, improve attendance and appraisals, and tackle bullying to enhance staff and patient experiences.
- Finance: Achieve a 5% recurrent cost reduction, secure system-wide savings, meet performance targets without extra income, and align corporate costs with national benchmarks while prioritizing safety and quality.

The conference emphasised alignment with the NHS Long-Term Plan, focusing on shifting care to communities, adopting AI, and reducing health inequalities. Guest speaker Dr. Kate Allatt highlighted the importance of person-centred care and effective communication.

Senior leaders shared 2024-25 achievements and 2025-26 ambitions, while the "Better Care Together" session gathered staff feedback on integrating care closer to patients' homes. The event underscored the workforce's critical role in delivering exceptional care and driving forward integration between the two Trusts.

2.12 Special Days/Weeks for professional groups

Since our last Board meeting, several topics, professional or interest groups or disciplines have had special days or weeks marked locally, nationally or internationally. These have included:

April

- Bowel Cancer Awareness Month
- World Autism Acceptance Week
- Stress Awareness Month
- Passover
- Multiple Sclerosis Awareness Week
- World Immunology Day

May

- Action on Stroke Month
- National Walking Month
- Deaf Awareness Week
- Maternal Mental Health Week
- World Asthma Day
- International Nurses Day
- International Clinical Trials Day
- Mental Health Awareness Week
- Global Accessibility Awareness Day
- Dementia Action Week
- World Pre-Eclampsia Day
- VE Day

2.13 Employee Recognition

Our *You Made a Difference Awards* are in their third year of operation. Nominations are reviewed and awards are made by a multi-professional panel.

You Made a Difference Award (March 2025): Julie Dagley, Domestic Assistant

You Made a Difference Award (April 2025): Firdous Patel, Midwife

WHH Thank You Awards – meet your 2024-25 finalists

On May 16, 2025, over 300 staff members gathered at the Titanic Hotel in Liverpool for the WHH Thank You Awards, a vibrant celebration of Warrington and Halton Teaching Hospitals NHS Foundation Trust's workforce. The event honoured 13 deserving winners with awards, recognising their outstanding achievements and dedication. The atmosphere was filled with inspiration, and positivity and created a memorable night for everyone.

I'd like you all to join me in celebrating our *Thank You Awards 2024-25* winners:
- **Planned Care Team of the Year** – Team River, Enhanced Midwifery Care Team
- **Unplanned Care Team of the Year** – Ward A8 (General Medicine)
- **Clinical Support Services Team of the Year** – Outpatients Department
- **Corporate Services Team of the Year** – Communications and Engagement Team
- **Living Our Values: Colleague of the Year (Clinical)** – Kaley Whelan, Trainee Advanced Clinical Practitioner (UEC, Acute Medicine)
- **Living Our Values: Colleague of the Year (Non-Clinical)** – Samantha Durcan, Medical Secretary (Palliative Care Team)
- **Innovation and Improvement Award** – Gynaecology Super Clinic Team
- **Culture and Inclusion Award** - Clare Fairhurst, Clinical Team Manager (Acute Medical Therapies)
- **Rising Star Award** – Erin Tighe, Financial Accounts Assistant (Management Accounts)
- **Leadership Award** – Lydia Davies, Lead Radiographer (Breast Screening Services)
- **You Made a Difference Award** – Wards A3 (Acute Cardiac Care Unit) and B18 (Respiratory Care)
- **People's Choice Award** – Louise Foley, Specialist Nurse (Colorectal Team)
- **Outstanding Achievement Award** – Lefteris Zabatis, Senior Strategic Project Manager, Strategy Team

I'd like to say a big thank you to all who attended and everyone who was involved in making the night a success. Thank you to everyone who took the time to nominate a colleague or team; to our staff stars who were shortlisted and became our 2024-25 finalists and winners; to our sponsors for making the event possible and our TYA planning team and communications colleagues.

2.14 Signed under Seal

Since the last Trust Board meeting, there have been no items signed under seal

3   RECOMMENDATIONS

The Board is asked to note the content of this report.

4   APPENDICES

Appendix 1: CEO Dashboard – Month 1 (April 2025)

Appendix 1 - CEO Dashboard Month 1 – April 2025

Quality

Operational Performance

Indicator	Target/Limit	Actual	SPC
Diagnostic waiting times - 6 Weeks	above 95%	96.13%	
RTT 18 Weeks	above 92%	56.55%	
RTT - patients waiting 52+ Weeks	0	1528	
Elective Outpatient activity	104%	94%	
A&E % patients seen within 4 hours	Below 78.00%	64.75%	
A&E % waiting longer than 12 hours	Below 2.00%	20.08%	
Cancer 28 Day Faster Diagnostic Standard	above 75%	74.20%	
Cancer 62 Day Wait	above 85%	73.40%	
Ambulance Handovers within 60 mins	100%	87.10%	
Cancelled Operations – 28 days	0	4	
Capped Theatre Utilisation	above 85%	78.90%	

Quality of Care

Indicator	Target/Limit	Actual	SPC
Incidents open over 40 days	0	9	
Sepsis Screening Emergency	above 90%	54.00%	
Sepsis Screening Inpatients	above 90%	70.00%	
Sepsis Antibiotics Emergency	above 90%	62.00%	
Sepsis Antibiotics Inpatient	above 90%	95.00%	
Inpatient Falls	30 (10% reduction from 2024/25)	26	
VTE	above 95.49%	94.40%	
Pressure Ulcers	11 (20% reduction from 2024/25)	18	
Medication Reconciliation (within 24 hrs)	above 80%	51.00%	
Complaints over 6 months	0	1	
Healthcare Infections - MRSA		0 YTD	
Healthcare Infections - MSSA		6 YTD	
Healthcare Infections – CDI (cumulative)	Thresholds not yet set for 2025/26	3 YTD	
Healthcare Infections - E. coli (cumulative)		8 YTD	
Healthcare Infections – Klebsiella (cumulative)		3 YTD	
Healthcare Infections - P. aeruginosa (cumulative)		1 YTD	
Maternity Postpartum Haemorrhage >1500ml	below 3.7%	5.50%	
MUST nutritional assessment completion	above 85%	68.43%	

Sustainability

Finance

Indicator	Target/Limit	Actual	SPC
Income & Expenditure (£m)	-£4.69	-£4.69	No SPC
Capital Spend (£m)	£0.33	£0.09	
Cash Balance (£m)	£10.64	£19.48	No SPC
Better Practice Payment Code (£m)	above 95%	53%	
Agency Reduction (£m)	£0.24 (30% reduction from 2024/25 plan)	£0.32	
Bank Reduction (£m)	£2.34 (10% reduction from 2024/25 plan)	£2.40	
CIP In Year Delivered in relation to plan	90% of plan	100%	
CIP In Year Delivered in relation to plan (Recurrent)	90% of plan	57%	

People

Workforce

Indicator	Target/Limit	Actual	SPC
Supporting Attendance	Below 5%	5.86%	
Turnover	Below 13%	11.68%	
Core/Mandatory Training	above 85%	90.26%	
PDR Compliance	above 85%	79.00%	

Strategy

- **WHH and BCH's respective Trust Boards have now approved the intention for WHH to formally acquire BCH and become one single integrated organisation.** These approvals trigger the start of a transaction process and it is anticipated that the single organisation will take effect from 1st April 2027, pending approvals. Work continues across all ten workstreams and the process of developing the case for change has commenced.

- **Over 95,000 additional diagnostic tests have been undertaken in Community Diagnostic Centre (CDC) spaces** since the first phase of the development opened in the Nightingale building in May 2023. The national CDC programme team have approached the Trust about the possibility of expanding the CDC facility at Halton Health Hub.

- The **brand-new Living Well Warrington online platform went live** to the public on 26th March. The site has received 35,000 views since launch. With the membership and offers listed growing daily, the platform showcases nearly 600 activities that support living well across Warrington.

- Work continues to implement the **new post menopausal bleeding pathway** within the CDC in Halton. This will enable women to access a one stop clinic for diagnosis of gynaecological cancers.

- The full **business case for development of the East Pathology Hub is in development** and will be shared with the executive team in June before being presented to the Board in July.

AGENDA REFERENCE:	**BM/25/06/36**	
SUBJECT:	**Board Assurance Framework**	
DATE OF MEETING:	4 June 2025	
AUTHOR(S):	Emily Kelso, Corporate Governance & Membership Manager	
EXECUTIVE DIRECTOR SPONSOR:	All Executives	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All	

LINK TO PUBLIC SECTOR EQUALITY DUTIES	*Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate*:			
		Yes	**No**	**N/A**
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	✓		
	Further Information:			
		Yes	**No**	***N/A***
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	✓		
	Further Information:			
		Yes	**No**	**N/A**
	3. Foster good relations between people who share a protected characteristic and those who do not	✓		
	Further Information:			

EXECUTIVE SUMMARY (*KEY ISSUES*):	**Board Assurance Framework** This report provides an update on the Trust's 10 strategic risks as per the Board Assurance Framework, following review by the assigned monitoring Committee. Each strategic risk is linked to one or more of the Trust's strategic objectives. A Risk Review Group has been established for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately. **Since the last Trust Board meeting:** • No risks have been closed or deescalated • No risk descriptions have been updated • There have been no updates to risk ratings • No target risk ratings or risk appetites have changed

	Key updates to existing risk; controls, assurances and gaps are detailed within section 2.6 of the report.
	Detailed individual strategic risk reports are included as **Appendix 1.**
	The Trust has an overall Risk Appetite Statement **(Appendix 2)** which is reviewed and approved annually by the Trust Board. In addition, each strategic risk on the BAF has been assigned a unique risk appetite as approved by its monitoring committee.

PURPOSE: *(please select as appropriate)*	Approval	To note ✓	Decision

RECOMMENDATION:	The Trust Board is asked to: • Discuss and note the updates to the Strategic Risk Register and Board Assurance Framework	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee, Finance & Sustainability Committee, Strategic People Committee, Audit Committee
	Agenda Ref.	Multiple
	Date of meeting	Multiple
	Summary of Outcome	Approved
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework	AGENDA REF:	BM/25/06/36

1. BACKGROUND/CONTEXT

It has been agreed that the Board receives an update on all strategic risks and any changes that have been made to the strategic risk register. This report provides an update on the Trusts strategic risks as per the Board Assurance Framework.

A Risk Review Group has been established for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately. Each risk is also monitored in an appropriate Committee and linked to the Trust's strategic objectives

The latest Board Assurance Framework (BAF) is included as **Appendix 1.** A summary of the current status of each of the Trusts strategic risks, should the proposed amendments within this paper be approved, is provided in the table below:

Risk ID	Exec Lead	Risk Description	Current Rating	Risk Appetite	Monitoring Committee
224	COO	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival resulting in an overcrowded Emergency Department.	20 (L5xC4) ↔	Open	QAC
1215	COO	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.	20 (L4xC5) ↔	Open	QAC
134	CFO	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton	20 (L5xC4) ↔	Open	FSC
2001	EMD	If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.	20 (L5xC4) ↔	Minimal	QAC
1114	EMD	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	16 (L4xC4) ↔	Minimal	FSC
1372	EMD	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems	16 (L4xC4) ↔	Minimal	FSC

		triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	16 (L4xC4) ↔		
2273	CSPO	If the Trust cannot deliver its strategic vision, secure funding for new hospital facilities, and the suport and resource required from the Cheshire & Merseyside ICS and beyond, it may fail to meet estates standards, provide quality services, and ensure a suitable environment, potentially leading to rising backlog maintenance costs, short-term fixes, non-compliance, and adverse effects on patient safety, outcomes, reputation, and finances	16 (L4xC4) ↔	Cautious	FSC
115	CN	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	12 (L3xC4) ↔	Seek	QAC
1134	CPO	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	12 (L3xC5) ↔	Open	SPC
2253	CSPO	If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities, and ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, including the limited capacity of shared Board members to effectively manage competing demands, potentially impacting both Trusts' decision-making and service management	9 (L3xC3) ↔	Open	EMT

The Trust has an overall Risk Appetite Statement **(Appendix 2)** which is reviewed and approved annually by the Trust Board. In addition, each strategic risk on the BAF has been assigned a unique risk appetite as approved by the monitoring committee.

2. UPDATES SINCE THE LAST MEETING

2 Since the last meeting

2.1 New risks

There have been no new risks added to the strategic risk register.

2.2 Amendment to risk ratings

There have been no amendments to risk ratings.

2.3 Amendments to descriptions

There have been no amendments to risk descriptions

2.4 De-escalation of risks

No risks have been closed or deescalated.

2.5 Risk appetite

There have been no amendments to risk appetites for any of the Trusts strategic risks.

2.6 Existing risks - updates

Detailed below are the updates that have been made to the risks since the last meeting.

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
224	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival resulting in an overcrowded Emergency Department.	**Controls** • Progress chaser in ED to support flow and timely • Winter escalation capacity (ward A10 & bay of 6 on Ward B4) planned to be open in Winter 2025/26 to support flow and urgent care	20	**None** ⟷
1215	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.	**Controls** • All performance activity monitored through weekly performance review group (PRG) • FOP Platform launched to support effective theatre scheduling	20	None ⟷
134	If the Trust is not financially viable then there may be an impact on patient safety, operational performance, staff morale and potential enforcement/regulatory action taken	**Controls** • Capital Plan for 2025/26 approved at the 2 April 2025 Trust Board meeting. • Revenue plans 2024/25. Operational Plan approved by Trust Board 28.04.2025 • 2024/25 deficit position £16.8m was in line with the forecast, for £5.5moff plan, subject to Audit. • Cash Support received for 2024/25 was £12.145m. • Delivery Unit Set Up - Delivery Unit Oversight Groups established, comprising the Delivery Unit Workforce (DUW), Delivery Unit Non-Pay (DUNP) and Delivery Unit Productivity (DUP), to provide robust oversight, challenge, and accountability for key financial and operational workstreams with focus on workforce pay, non-pay expenditure, and productivity improvements. **Assurances** • The 23/24 the control total was exceeded by the stretch target set by the ICS. The 2024/25 position was £16.8m deficit which was in line with the forecast and £5.5m off plan. The Trust has highlighted the level of risk throughout the year. • Delivered 2023/24 and 2024/25 Capital Plans • Unqualified audit opinion (2024/25) submitted on time	20	None ⟷

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		• Changes to WTE have been reviewed by the Finance & Sustainability Committee during the year and the Trust has seen a significant reduction in agency with an increase in bank and substantive staff. The 2024/25 challenge was to keep agency to below the 3.2% ceiling and reduce bank. For 2024/25 agency was 1.3% of payroll, lower than the 3,2% ceiling. • Key financial controls review 2024/25 received high assurance for accounts receivable, general ledgers and treasury management with no recommendations. • Operational Plan submitted in line with timetable. **Control & Assurance Gaps** • Risk of over performance of activity in May may not be paid due to cap on income and affordability • Risk funding of pay award above 2.8% • Risk delivery of the system wide (Level 3) COP £12M		
2001	If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.	Current services included in the Fragile Services Oversight program are: **(new services added)** • Cancer Services • Chronic Pain	20	none ↔
1114	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	**Assurances** • Digital Services uses several cyber threat intelligence services (C&M Cyber Group, NCSC, NHSE CSOC) • Audit on 3rd party vendor management by MIAA (waiting on audit report) **Controls** Unisoft Server upgraded to Windows 2019	16	none ↔
1372	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	**Controls:** • The collaboration agreement has been developed and endorsed by EMT and Board • Approach to convergance and single instance architecture agreed wih FD team **Gaps In Assurance** • FD convergence guidance remains a potential risk – though agreement of a single instance architecture with multiple tenants with FD has largely mitigated this • Complexity of coterminus LIMS implentation presents an emerging risk which requires a mitigating plan	16	**None** ↔

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		• FD now require a single OBC and FBC for EPRIB and Cabinet Office approval		
115	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	**Controls** • NHSP Request Review /10% reduction review Meetings chaired by Chief Nurse or Deputy Chief Nurse every week • Monthly review of bank use/staffing challenges at Executive Management Team Meeting, • Twice daily Acuity Recording on Safe Care **Assurances** • Increase in registered nursing establishment in the Emergency Department, November 2024 reducing band 5 vacancy rate to 32.85 In April 2025 WTE from 46.84 WTE in May 2024 • Overall CHPPD sustained between 7.3-7.5 in Q4. • Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 14.17% in March 2025 • CSWD 5 cohorts of 15 CSWDs will be deployed throughout 2025, The first cohort commenced April 2025 • 19 wards achieved the 90% fill rate on day shifts and 23 ward achieved 90 % fill rates on nights **Assurance Gaps** • 446 Red Flags reported in March 2025 compared to 368 August 2024- Red Flags were linked to difficulties in providing enhanced care. • In quarter 4 over 1200 patients were admitted to WHH with a mental health condition	12	none ⟷
1134	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	**Sickness Absence** The rolling 12-month sickness absence rate is 5.9% as at April 2025 and is showing a slight increase from February 2025 (5.87%). Trust target from April 2025 is 5% as approved by the Strategic People Committee following a recent benchmaking exercise across the C&M region and consideration of health inequalities in the community we recruit staff from. **Controls** • New stage 3 absence process has been successfully piloted to provide a compassionate and dignified exit out of the organisation on the grounds of ill health capability. **Assurance** • The Trust has seen a significant improvement in long term sickness absence rates since the full implementation and transition on to the new Supporting Attendance policy reducing from 4.39% in April 2022 to 3.06 % in April 2025. • Welcome Back Conversations annual compliance decreased to 72.18% In April 2025, below traget of 85%. Review underway,	12	none ⟷

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		historically low compliance attributed to delays in recording data and reporting periods. **Turnover and Attraction** Turnover in April 2025 remains below the target of 13% at 11.6%, a 1% decrease from the figure reported in Frebruary 2025. Turnover of permanent staff in April 2025 was 11.01%. The Trust's April 2025 vacancy rate has decreased significantly to 7.00% from 8.00% in February 2025, Trust target is below 9%. **Controls** • Rugby League Cares have been supporting WHH since July 2021 and have been working in areas offering drop-in sessions and tailored programmes to support teams and individuals to keep well in work however this programme ceased due to a lack of continued funding on 31/03/25. **Assurances** • The responses to Exit Interviews are positive, only 11.34% (April 2025) of questions answered are negative, with looking forward to going to work receiving the highest proportion of negative responses. • As a result of improving turnover and attraction, the substantive workforce has grown significantly since Apr 23, when it was 4,034 FTE. April 2025 staff in post is 4,784 FTE.. • Staff completing apprenticeships is above target at 3.6%, target is 2.3% **Temporary Staffing and Agency spend** Bank and Agency reliance in April 2025 reamined at 12.9% . The Trust target is 9%. Bank reliance has increased slightly to 11.82% from11.2% in April 2025 and agency reliance continues to reduce t and reamins at 1.4%.		

3. RECOMMENDATIONS

The Board is asked to:
• Discuss and note the updates to the Strategic Risk Register and Board Assurance Framework

Board Assurance Framework - May 2025

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Board Assurance Framework
The Board Assurance Framework (BAF) focusses on the key strategic risks i.e. those that may affect the achievement of the Trust's Strategic Objectives

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite	Monitoring Committee
224	COO	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival resulting in an overcrowded Emergency Department.	1	20 (L5xC4)	8 (L2xC4)	Open	Quality Assurance Committee
1215	COO	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.	1	20 (L4xC5)	6 (L3xC2)	Open	Quality Assurance Committee
134	CFO	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton	3	20 (L5xC4)	12 (L4xC3)	Open	Finance & Sustainability Committee
2001	EMD	If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.	1	20 (L5xC4)	6 (L2 xC3)	Minimal	Quality Assurance Committee
1114	EMD	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	1	16 (L4xC4)	5 (1x5)	Minimal	Finance & Sustainability Committee
1372	EMD	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	3	16 (L4xC4)	8 (L2xC4)	Cautious	Finance & Sustainability Committee
2273	CSPO	If the Trust cannot deliver its strategic vision, secure funding for new hospital facilities, and the suport and resource required from the Cheshire & Merseyside ICS and beyond, it may fail to meet estates standards, provide quality services, and ensure a suitable environment, potentially leading to rising backlog maintenance costs,	3	16 (L4xC4)	9 (L3 xC3)	Seek	Finance & Sustainability Committee

		short-term fixes, non-compliance, and adverse effects on patient safety, outcomes, reputation, and finances		 	 		
115	CN	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	1	12 (L3xC4)	8 (L2xC4)	Minimal	Quality Assurance Committee
1134	CPO	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	2	12 (L3xC4)	8 (L2xC4)	Open	Strategic People Committee
2253	CSPO	If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities, and ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, including the limited capacity of shared Board members to effectively manage competing demands, potentially impacting both Trusts' decision-making and service management	1,2,3	9 (L3xC3)	2 (1LxC2)	Open	Executive Management Team

Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.
Strategic Objective 2: We will… Be the best place to work with a diverse and engaged workforce that is fit for now and the future
Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities

Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Finance Officer (CFO), Chief People Officer (CPO), Executive Medical Director (EMD), Chief Nurse (CN), Chief Strategy and Partnerships Officer (CSPO)

Board Assurance Framework

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Risk ID	224	**Executive Lead**	Chief Operating Officer			
Strategic Objective		**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			**Rating**	

		Rating
Initial	16(L4xC4)	
Current	20(L5xC4)	
Target	8 (L2 xC4)	

Risk Description: If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival resulting in an overcrowded Emergency Department.

Risk Appetite: **Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.

Risk Movement

Chart values: 16 (INITIAL), 16 (PREVIOUS), 25 (PREVIOUS), 20 (CURRENT)

Assurance Details

Controls
- Trust Wide Capacity meetings led by the Tactical Manager for the day four time a day, bed reports detailing site position, risks and actions circulated 6 times per day
- Strategic, Tactical, Operational management structure in place with clear roles and responsibilities aligned to roles
- Bi-annual training provided to Tactical managers provided by the EPRR Lead and Director of Operations and Performance
- Daily C&M system calls with the system control centre to escalate any risks or any external delays
- ED Escalation processes/intentional rounding with ED Consultant and Nurse in charge.
- Private Ambulance Transport to complement patient providers in and out of hours
- Frailty Assessment Unit FAU/ operational 5 days per week.
- Gynae Assessment Unit (GAU) and Paediatric Assessment Unit (PAU) operational 7 days per week.
- Relaunch of the deflection policy for minor injury patients overnight, where appropriate.
- Enhanced Paediatric ED opened in May 2021 that encompasses a larger footprint & more cubicle space. This supports compliance with RCEM guidance.
- Co-located minors area adjacent to the SDEC centre and ED ambulatory signed off to allow for a UTC type model on the Warrington site. Became operational April 24.
- Additional bed capacity opened in response to surge in hospital
- Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place.
- Same Day Emergency Care Centre (SDEC) completed July 2022. Open 24/7.
- Co-located and upgraded Minor Injuries nit.
- Meetings with senior leaders from the ICB and Local Authority to review and discharge taking place weekly.
- Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput. Reports monitored via Unplanned Care Group, ED & KPI Meetings
- Additional Senior Manager on call support a weekends
- Senior Dr at Triage Function
- CT scanner co-located in the main body of the ED department in 2023.
- Phlebotomy business case approved to support earlier decision making and flow in AMU to support flow out of the ED for acute medical patients.
- Winter planning in place to identify additional community and Trust based capacity to support expected activity levels for winter
- Virtual frailty ward, live from 1st February 2023, in line with national planning. This will help reduce admissions from care home to A&E
- Additional Nurse Staffing paper to support increases in the substantive workforce and manage escalation areas supported by the Trust Board
- On a daily basis the Trust utilises the SHREWD Resilience system to inform tactical and strategic site decision making in relation to flow and occupancy.

	- Progress chaser in ED to support flow and timely - Introduction of the new Manchester Triage Process from 14th April 2024 to support reduced overcrowding in ED and improve clinical quality and patient experience - Winter escalation capacity (ward A10 & bay of 6 on Ward B4) planned to be open in Winter 2025/26 to support flow and urgent care - The Performance Improvement & Oversight Group has been established in place of the ED Improvement Gorup and is the oversight group for the performance of the Urgent & Emergency Care System Improvement Group - The Performance Improvement & Oversight Group reports to the Finance & Sustainability Committee **Assurances** - System actions agreed supporting the Winter Plan - Redeveloped ED 'at a glance' dashboard - Trust implemented NHS 111 allowing for directly bookable ED appointments - Integrated discharge Team in place - Respiratory Ambulatory Care Facility agreed. - Royal College Emergency Medicine Resetting ED Care guidance received, acted upon and achieved - Same Day Emergency Care Centre (SDEC) opened July 2022 - Plans to reduce length of stay for criteria to reside patients using SAFER methodology. - Following closure of the Lilycross facility at the end of May 2023, additional capacity has opened in Statham Manor, Grapenhall Manor and Oak Meadow. This replacement capacity is open and operational. - As a result of national urgent care tiering (Warrington placed in Tier 1), the Trust continue working with ECIST to support a service improvement programme. - Continuous flow commenced on 8th October 2023. - Triage and streaming test of change commenced in November 2023 to improve productivity and utilisation of assessment areas to support lowering ED occupancy. - Transition to type 5 SDEC reporting went live on 1st November 2023. This will support improvements in streaming and data to allow the organisation to plan access and flow more robustly. - Reconfiguration of the ED footprint took place on 8th November 2023, to create a new ED admission area. This will support the reductions in 12-hour time in department as referenced in the Tier 1 urgent care metrics. - As part of being in tier 1 urgent care, the Trust and wider system were supported by Newton to undertake a place diagnostic on capacity and demand. The outcome has instigated a project to help improve flow, reduce attendances and thus lower bed occupancy. - Urgent & Emergency Care System Improvement Group established in May 2024. The aim of the Group is to deliver the opportunities identified by the Newton work. It covers 5 workstreams with system partners to improve urgent care performance and eradicate corridor care. This programme of work feeds into the ICB Urgent Care programme of work. - Review of the ED footprint being undertaken to identify opportunities to increase capacity and improve efficiency. - Updated nursing documentation to include risk assessment for when patient is cared for in an escalation space/corridor
Assurance Gaps	**Gaps in Controls** - Ongoing industrial action across a number of staffing groups including junior medical staff. **Gaps in Assurances** - Increase growth of higher acuity in types 1 & 3 as a result of population need and lack of access to Primary Care

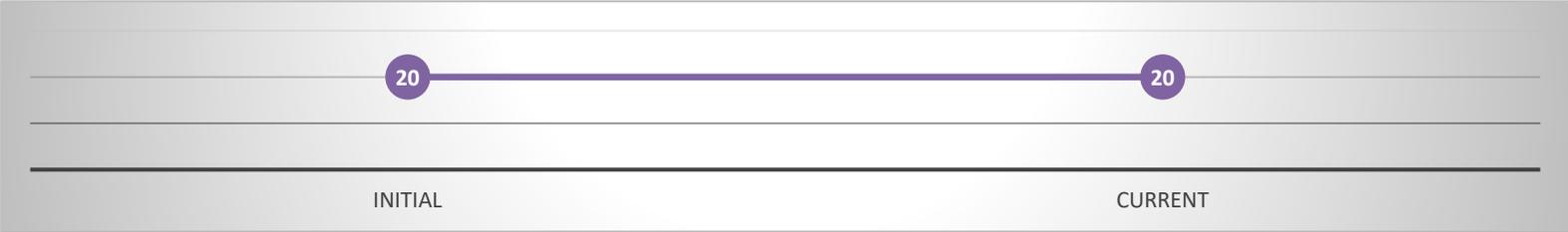| Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continued Escalation of Breaches and Patients Requiring Admission	Escalation of 4 hours quality standard and 12-hour decision to admit emergency access standard.	Escalation per ed safety escalation via Bed Meeting, Tactical Command and SMOC (out of hours) and Executive on Call.	Bowman, Karen	31/03/2025 (ongoing)	
Ongoing Monitoring of the Emergency Access Standard	ED Insight report daily SITREP report National report and benchmarking outcome UEC north dashboard	Ongoing monitoring of risk via daily report SITREP, Daily Capacity and Demand report from 4* daily bed meetings.	Bowman, Karen	31/03/2025 (ongoing)	

	Robust ongoing monitoring	Weekly PRG and monthly Unplanned Care Performance Meetings.			
Working with wider system on wider sustainability	Undertake System UEC improvement work focussing on admission avoidance	Complete project in line with timelines	Moore, Dan	31/03/2025	

Risk ID	1215	Executive Lead	Chief Operating Officer	Rating	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.			Initial	25 (L5xC5)
				Current	20 (L4xC5)
				Target	6 (L3xC2)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Assurance Details	**Controls**. • Inpatient capacity is reviewed with the patient flow and CBU teams daily through the Bed Meetings to ensure that there is adequate capacity for all patient groups to be admitted. • Weekly review meetings with C&M diagnostics hub, Mutual aid opportunities utilised across C&M to reduce delays • Recruitment to Dom Care ICAHT & Discharge Team posts agreed with the System Sustainability Group for the workplan for 2023/24 • Workforce is continually reviewed to ensure that all wards and teams are staffed safely. • Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery, via the Performance Review Group and weekly PTL meetings • Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery • The Halton site developed as a cold elective site to protect it from cancelations as a result of urgent care pressures. • Capacity identified and being utilised with appropriate independent sector providers and through mutual aid and surgical hubs • Capital build approved via the national Target Investment Fund (TIF) of the development of the Halton site. The outcome of this project will increase diagnostic & elective capacity for the Trust in the form of an additional Endoscopy room, a 5th Theatre as CSTM, a day case unit and increased CT and MR capacity, due Septe 2-25 (all phases to be complete) • Weekly theatre scheduling to ensure listing of patients in line with national guidance, with the support and guidance of Cheshire and Merseyside Productive Partners • Bioquell Pods deployed in ICU in March 2021 to support flow and IPC compliance. This will help reduce instances of having to escalate capacity to the Main Theatre at the Warrington site. • Continue to specifically focus on and monitor patients waiting greater than 52 weeks & 65weeks • Continue to ensure urgent cancers are prioritised in line with national guidance. • Continued use of Insourcing and outsourcing providers (NHS approved contractors) in 2025/2026 to support recovery will be reviewed to ensure value for money • Ongoing validation of the trust waiting lists to improve data quality • All performance activity monitored through weekly performance review group (PRG) • FOP Platform launched to support effective theatre scheduling **Assurances** • All elective patients have been clinically reviewed and categorised in line with national guidance. • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • Post Anaesthetic Care Unit (PACU) operational from January 2021				

	• New Clinical Treatment Suite opened in the Nightingale Building in May 2022 to support the reduction in chronic pain waiting lists an increase theatre capacity to support restoration and recovery. • Same Day Emergency Care Centre (SDEC) opened in August 2022 • Bioquell Pods in ED live and operational • Harm and waiting lists reported to Quality Assurance Committee, Finance & Sustainability Committee and Patient Safety & Clinical Effectiveness Sub-Committee. • Respiratory nursing business case approved to support step down of respiratory patients from ICU to B18 earlier in their care pathway thus creating ICU capacity to support planned care • Reviewing workforce pay incentives to create additional capacity in non-contracted work time e.g. evening and weekends. This links to the MIAA WLI Review & recent review of the rate card payments • Regular meetings and communication with the ICB and primary care GP's to inform them with recovery progress within the organisation and to highlight/address any identified problems. • Participation in the national 'My Planned Care' scheme to support and inform patient waiting time status and support safe management of waiting lists • Productivity Improvement Oversight Group (from May 2024) in place to deliver the GIRFT/Efficiency programme to increase theatre and outpatient productivity and utilisation • The Trust has been confirmed as the regional diagnostic hub to support the reduction of local and system waiting lists. • New CT and MR scanner replacement to be undertaken in 2023/24 • CDC phase 1 gone live in July 2023. CDC phase 3 including CT & MRI due to open in spring 2025 • Trust Board support for additional use of independent sector to reduce waiting times. Monthly reporting to the Finance and Sustainability Committee. • Regional funding to provide 10 additional Cystoscopy lists by April 25 and on-going mutual aid with Arrow Park for Sleep studies
Controls & Assurance Gaps	• Capacity challenge with social workers to keep on top of demand and necessary patient assessments. • Estates work is required to complete the development of the Elective Centre at Halton and the reconfiguration of the day case facility. • Limited bed base within A5 elective footprint on the Warrington site. • Workforce capacity challenges in the medical workforce

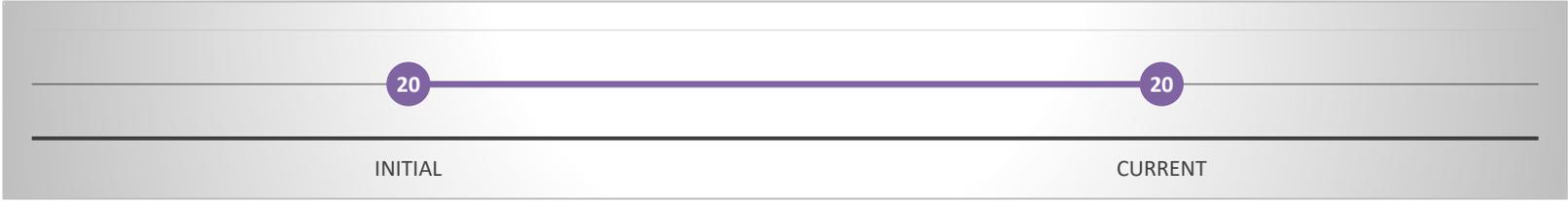| Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Working with wider system on wider sustainability	Undertake System UEC improvement work focussing on admission avoidance	Complete project in line with timelines	Moore, Dan	31/03/2025 Ongoing	

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID	134	Executive Lead:	Chief Finance Officer	Rating	
Strategic Objective		**Strategic Objective 3:** We will...Work in partnership with others to achieve social and economic wellbeing in our communities.			
Risk Description		If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton		**Initial:**	20 (L5xC4)
				Current:	20 (L5xC4)
				Target:	12 (L4xC3)
Risk Appetite		**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.			

Risk Movement

20 —————————————————— 20

INITIAL   CURRENT

Assurance Details

Controls
•Core financial policies controls in place across the Trust
•Finance and Sustainability Committee (FSC), Financial Resources Group (FRG) and Capital Planning Group (CPG) oversee financial planning
• Deputy CEO led improvement meeting (inc finance & improvement) now take place three times per month
• Procurement/tender waiver training in place
• TIF funding relates to the Halton Elective Centre, and this has now been approved (£9.2m capital over 3 years)
• Latest guidance from MIAA Counter Fraud Team circulated
• Counter Fraud campaign took place for national anti-fraud week 18/11/24
• Revised approach to GIRFT/ improvement/ CIP. Leadership from Executive Medical Director and joint reporting to FSC embedded.
• Appointed GIRFT Finance Lead and 5 PAs allocated, Head of Improvement
• Financial strategy developed to support improvement in financial sustainability.   2022-2027 Financial Strategy approved by the Trust Board in May 2022
• High Level 5-year plan presented to the Finance & Sustainability Committee in April 2024
• CDC phase 1 & 2 complete. Phase 3 to be completed by Spring2025
• Capital Plan for 2025/26 approved at 2 April 2025 Trust Board meeting.
• Revenue plans 2024/25. Operational Plan approved by Trust Board 28.04.2025
• Introduced system of escalation where there are risks to CIP delivery
• 2024/25 deficit position £16.8m was in line with the forecast, for £5.5moff plan, subject to Audit.
• New process introduced that any new revenue spend must be submitted to the Executive Team and/or Trust Board for approval as appropriate. Approval will only be provided if it is self-funding or relating to patient/staff safety and consideration whether CIP has been fully identified.
• In addition, new revenue spend to support activity targets is approved by Executives/ Trust Board only when the cost does not exceed tariff, all internal options have been considered (WLI, productivity) and no mutual aid is available
• Introduced process for oversight of unfunded and partially funded cost pressures via routine reporting to the Executive Team and the FSC with Deep Dive at FSC on highest cost
• Tightening controls of non-pay expenditure with executive review of catalogue spend and implemented cease option to purchase some items
• Cash Support received for 2024/25 was £12.145m.

• Enhanced ECF meetings in place with Chief Executive sign off, with ICS invited. Bridgewater Community Healthcare NHS FT in attendance.

	• Urgent & Emergency Care System Improvement (UECSIP) Lead with Place support • Introduced system of escalation where capital paperwork has not been produced by Q1 • Executive Review of CIP gap and unfunded cost pressures. • Review of non-recurrent CIP and move to recurrent if possible • Fortnightly Executive led meeting to monitor spend on WLI/ Insourcing/ LLP to support 65 & 52 Week recovery. review of Nurse variable pay – 3 times per week Weekly review of medic variable pay PWC final report signed off, recommendations being actioned and monitored each has an Exec lead and PID. 2024/25 received high assurance for gen ledger, accounts receivable, accounts payable, treasury management, with no recommendations to implement Implemented reduction in bank rates 13/01/25, reducing exp circa £700k p.m. National cash team have indicated that they will not accept cash support application in April 2025 / Q1, the suggested new process will be a meeting with Provider Dof and NHSE Deputy CFO. The Trust has provided the regional team with our Q1 cash requirements which they will collate and submit to the national team for an indication of potential cash requirements. • Delivery Unit Set Up - Delivery Unit Oversight Groups established, comprising the Delivery Unit Workforce (DUW), Delivery Unit Non-Pay (DUNP) and Delivery Unit Productivity (DUP), to provide robust oversight, challenge, and accountability for key financial and operational workstreams with focus on workforce pay, non-pay expenditure, and productivity improvements. **Assurances** • The 23/24 the control total was exceeded by the stretch target set by the ICS. The 2024/25 position was £16.8m deficit which was in line with the forecast and £5.5m off plan. The Trust has highlighted the level of risk throughout the year. • Delivered 2023/24 and 2024/25 Capital Plans • Unqualified audit opinion (2024/25) submitted on time • Completed MIAA Governance Checklist received by Audit Committee • Monthly Report to Executive Team Meeting and FRG highlights the number of retrospective waivers compared to the previous year, the number of staff trained and the number of staff who have received training but not followed the correct process. • Refresher training offered to those who undertook training over 12 months ago but then submitted a retrospective waiver • Capital is reported monthly to FSC detailing all schemes above £500k monitoring underspends against plan and expected end date. This is in line with MIAA recommendations. • Changes to WTE have been reviewed by the Finance & Sustainability Committee during the year and the Trust has seen a significant reduction in agency with an increase in bank and substantive staff. The 2024/25 challenge was to keep agency to below the 3.2% ceiling and reduce bank. For 2024/25 agency was 1.3% of payroll, lower than the 3,2% ceiling. • C&M ICS have indicated that there should be a 4% reduction in staffing in the 2025/26 plan in line with the 5% CIP target • HFMA self-assessment completed and audited. • We allocated CIP targets for 2024/25 including additional 2% reduction on non-clinical staffing and an additional 1% in second half of the year • Richard Barker/Graham Urwin Letter re: financial controls received. All actions received by the Finance & Sustainability Committee and the Trust Board. Response has been provided. • Continue to work with the system through the Warrington System Sustainability Group and One Halton to support system priorities and long-term sustainability. • Key financial controls review 2024/25 received high assurance for accounts receivable, general ledgers and treasury management with no recommendations. • System-wide diagnostic undertaken to quantify the operational opportunities to improve UEC effectiveness and efficiency across Warrington & Halton to provide clarity of operational and financial opportunities and outcomes by organisation. • Operational Plan submitted in line with timetable. • Quarterly reports to be submitted to the Finance & Sustainability Committee to review the cash position, plus request for cash support approved at Trust Board as required. • Replied to the National Team to confirm enhanced control for pay and non-pay are in place and adhered to in line with cash support requirements
Control & Assurance Gaps:	• Non-recurrent and unidentified CIP, and high-risk schemes, presents a risk to in-year and future year financial position. • No external funding support for Halton Healthy New Town or Warrington Hospital new build. • Risk of unforeseen costs and under delivery of activity and income due to further Industrial action / Acuity of patients / NCTR / growth in ED attendance • Availability of social care to support the current super stranded position (currently c22% of bed base). Estimated annual cost of circa £11m

	• Additional capacity opened across the Trust supported in part by non-recurrent funds. This presents a risk to sustainability as capacity is funded part year only • Additional capacity remained open in quarter 1 expected to closed in June 2025, capacity which should have closed mid-January remained open in March 2025 • Required to deliver additional activity within existing resources whereby funding will be lost if activity not delivered within PbR • Risk to financial freedoms as the Trust has a deficit plan & requires cash support • Achieving 104% of 19/20 in core capacity is key to delivery of GIRFT/ CIPThere is a risk that NHSE will not approve the cash request. Mitigations to this could include, using capital cash in the short term and delay of payments to creditors •Risk of over performance of activity in May may not be paid due to cap on income and affordability • Risk funding of pay award above 2.8% • Risk delivery of the system wide (Level 3) COP £12M

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Output of review undertaken of CIP, cost pressures and benefits realisation to be monitored via the Committee structure	Report outcome of CIP, cost pressures and benefits realisation review to Finance & Sustainability Committee	Report via Committees	Hurst, Jane	31.03.2025	Complete
Review of 2024/25 CIP / GIRFT / Improvement plans	Report outcome of CIP, cost pressures and benefits realisation review to Finance & Sustainability Committee	Report via Committees	Hurst, Jane; Fitzsimmons Paul, Gardner, Lucy; Moore, Dan	31.03.2025	

Board Assurance Framework

Risk ID	2001	**Executive Lead**	Executive Medical Director	**Rating**	
Strategic Objective		**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			
Risk Description		If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.		Initial	20 (L5 xC4)
				Current	20 (L5xC4)
				Target	6 (L2 xC3)

Risk Appetite	**Minimal –** Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.

Risk Movement	
	20 20 INITIAL CURRENT

Assurance Details	The Trust defines a Fragile Service for inclusion in its oversight program as 'A Service which is at risk of deterioration with a resulting significant risk to the quality of patient care, with particular reference to patient safety and risk of harm'. Current services included in the Fragile Services Oversight program are: • Urology • Orthopaedics – Fractured Neck of Femur • ENT Surgery • Cardiology/Cardiorespiratory • Cancer Services • Chronic Pain **Controls** • Formal process in place for identification and designation of Fragile Services • Focussed additional support to Fragile service from senior Medical, Nursing and Operational leadership teams • Appropriate prioritisation of Fragile Service Revenue and Capital Requests **Assurances** • Monthly oversight through Fragile Service Reports to Patient Safety and Clinical Effectiveness Subcommittee (PSCESC) • Escalation to Quality Assurance Committee via PSCESC escalation reports • Bi-monthly Fragile Services report to Trust Board

Assurance Gaps	• Capacity constraints impinging on Fragile services (Staffing, theatres, diagnostics, outpatients, bed base) • Increasing demand

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Fragile services actions to be managed through individual Fragile Services action plans	Fragile Services action plans reviewed at PSCESC	Continued review of Fragile Services action plans at PSCESC	PF	ongoing	

Board Assurance Framework

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Risk ID	1114	**Executive Lead**	Executive Medical Director	**Rating**	
Strategic Objective		**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.			

		Rating	
Risk Description	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	**Initial**	20 (L5xC4)
		Current	16 (L4xC4)
		Target	8 (L2xC4)
Risk Appetite	**Minimal –** Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.		

Risk Movement	
	20 — 16 — 20 — 16
	INITIAL — PREVIOUS — PREVIOUS — CURRENT

Assurance Details

Assurace
- Risks for Cyber on Trust's risk register in line of national requirements of the Data Security Protection Toolkit (DSPT) & NHS England
- Digital Governance Structure including bi-weekly structured Senior Leadership Team meetings, monthly Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Information Governance and Records Sub-Committee, Service Delivery Group with escalations to the Quality Assurance Committee and Finance Sustainability Committee. The high level Quality Assurance Committee report provides assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Data Incidents/Audit Actions/IG training figures).
- Digital annual IT audit plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with MIAA Management response with progress monitored at the Trust Audit Committee.
- Trust benchmarking activities including Use of Resources reviews (Model Hospital).
- New updated ITHealth Assurance Dashboard is live, monthly external network penetration testing is now in place using NHS England's VMS service and BitSight security score is live.
- Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee.
- Digital Services have implemented all national guidance regarding Log4J vulnerabilities highlighted by NHS Digital
- WHHT return for assurance re cyber security to NHS England
- Active core member C&M ICB Cyber Core Group, C&M ICB Cyber Security Group and the Cyber Associates Network (CAN)
- Outcome of the third Phishing exercise by NHS England, communications have been sent out to staff members who entered details for awareness.
- Digital Services uses several cyber threat intelligence services (C&M Cyber Group, NCSC, NHSE CSOC)
- Audit on 3rd party vendor management by MIAA (waiting on audit report)

Controls:
- Digital Operations Governance including supplier management, product management, cyber management, Business Continuity And Disaster Recovery Governance and customer relationship management with CBUs (e.g. The Events Planning Group) and an Information Security Management System (ISMS) based upon the principles of ISO27001 security standard.
- Digital Change Management regime including the Digital Development Group, the WHH Change Advisory Group, The Digital Transformation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions.
- Trust Data Quality Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting EPR Training regime for new starters including doctor's rotation and annual mandatory training.
- External NHS England approved Cyber Training for the Trust Exec Board
- The use of automatic patching software to rollout security updates to devices.

	• Existing external network traffic is monitored by NHS Digital for both HSCN & Internet links. • Secondary secure backup at Halton Data Centre • Remote devices no longer bypassing the web proxy • New Phishing exercise by NHS England has been arranged for 24/25 • Local device (PC & laptop) based firewalls now enabled • Vulnerability identified by Dedalus obtaining elevated SQL access to data in ORMIS has been patched • MFA active on for NHSMail • MUSE migrated to new server • Unisoft Server upgraded to Windows 2019
Assurance Gaps	**Gaps In Assurance:** • Achieving 98% standards of mandated compliance with DSPT, incorporating CE+ (moderate assurance given by MIAA for the standards audited and substantial in respect of the veracity of the self-assessment (23/24). 24/25 assessment is being conducted during February and April 25 • 24/25 DSPT has been aligned to the new Cyber Assurance Framework. No Trust is expected to be compliant until 2030. **Gaps In Controls:** • No real-time early warning of zero-day attacks due to the lack of network pattern matching software. • Ability to mitigate cyber configuration of nationally provided systems (e.g. ESR) and non-Microsoft devices (that meet a clinical need). • Using generic logins staff usernames and passwords are stored in browser when selecting "remember me" • No dedicated logging tool to pull all key logs together and provide useable alerts. • Lack of process to proactively check antivirus/MDE alerts in console. MIAA to review processes and tools • Administrator accounts still have access to the Internet & email, although only used when required (SIRO approved process, best solution between operational vs security). • Using unsupported software SharePoint 2010 for the Hub • No controls in place for Bluetooth connectivity. Would be difficult to implement. • MFA on limited number of systems • Limited 24/7 dedicated cyber cover • SmartSheets (cloud-based) currently does not have an attachment scanning service to scan for potential virus payloads, it's on their roadmap, but no confirmed date • CISCO network requires a hardware refresh • Version 7 of Clinisys Ice is end of life • Lack of an automated Medical device / Internet of Things asset register and vulnerability scanning • No Privilege Access Management (PAM) in place for Domain Admin/Admin accounts • Weak cyber controls in the supply chain (3rd party vendors), could that filter down and affect the Trust network. • Unsupported software being used by BadgerNet

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems. Consequently, any server or system reliant on Windows Server 2003 and Windows Server 2008 (from Jan 2020) presents a cyber-security risk to the Trust.	Migrate all 2003 and 2008 servers to 2016.	HR to move the remaining ECF process from SharePoint 2010 to ESR by April/May 2025. IT Services working with the Communication Team to remove the remaining Shared Calendars from SharePoint 2010 to SharePoint Online or NHSMail. CNIO reviewing whether the NICE guidance on SharePoint 2010 is still current and safe advice.	Deacon, Stephen	31/05/25	

We either need to migrate or decommission the unsupported Windows Server 2003 and Windows Server 2008 to Windows 2016 (Latest server operating system).					
Support for Windows Server 2012 will cease . As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems from that date going forward. We either need to migrate or decommission the 70 unsupported Windows Server 2012 to the latest server operating system.	Migrate/decommission Server 2012 servers	Update to the 2012 EOL project: Endoscopy Server Testing of the migrated reports found the technical process that HD clinical are using to migrate reports from old system to new is unreliable. While working with the vendor to resolve, an in place upgrade of the server operating system is being considered. This would resolve any cyber-related issues. The server team successfully upgraded the operating system of the Windows 2012 Unisoft Server to Windows Server 2019. Testing of the records opening and displaying correct was a success.	Waterfield, Tracie	31/03/25	19/03/2025
Multifactor authorisation (MFA/PAM) review of Trust critical systems	Multifactor authorisation (MFA) review of Trust critical systems as data has shown that majority of cyber attacks can be prevented within 20 minutes of the initial attack starting with MFA compared to organisations who don't use MFA.	National monies identified and obtained for the purchase of a Privilege Access Management (PAM) system. This will protect network accounts with elevated admin controls, whether on the network or on the critical systems. Evaluation and purchase of a common PAM system between WHHT & BW is being considered. Once purchased the system will need to be installed and configured.	Deacon, Stephen	31/05/2025	
Migrate Windows 10 to Windows 11	Migrate Windows 10 to Windows 11 before end of life date of 30/10/25	Migrate Windows 10 to Windows 11 before end of life date of 30/10/25 Process: Testing in IT Services (COMPLETE) Testing with critical systems (COMPLETE) Rollout with new devices (STARTED)	Waterfield, Tracie	31/10/2025	

		Rollout with rebuilt devices (STARTED)			
Migrate/decommission Windows Server 2016	Migrate/decommission Windows Server 2016 to the newest version of Windows Server as support for security updates case in Oct 2026	Develop action plan for migration for the more difficult servers to migrate. Currently 8/67 (12%) have been migrated or decommissioned.	Waterfield, Tracie	29/01/2027	
Removal of generic Window accounts	Removal of generic Window accounts	Plan for the removal of generic Window accounts in clinical areas to reduce cyber risks. Staff to log in as their own accounts. Planning of the removal is required to minimise clinical disruption to patient care.	Waterfield, Tracie	31/12/25	
Mitigate the unsupported software used in BadgerNet	BadgerNet products have been discovered to have 2 3rd party components used within BadgerNet that no longer under support from their vendors. They have made NHS England and the National Chief Midwifery Information Officer (CMdIO) team aware and provided a mitigation plan.	The 69 release of the software is was installed on the18th March to retire the code referring to the out-of-support software The software is still on the clients, however, 70 release in June will clean up the software fully which will require a client install. Whether we remove the binaries or wait until release 70 client will be individual trust decision. Vendors and NHS Cyber Security Operations Centre (CSOC) consider the risk to be low. While no vulnerabilities have been found in SQL CE v3.5, it's important to note that it will not receive patches if any are discovered in the future.	Deacon, Stephen	30/06/25	

Board Assurance Framework

Risk ID	1372	Executive Lead	Executive Medical Director	Rating	
Strategic Objective	**Strategic Objective 3:** We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				

Risk Description	If the Trust is unable to procure a new Electronic Patient Record then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and a risk to patient safety			**Initial**	12 (L3 xC4)
				Current	16 (L4xC4)
				Target	8 (L2 xC4)

Risk Appetite	**Cautious –** Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential.

Risk Movement	

Risk movement chart showing value 12 at INITIAL rising to 16 at CURRENT.

Assurance Details	**Assurances:**

Assurances:
- Clear reporting line from EPR Project Group via escalation/assurance route through Digital Strategy Group, FSC and Trust Board)
- Regular, documented conference calls with the ICS and NHSE – external partners supportive of managed convergence relaunch with partner Trust.
- Program Governance and PMO function refreshed and improved following lessons learnt exercise
- EPR project group has oversight on state of readiness for deployment and associated risks
- Plan in place to mitigate for potential coterminous implementation of LIMS – January 2025

Controls:
- Contract in place for a 3 (+2) year tactical Lorenzo contract in support of time required to complete the procurement and deployment of a new EPR
- Trust financial modelling includes 5-year Lorenzo costs
- ICB Executive Leads and FD program supportive of managed convergence relaunch in partnership with Merseyside and West Lancs NHS Trust – with output based specification (OBS) and pre procurement evaluation criteria complying with managed convergence guidance.
- Senior Programme Manager assigned, Program Director post to be advertised
- Financial modelling of realistic options to provide genuine 5, 10 and 15 year options to control whole life costs
- Partnership procurement will lead to identification of further realistic cash releasing / cost reduction benefits
- The collaboration agreement has been developed and endorsed by EMT and Board
- Approach to convergance and single instance architecture agreed wih FD team

Assurance Gaps

Gaps In Assurance
- FD convergence guidance remains a potential risk – though agreement of a single instance architecture with multiple tenants with FD has largely mitigated this
- Complexity of coterminus LIMS implentation presents an emerging risk which requires a mitigating plan
- FD now require a single OBC and FBC for EPRIB and Cabinet Office approval

Gaps In Controls
- Lorenzo is at end of life and is unlikely to see significant future development or enhancements
- Delay to implementation could push implementation date past Lorenzo contract and Lorenzo sunsetting date with significant financial and clinical risk
- Phasing of frontline Digitisation Funding with funding availability does not match the timing of forecast expenditure
- Deficit in programme year 3

Board Assurance Framework

	• Further assurance required regarding state of readiness for implementation				
Recommendation	**Action Description**	**Actions Required**	**Responsible Officer**	**Deadline Date**	**Completion Date**
Develop the programme governance model for the joint EPR procurement, and subsequent implementation for approval by trust boards	Develop the programme governance model for the joint EPR procurement, and subsequent implementation for approval by trust boards	The governance chart is in draft awaiting for the joint Exec Programme Board to be set up. Exec to Exec meeting took place 10th March working towards setting up Exec Programme Board in April.	Poulter, Tom	30/04/2025	1/425
Co-develop procurement (and if possible, implementation) timeline with LPP for Trust Board approval	Co-develop procurement (and if possible, implementation) timeline with LPP for Trust Board approval	Joint planning meeting took place 4th March joint plan agreed ready for Exec Programme Board approval. Working towards setting Exec Programme Board in April	Poulter, Tom	30/04/2025	1/4/25
Co-develop a single OBC and FBC for the joint procurement as mandated by FD	FD require a single OBC and subsequent FBC	MWL and WHH teams supported by NHSE developing single OBC	Poulter, Tom	30/6/25	

Risk ID:	2273	Executive Lead:	Chief Strategy and Partnerships Officer		Rating	
Strategic Objective	**Strategic Objective 3:** We will...Work in partnership with others to achieve social and economic wellbeing in our communities					
Risk Description:	If the Trust cannot deliver its strategic vision, secure funding for new hospital facilities, and the support and resource required from the Cheshire & Merseyside ICS and beyond, it may fail to meet estates standards, provide quality services, and ensure a suitable environment, potentially leading to rising backlog maintenance costs, short-term fixes, non-compliance, and adverse effects on patient safety, outcomes, reputation, and finances				**Initial**	16 (L4xC4)
					Current	16 (L4xC4)
					Target	9 (L3 xC3)
Risk Appetite	**Seek** - Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).					

Risk Movement	
	16 ———————————————————— 16
	INITIAL CURRENT

Control & Assurance Details	**Controls**
	• Annual capital funding is allocated for mandated and statutory estates projects.
	• Estates team manages Planned Maintenance (PPM) and reactive maintenance through CAFMS.
	• Six Facet survey annually assesses estate conditions, informing backlog maintenance priorities.
	• The 10-year planned maintenance capital program is updated yearly based on the Six Facet survey and completed works.
	• Effective clinical networking and partnerships are in place.
	• Full delivery of the TIF (elective) programme due to complete in 2024/25, which includes £9m investment to provide 2 new operating theatres, an Endoscopy Room and Elective ward capacity.
	• Full Business Case (FBC) for Pathology Hub to be created with MWL to be presented to the Trust Board in Quarter 1 2025/26
	• CSPO participates in Runcorn and Warrington Town Deal Boards, overseeing £50m in regeneration funds.
	• Living Well Hub funded via Warrington Town Deal fund led by WHH opened in March 2024
	• Runcorn Health & Education Hub funded by the Runcorn Town Deal led by WHH due to open in Quarter 4 2025/26
	• Strategy refresh for 2025/26 approved by the Trust Board.
	• WHH leads on addressing health inequalities and sustainability, with initial recognition in Cheshire & Merseyside.
	• Consistent Trust representation in Cheshire & Merseyside ICS and Place-based boards.
	• One Public Estate funding supports Halton redevelopment and Warrington public sector estate review.
	• Partnerships with educational institutions have enable tailored education and research.
	• CSPO co-led CMAST priorities for ICB 5-Year Joint Forward Plan.
	• Trust estates priorities reflected in the ICB infrastructure plan.
	• Agreement from the Boards of Warrington & Halton and Bridgewater to progress transaction to become a single organisation in 2027
	• Joint Executive Team meetings with Bridgewater Community Healthcare NHS FT.
	• Estates strategy for new hospital plans completed.
	• External funding sought for estates developments supporting new hospitals.
	• All partners support new hospitals plans, including MPs, Councils, Education Providers, Place Partners, and ICB.
	• Financial and economic cases for new hospitals to be updated, with funding options explored.
	• Capital Planning Group oversees capital funding allocation, prioritised schemes reported monthly
	• Health and Safety Sub-Committee escalates estates issues, managed through relevant safety groups.
	• The Government's White Paper, "Integration and Innovation: working together to improve health and social care for all," published in February 2021, continues to inform and guide Trust activities.
	Assurances
	• 3 Phase CDC funded nationally due to complete in June 2025. CDC Phase 2 opened in December 2023, including ultrasound, spirometry, sleep studies, audiology, and phlebotomy services at Halton Health Hub. CDC Phase 3 (including CT and MRI) is scheduled for June 2025.
	• Regular meetings through Capital Planning Group and Tactical Estates Group (TEG) support decision-making on estate allocations and capital expenditure.
	• Estates priorities identified through PLACE assessments, health and safety audits, and risk registers.
	• Safety and Compliance - Ongoing monitoring for compliance with Health Technical Memorandum (HTM) standards, with actions taken to reduce identified risks.
	• Remedial Works - RAAC survey completed, identifying small extension building with RAAC, with NHSE funding secured for necessary remedial actions, including roof replacement. Environmental health inspection upgrades completed for Warrington kitchen facilities in October 2024
	• Halton Health Hub opened in November 2022 in Shopping City, Runcorn, supported by Halton Borough Council and Liverpool City Region Town Centre Fund for a phased reconfiguration of the Halton site.
	• The Trust has been selected as a site for one of two endoscopy hubs in Cheshire & Merseyside, with the hub opening in 2024.
	• Strategic and Collaborative Efforts - Regular strategy updates are provided to the Council of Governors and Trust Board. The Trust is engaged in national initiatives, including securing funding for a single Laboratory Information Management System (LIMS) for Cheshire & Merseyside, with the draft business case approved by the Trust Board in June 2024

Assurance Gaps	**Funding and Financial Challenges**
	• **Unsuccessful NHP Phase 3 Funding:** The Trust was unsuccessful in securing funding via the NHS Phase 3, which is a major setback for completing the development of the phased new hospital plan, with funding for a new hospital unlikely before 2040.
	• **Limited Capital Funding:** There is a lack of sufficient capital funding nationally to address the full backlog, which delays and limits key infrastructure and maintenance projects.
	• **Unfunded Maintenance Costs:** Unforeseen and emergency maintenance costs continue to be a significant burden on the income and expenditure (I&E) budget, making it harder to stay on top of all required maintenance and upgrades.
	• **Cost Pressures on Capital Schemes:** The process to obtain full design costs for capital schemes is lengthy, and with the uncertain market conditions, this adds additional pressure on project timelines and costs.

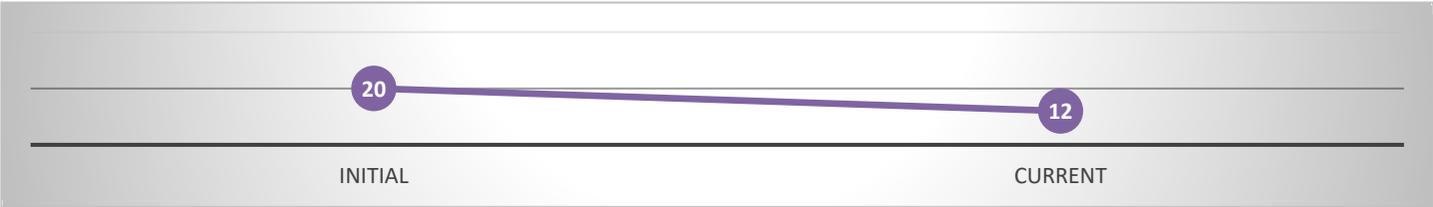|	
	• Trust allocates depreciation generated capital funds to mandated and statutory estates projects and is therefore reliant on external funding via bids for strategic development. **Staffing and Resource Constraints -** Staffing shortages further exacerbated by the requirement to meet non-clinical Cost Improvement Program (CIP) targets, adding strain to already stretched resources. **Operational and Infrastructure Issues -** Some equipment is difficult or impossible to access for maintenance due to age and design, and the absence of a permanent decant ward complicates this further, particularly for ongoing repairs or upgrades. **Governance Development at Place Level:** Self-assessments indicate that Halton is in the early stages of its place-based governance development, while Warrington is more established. There is a need for further development to ensure that both boroughs can benefit from potential future autonomy

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Phased redevelopment plan	Develop phased redevelopment plan with support from architects and cost advisors	Funding reallocation supported by Trust Board. Formally reallocate funding via CPG and FSC. Commission/appoint team to develop plan. Awaiting release of funding prior to commencing work	Lucy Gardner	30.03.2026	
Continue to raise profile and importance of need for new hospitals in Warrington and Halton.	Partners to attend new hospitals oversight meeting and raise case of need via appropriate channels.	Ensure meetings and appropriate updates take place.	Lucy Gardner	31.03.2026	
Actively participate in and contribute to the development of integrated care partnerships at Place & provider collaboratives at regional level.	Participate in meetings and influence new governance development.	Participate in meetings and influence new governance development.	Lucy Gardner	30/04/2025	Completed 30.4.25
Ensure sufficient capacity to deliver increased number of capital projects	Agree funding mechanisms for gaps identified.	Interim arrangements to support delivery given lack of available funding	Lucy Gardner & Dan Moore	30/04/2025	

Board Assurance Framework

NHS Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Risk ID	115	Executive Lead	Chief Nurse	Rating		
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				**Rating**	
Risk Description:	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.			**Initial**	20 (L5xC4)	
				Current	12 (L3xC4)	
				Target	8 (L2xC4)	
Risk Appetite	**Minimal –** Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.					

Risk Movement	

INITIAL 20 — PREVIOUS 25 — PREVIOUS 20 — PREVIOUS 16 — PREVIOUS 20 — PREVIOUS 16 — CURRENT 12

Assurance Details:

Controls
- 6 weekly rostering, sign off by Matrons, oversight by Lead Nurses and monitored through monthly Workforce Review Group (WRG)
- Weekly ERostering KPI sign off meetings in place.
- NHSP Request Review /10% reduction review Meetings chaired by Chief Nurse or Deputy Chief Nurse every week
- Bi-annual acuity reviews completed with analysis of results to ensure establishment levels align to dependency and acuity.
- Twice daily review of red flag data to identify staffing, patient acuity and dependency across all clinical areas with movement off staff and consideration of skill mix to ensure safe staffing levels.
- Temporary staffing requested via NHS Professionals, process in place to fill shifts via bank prior to escalation to agency request via agreed Agency Managed Service
- Staff numbers and skill mix and professional judgement recorded daily on Gold Command report for transparency of clinical decision making.
- Workforce Review Group in place to monitor progress against recruitment and retention planning across the Trust.
- Agency reduction plan in place
- Local workforce plans in place for Emergency Department and Maternity with additional support from Executive Team
- Local recruitment in place targeting ED and Endoscopy who have had recent investment/establishment increases.
- Open advert for RN/HCSW recruitment
- Quarterly recruitment events in place
- Sickness absence being manged in line with Trust policy.
- Monthly Cost Pressure Clinics in place reviewing sickness management/recruitment/skill mix/supernumerary status/maternity leave cover plans Monthly review of bank use/staffing challenges at Executive Management Team Meeting,
- Weekly review of bank use/staffing challenges by Chief Nurse/ Deputy Chief Nurse/Director of Governance
- Gant Chart mapping projections of Maternity Leave and Supernumery Staff
- Sickness Clinics held monthly with Chief Nurse
- Twice daily Acuity Recording on Safe Care

Assurances
- Increase in registered nursing establishment in the Emergency Department, November 2024 reducing band 5 vacancy rate to 32.85 In April 2025 WTE from 46.84 WTE in May 2024
- Nursing: Registered Nurse turnover has decreased from 17.34% in January 2023 to 9.81% in March 2024
- Overall CHPPD sustained between 7.3-7.5 in Q4.

	• Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 14.17% in March 2025
	• Quarterly recruitment events for RN and continuous advert with regular shortlisting and interviews for HCA Vacancy,
	• Support and guidance to student nurses from the beginning of their training to qualifying through the STEPP programme.
	• Cost avoidance of £2,314,398 m (end December 2025) from agency managed service contract started August 2022
	• CSWD 5 cohorts of 15 CSWDs will be deployed throughout 2025, The first cohort commenced April 2025
	• Part of the Cheshire and Mersey staff Retention Forum to share and benchmark retention plans and receive support from ICS Retention Lead
	• Minimum staffing levels agreed for every ward, analysis of monthly shift fill completed with mitigation plans in place and reported to Trust Board bi-monthly.
	• Site Manager and Matron on site until 8pm (Warrington and Halton site) on weekends
	• Rolling recruitment for RN and HCA posts, weekly interviews
	• Leaver data is closely monitored, and the Board of Directors have supported a position of over recruitment to enable replacement of leavers in a timely manner.
	• Internal Transfer process in place for staff to support retention.
	• Nurse Staffing and Clinical Outcomes Group provides a forum through which nurse staffing and clinical outcomes data sets could be reviewed and triangulated to highlight wards or departments at risk.
	• 19 wards achieved the 90% fill rate on day shifts and 23 ward achieved 90 % fill rates on nights
Assurance Gaps	• Increased operational capacity and demand results in the need to open additional areas to provide patient care, increasing the staffing need e.g. Treatment/MDT rooms on B14, B19; accelerated transfers and boarding out of hours – an average of 35 additional escalation beds per day were open throughout January 2025
	• Increased requests to provide enhanced care.
	• Necessity to consistently 'board on wards' with 1 extra patient and to ensure safety is maintained – the decision to increase to 2 extra patients.
	• Continued escalation during winter of ward A10 and intermittent escalation of Cardiac Catheter Lab and overnight in Discharge lounge
	• Partially funded revenue requests
	• Time to post when recruiting new staff.
	• 446 Red Flags reported in March 2025 compared to 368 August 2024- Red Flags were linked to difficulties in providing enhanced care.
	• In quarter 4 over 1200 patients were admitted to WHH with a mental health condition
	• Admissions of patients over 65 continues to range between 900 to 1000 per month.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Focus upon the Workforce Strategy to proactively retain, fill and review vacancies alongside care need. To include succession planning and staff opportunities.	Assurance of Workforce Strategy progress through the Workforce Review Group and associated workplans.	Workforce Review Group to provide updates on specified workstreams to the Quality Assurance Committee and Strategic People Committee as part of the staffing report, ahead of submission to the Board of Directors. This will include: • Domestic and international nursing recruitment – complete? • Position and plans for staff retention. • Planning for the future – succession planning and staff development. • 6/12 establishment reviews. • Triangulation of staffing position alongside patient safety measures.	Chief Nurse	19/10/24	November 2024

Board Assurance Framework

Risk ID	1134	Executive Lead	Chief People Officer	Rating	
Strategic Objective	**Strategic Objective 2:** We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff			**Initial**	20 (L4xC5)
				Current	12 (L3xC4)
				Target	8 (L2xC4)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				

Risk Movement	
	20 INITIAL → **12** CURRENT

| Control & Assurance Details | **Sickness Absence**
The rolling 12-month sickness absence rate is 5.9% as at April 2025 and is showing a slight increase from February 2025 (5.87%). Trust target from April 2025 is 5% as approved by the Strategic People Committee following a recent benchmaking exercise across the C&M region and consideration of health inequalities in the community we recruit staff from. .
Controls
- Supporting Attendance Policy implemented in February 2022 and reviewed post 6 months implementation, updated policy implemented April 2023. Review of Supporting Attendance Policy underway March 2025.
- Supporting Attendance clinics held in partnership with HR Business Partners and CBU areas to provide an overview of policy, associated paperwork and interventions to support managers.
- Support continues within areas of high sickness and low compliance WBC figures. Providing coaching support to managers, compliance audits and communication campaigns focusing on staff to ensure they have a WBC so their wellbeing is supported.
- Occupational Health and Wellbeing triangulation meetings with HR colleagues to review and progress individual cases under the formal stages Supporting Attendance Management.
- Focused welcome back conversation recording and internal audit
- Following an MIAA Audit, the HR team have worked with CBUs to develop an audit framework to provide greater assurance regarding compliance with the Supporting Attendance policy by managers.
- Sickness absence, turnover and attraction workstreams have been reviewed in line with the ICB letter and action plans updated to ensure all actions from the letter have been considered.
- New stage 3 absence process has been successfully piloted to provide a compassionate and dignified exit out of the organisation on the grounds of ill health capability

Assurance
- The Trusts wellbeing offers continue to be well utilised, supporting people to remain in work. The Trust has received national recognition from NHS Employers for our Check In Conversation, and local recognition for our Health and Wellbeing Hub.
- The Trust has seen a significant improvement in long term sickness absence rates since the full implementation and transition on to the new Supporting Attendance policy reducing from 4.39% in April 2022 to 3.06 % in April 2025.
- Pro-active health interventions offered to support staff to remain well including cardiac clinic and wellbeing day with referrals to smoking cessation, G.P.'s and counsellors as appropriate. Well attended by staff.
- Deep dive focus into Nursing and Midwifery sickness absence currently taking place due to rates being higher according to Model Hospital data. |
|---|---|

- Welcome Back Conversations annual compliance decreased to 72.18% In April 2025, below traget of 85%. Review underway, historically low compliance attributed to delays in recording data and reporting periods.

Turnover and Attraction

Turnover in April 2025 remains below the target of 13% at 11.6%, a 1% decrease from the figure reported in Frebruary 2025. Turnover of permanent staff in April 2025 was 11.01%.

Retirements are reducing, with relocation the fastest growing reason for people leaving. Work/life balance remains the main reason for leaving.

The Trust's April 2025 vacancy rate has decreased significantly to 7.00% from 8.00% in February 2025, Trust target is below 9%.

Controls

- Exit Interview process - collation and analysis of data captured enables themes to be identified and targeted actions implemented. This information is available on the Trust Workforce Information Dashboard for all managers to review.
- Further review of the leavers process is underway with the development of a SOP for stay conversations and an options appraisal review of the current exit interview process.
- Rugby League Cares have been supporting WHH since July 2021 and have been working in areas offering drop-in sessions and tailored programmes to support teams and individuals to keep well in work however this programme ceased due to a lack of continued funding on 31/03/25.
- Grief and Menopause cafes implemented to support individuals
- Social media accounts have been created to support recruitment attraction across a number of social media platforms
- Financial wellbeing resources have been implemented to support the workforce and retention including Wagestream
- A dedicated area to supporting Agile/Flexible working is available on the extranet, and as part of the culture plan, an improved approach to agile and flexible working has been lauched through the #MYFlex campaign which incldues two wards going live with preference rostering from Jan 2025.
- Implementation of ECF panels throughout the organisation ensuring vigorous scruitiny of vacancies across the Trust. Promoting internal recruitment and secondment opportunities and also collaborative ring fenced opportunites for Bridgewarer staff and vice versa.
- To support with attraction, the Trust has adopted a coordinated approach to recruitment which has included:
  - Enhanced HCA recruitment events
  - Investment in TRAC (Recruitment system)
  - Enhanced Student Nurse recruitment
  - Enhanced wellbeing benefits package (financial and mental)
  - Improvements in agile/flexible working
  - Enhanced retirement support/offers

Widening Participation Team well established to support attraction from the wider community into different roles at the Trust as well as supporting apprenticeships to support staff development and retention.

Assurances

- The Trusts wellbeing offers continue to be well utilised, supporting people to remain at WHH.
- As a result of analysis of exit interviews, a theme identified was working hours and flexible working. #MYFlex campaign has been launched with a central recording of flexible working requests enabling greater understanding/scrunity.
- The responses to Exit Interviews are positive, only 11.34% (April 2025) of questions answered are negative, with looking forward to going to work receiving the highest proportion of negative responses.
- As a result of improving turnover and attraction, the substantive workforce has grown significantly since Apr 23, when it was 4,034 FTE. April 2025 staff in post is 4,784 FTE..
- Staff completing apprenticeships is above target at 3.6%, target is 2.3%

Temporary Staffing and Agency spend

Bank and Agency reliance in April 2025 reamined at 12.9% . The Trust target is 9%. Bank reliance has increased slightly to 11.82% from11.2% in April 2025 and agency reliance continues to reduce t and reamins at 1.4%.

Controls

- Bank reliance is driven by the Trusts plan to reduce overall reliance on agency workers. The contingent workforce remains part of safe care.
- The additional controls and challenge for pay spend that have been identified to support a reduction in premium pay are:

	o ECF process for non-clinical vacancies, overtime and medical agency. • The Resourcing Task and Finish group previously worked with staff group leads to benchmark the Trusts compliance with Job Planning, Rostering and Workforce Reporting against the nationally expected standards. The gap analysis enabled the organisation to develop plans to improve the effectiveness of workforce deployment. The recent PWC audit has reviewed the plans and developed an action plan to address some of the gaps to enable the Trust to effectively and cost efficiently deploy it's workforce. **Assurances** • Compliance against our processes and rate cards is monitored through the Finance and Sustainability Committee • To support agency controls, a refined ECF process has been introduced. • Compliance with Job Planning, Rostering Levels of Attainment and Workforce Reporting against the nationally expected standards have been shared with Executives.
Assurance Gaps	• Sickness absence continues to be above target. It is demonstrating an improving variation. This is reflective of sickness absence regionally. • Bank and agency reliance continues to be above target and is demonstrating special cause variation of a concerning nature. • Lack of assurance regarding reduction of unplanned bed capacity which impacts temporary staffing and agency spend. • Exit interview completion rates are low, currently reviewing process to improve completion rates.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Developing an ongoing proactive approach to support staff to stay well	Develop a proactive approach to supporting staff to stay well including wellbeing days, cardiac clinics, smoking cessation.	• Analysis of areas with high sickness absence to develop targeted interventions • Review of health inequalities data for local area to inform proactive health interventions for staff • Develop a plan for implementation of proactive health support for staff	Laura Hilton & Carl Roberts	31.08.25	
Embed an agile and flexible working culture within all WHH Teams – linked to WHH Culture Plan	As part of the WHH Culture Plan, through engagement, development and refined processes, support WHH leaders to embrace agile and flexible working.	• Engage with Senior Leaders to establish support for an agile and flexible working culture within all WHH Teams • Develop a campaign to promote WHH as an agile working/flexible employer • Development of WHH Leaders to enable them to support their teams to work in an agile/flexible way • Develop an approach to how WHH staff request flexible/agile working – thus enabling further oversight of requests	Carl Roberts	31.03.2025	Complete
Review of Exit Interview Process to Support Improvement of Completion Rates	As part of the Delve OD programme within the People Directorate there is a further review of the leavers process is underway with the development of a SOP for stay conversations and an options	• Develop SOP for Stay Conversations • Develop Options Appraisal for exit interview process to inform future approach. Depending on the option agreed will determine	Laura Hilton	31.07.25	

	appraisal review of the current exit interview process.	future actions to address exit interview compliance.			
Develop an approach to exert greater pay and discretionary spend controls.	In line with the work with PWC and the Trust Vacancy Control processes (ECF), develop similar approaches to ensure appropriate controls are in place relating to all pay spend, including: • Overtime • WLIs • Bank • Agency • Substantive roles	• Complete a gap analysis to understand the current levels of pay control across all staff groups. • Using the gap analysis and working with the Staff Group leads, develop systems/processes to ensure appropriate pay controls are in place. • Where required, make recommendations for process/system improvements. • Establish a long-term approach to monitoring pay controls at a staff group and/or CBU level.	Gemma Leach	31/11/2024	Actions partially complete, actions now superseded by the PWC action plan.
Secure funding for Rugby League Cares for next 12 months	Following the cessation of the RLC funding on 31/03/25 the Trust will scope out and look at alternative methods of funding RLC for another 12 months.	• Establish potential internal funding streams • Establish potential external funding streams • Write a business case / bid to access relevant funding	Caroline Eardley	30.06.25	

Board Assurance Framework

Risk ID	2253	Executive Lead	Chief Strategy and Partnerships Officer		Rating	
Strategic Objective			**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. **SO2** We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future **SO3** We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			
Risk Description			If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities and ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, including the limited capacity of shared Board members to effectively manage competing demands, potentially impacting both Trusts' decision-making and service management.	**Initial**	9 (L3 x C3)	
				Current	9 (L3 x C3)	
				Target	2 (L1 x C2)	
Risk Appetite			**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.			

Risk Movement

9 ●————————————————————————● 9

INITIAL JAN 25   CURRENT JAN 25

Assurance Details

The integration programme- "Better Care Together" has been established. Each workstream is developing a delivery plan and working with partners to deliver objectives.

Over the coming months, we will be working to finalise governance arrangements, introduce a shared executive team, and make progress in delivering improved pathways for our patients. Together, we will develop new and improved ways of working, starting first with services identified as an urgent priority. Subject to all necessary approvals, we hope to become a single organisation as soon as possible.

Controls
- Nikhil Khashu commenced as Chief Executive Officer for both Trusts on the 1st November
- Paul Fitzsimmons appointed as joint Executive Medical Director
- Dan Moore appointed a joint Chief Operating Officer
- Summary case for change – approved – Novembver 2024
- Signed data sharing agreement

Assurance
- Workstreams identified 6, 12 and 24 month priorities
- Programme governance arrangements in place, including joint executive team meetings, delivery group and steering group
- Held joint board sessions
- Developed and approved initial milestone plan
- Held first clinical and operational services workshop to identify where services can align to deliver patient benefit
- Contract Review
- Communication and Engagement Plan drafted

Assurance Gaps
- Lack of integrated governance systems

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Boards at both Warrington and Halton Teaching Hospitals (WHH) and Bridgewater Community Healthcare FT (BCH) to approve the recommendation for WHH to acquire BCH	Boards at both WHH and BCH to discuss the recommendation for WHH to acquire BCH to be presented to retrospective Boards on 5th and 6th of February 2025	Proposal for WHH to acquire BCH to be presented to respective Boards on 5th and 6th February 2025.	Lucy Gardner	06.02.2025	Complete 6.2.25
Implement a more integrated governance structure to support timely and effective decision making	Develop, agree and implement a joint integrated governance structure	Develop, agree and implement a joint integrated governance structure.	John Culshaw	01.04.2025	People committee in common established April 2025

Appendix 2

Risk Appetite Statement

WHH is an ambitious organisation – ambitious for its patients, its workforce and for the communities it serves.

Our goal is to provide high quality care that put patients first, is both safe and effective and delivers an excellent patient experience. Alongside this, we aim to be the best place to work, with a diverse and engaged workforce, fit for now and the future. Together with our partners in the health and social care system, we will design our services to be fit for purpose, more integrated in order to achieve social and economic wellbeing in our communities.

The NHS unquestionably faces unprecedented economic and operational challenges, but these challenges are magnified at a local level by additional demographic factors, as well as specific WHH issues. The latter includes, for example, an aging estate on both our hospital sites. Achieving our goals, whilst meeting these challenges, will require significant change as well as extensive collaboration with partners across the NHS family and across the wider, public and third sectors. This degree of change brings significant opportunity but, correspondingly, it requires us to take more risk. Thus, we must endeavour to strike the best balance between the two.

Accordingly, we will continue to be guided by our risk management policy in order to understand and control risk. We will continue to develop our corporate risk register to monitor significant operational risks. We will also continue to apply our board assurance framework to monitor strategic risks and ensure that the risks we take are consistent with the risk appetite set by the Board.

Our risk appetite, therefore, represents a collective agreement, understanding and decision by the Board about the level of risk that we are prepared to accept, after balancing the potential opportunities and threats any given situation presents.

To ensure clarity, we have broken down our approach to expressing our risk appetite into the five main types of risk facing the majority of NHS provider organisations within our own context and terminology: namely, quality; financial and operational sustainability; regulation; people; and reputation.

Quality
Providing the best care and treatment we can is our purpose. We will actively avoid risks to the quality of clinical services and will take a cautious and balanced approach. Where innovation may improve quality of care we will however be more open to risk. When making significant decisions about our services, we will assess and record any risks affecting safety, patient experience and clinical effectiveness, and apply the necessary control measures. The impact of changes on quality will be monitored continuously and reported using both quantitative data and qualitative intelligence.

People
We aim to provide a supportive and inclusive culture and working environment, in which both individuals and teams can thrive. We recruit, develop and train current as well as future staff. To achieve our goals in respect of quality services and financial sustainability we will need to take significant decisions about services that will affect our people and may impact their working arrangements. We are therefore open to risk where we can demonstrate longer-term benefits to patients from our decisions. In arriving at those decisions, we will engage with our staff to shape our proposals, in order to maximise the positive impact on patient care and mitigate any potential adverse impact on staff.

Financial and Operational Sustainability
We aim to be a highly productive organisation that consistently delivers on all our constitutional performance standards whilst demonstrating public value for money with integrity and probity. We aim to continuously

improve and innovate in the best interests of our patients, staff and communities. We are therefore open to seek out risk through innovative approaches, subject to appropriate procedures and controls.

Regulation

Our first aim is to provide safe and effective patient care, alongside an efficient use of resources. We use our regulated status to provide assurance of the quality of the services that we provide, the environment that we operate within and our efficiency. Our regulatory environment assists us in promoting outstanding patient care, working in collaboration with health and social care partners. We are therefore open to this risk.

Reputation

We are an outward-looking organisation and are determined to contribute fully to partnership working within our system and beyond - for example, with other health and social care organisations, local authorities, education partners, and the voluntary, community and faith sectors. Involvement of patients and the public is important to us, and we proactively include them and their representatives as part of our decision-making processes. We are open to reputational risk in that we may take decisions which may attract challenge when we can clearly demonstrate that they will achieve at least the same, if not better, outcomes for our patients, workforce, and the communities we serve

General Risk Appetite Principles

Methods of controlling risks must be balanced. The Trust may accept some high risks either because of the cost of controlling them, or to deliver innovation or use resources creatively when this may achieve substantial benefit.

As a general principle the Trust has a low tolerance for, and will therefore seek to control, all risks which have the potential to:

• Expose patients, staff, visitors and other stakeholders to harm
• Compromise the Trust's ability to deliver operational services
• Adversely impact the reputation of the Trust
• Have severe financial consequences which may impact on the Trust's future viability
• Cause non-compliance with law and regulation.

Risk appetite definitions for levels of risk appetite are set out in table 1, below.

These have been adopted from the Good Governance Institute's Risk Appetite for NHS Organisations Matrix2.

None	Avoidance of risk is a key organisational objective.
Minimal	Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.
Cautious	Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.
Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.
Seek	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).
Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.

AGENDA REFERENCE:	BM/25/06/37	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	4th June 2025	
AUTHOR(S):	Bethan Thompson – Senior Performance and Systems Development Lead Janet Parker – Deputy Chief Finance Officer	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons – Executive Medical Director Alison Kennah – Chief Nurse Michelle Cloney – Chief People Officer Jane Hurst – Chief Finance Officer Dan Moore – Chief Operating Officer and Deputy Chief Executive	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate*)	**224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety. **1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) as a consequence of the COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **134** If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton. **115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	

LINK TO PUBLIC SECTOR EQUALITY DUTIES	*Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:*			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant	**Yes**	**No**	*N/A*
				✓

	protected characteristic and those who do not			
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust has 63 IPR indicators which have been placed into the following categories based on SPC/Making Data Count "Assurance" and "Variation" principles and performance. **Table 1** sets out the "Assurance" and "Variation" of all indicators, of these, there are **3 indicators that are both failing and have special cause variation of a concerning nature**, these are: • *58. Capital Programme – % delivered against plan (NEW)* • *59. Better Practice Payment Code – % cumulative performance (NEW)* • *61. CIP (recurrent) – % delivered against plan* There are **2 indicators that have special cause variation of a concerning nature and do not have a target**, these are: • **13. Mortality ratio** – HSMR • **14. Mortality ratio** – SHMI The below indicators were previously both failing and had special cause variation of a concerning nature; **these now no longer fall into one, or both, of these categories.** • Mixed Sex Accommodation Breaches (ITU) • Sepsis - % screening for all emergency patients • A&E Waiting times - % patients waiting under 4 hours from arrival to admission, transfer or discharge • A&E Waiting times - % patients waiting under 4 hours from arrival to admission, transfer or discharge (including WUTC) • Supporting Attendance At Month 1 the Trust has recorded a deficit position of £4.7m (before deficit support) which is in line with plan. After deficit support funding the deficit reduces to £3.1m.			
PURPOSE: *(please select as appropriate)*	Approval ✓	To note ✓		Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee. 2. Note the contents of this report.			

PREVIOUSLY CONSIDERED BY:	Committee	Finance + Sustainability Committee
	Agenda Ref.	FSC/25/05/046
	Date of meeting	02/06/2025
	Summary of Outcome	Changes to the capital contingency supported and approved.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	AGENDA REF:	BM/25/06/37

1. BACKGROUND/CONTEXT

1.1 IPR Indicators

All 63 Integrated Performance Dashboard (IPR) indicators have been placed into one of several "Assurance" categories and one of several "Variation" categories as determined by the principles of Statistical Process Control (SPC) and Making Data Count.

Appendix 1 details "Making Data Count" icons and data in relation to SPC.

The Integrated Performance Dashboard (**Appendix 2**) has been produced to provide the Trust Board with assurance in relation to the delivery of all Key Performance Indicators (KPIs) across the following areas:
- Quality
- Access and Performance
- Workforce
- Finance and Sustainability

2. KEY ELEMENTS

2.1 Making Data Count Assurance and Variation Categories

Table 1 contains the number of IPR indicators in each Making Data Count "Assurance" and "Variation" category.

Table 1: KPIs by Assurance and Variation Categories

	Special Variation of a Concerning Nature	Common Cause Variation	Special Variation of an Improving Nature	No SPC/Not Enough Datapoints/NA
	CONSISTENTLY FAILING TARGET & DECLINING PERFORMANCE	**CONSISTENTLY FAILING TARGET & VARYING PERFORMANCE**	**CONSISTENTLY FAILING TARGET & IMPROVING PERFORMANCE**	**CONSISTENTLY FAILING TARGET & NO SPC**
Consistently Fails the Target (based on the last 7 months)	**Finance** 58. Capital Programme **(£0.09m - £0.33m target)** ↓ 59. Better Payment Practice Code **(53% - 95% target)** ↓ 61. Cost Improvement Programme (recurrent forecast) – In year performance to date **(£0.47m – £0.82m target)**	**Quality** 1.Incidents 11. Medication Safety - Reconciliation within 24 hours 17. Friends and Family (ED and UCC) 18. Mixed Sex Accommodation Breaches (Non ITU) ↑ 19. Sepsis - % screening for all emergency patients ↑ 20. Sepsis - % screening for all inpatients 21. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1h of diagnosis 26. MUST nutritional assessment completion **Access & Performance** 27. A&E Wait Times - % patients waiting under 4 hours (including WUTC) ↑ 28. A&E Wait Times - % patients waiting under 4 hours (excluding WUTC) ↑ 29. A&E Wait Times – % patients waiting longer than 12 hours from arrival to admission, transfer, or discharge 31. Ambulance Handovers within 15 minutes 32. Ambulance Handovers within 30 minutes 33. Ambulance Handovers within 60 minutes 37. Referral to treatment Open Pathways 38. RTT - Number of patients waiting 52+ weeks 39. 28 Day Faster Cancer Diagnosis Standard 41. Cancer 62 Days First Treatment 50. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation ↓ 51. Capped Theatre Utilisation **Workforce** 52. Supporting Attendance ↑	**Workforce** 55. PDR compliance	

	INCONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE	INCONSISTENTLY PASSING TARGET & VARYING PERFORMANCE	INCONSISTENTLY PASSING TARGET & IMPROVING PERFORMANCE	INCONSISTENTLY PASSING TARGET & NO SPC
Inconsistently Passes/Fails the Target	**Access & Performance** 35. Patients seen in the Fracture Clinic within 72 hours ⬇	**Quality** 3. Healthcare Acquired Infections (MSSA) 4. Healthcare Acquired Infections (CDI) 5. Healthcare Acquired Infections (Ecoli) 6. Healthcare Acquired Infections (Klebsiella) 7. Healthcare Acquired Infections (PA) 8. VTE Assessment ⬆ 9. Inpatient Falls & harm levels 10. Pressure Ulcers 15. Complaints ⬇ 24. Maternity Postpartum Haemorrhage **Access & Performance** 45. Elective Outpatient Activity **Finance** 62. Agency Reduction 63. Bank Reduction	**Quality** 22. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1h of diagnosis **Access & Performance** 36. Diagnostic Waiting Times 6 Weeks ⬆	
	CONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE	CONSISTENTLY PASSING TARGET & VARYING PERFORMANCE	CONSISTENTLY PASSING TARGET & MAINTAINING/IMPROVING PERFORMANCE	CONSISTENTLY PASSING TARGET & NO SPC
Consistently Passes the Target (based on the last 7 months)		**Quality** 16. Friends and Family (Inpatients & Day cases) 23. Acute Kidney Injury **Access & Performance** 40. Cancer 31 Days First Treatment 49. Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicator was in progress at the time of reporting. **Finance** 60. Cost Improvement Programme – In year performance to date (£m)	**Workforce** 53. Turnover 54. Core/Mandatory Training	

	NO ASSURANCE SPC & DECLINING PERFORMANCE	NO ASSURANCE SPC & VARYING PERFORMANCE	NO ASSURANCE SPC & IMPROVING PERFORMANCE	NO ASSURANCE SPC & NO SPC
No SPC **No SPC/Not Enough Datapoints/Not Applicable**	**Quality** 13. Mortality ratio – HSMR 14. Mortality ratio - SHMI	**Quality** 2.Healthcare Acquired Infections (MRSA) 25. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT)) **Access & Performance** 30. Average time in department ED ⬇ 42. Reduction in Outpatient Follow Ups 46. Super Stranded Patients 47. No Criteria to Reside (NCTR) 48. % Patients discharged to their usual place of residence	**Access & Performance** 34. Type 5 attendances	**Quality** 12. Staffing - Average Fill Rate **Access & Performance** 43. Elective Recovery Activity (Grouped SPCs) 44. Elective Recovery Diagnostic Activity **Finance** 56. Trust Financial Position (£m) 57. Cash Balance (£m)

Areas requiring focus – areas are failing to meet the target and declining in performance
Areas exceeding the target and continuously maintaining/improving performance

Areas of a concerning nature due to either: • **indicators not meeting (failing) their set target**   • **declining nature of the performance**
⬆ **Improved category from previous IPR**   ⬇ **Declined category from previous IPR**   * **New metric**

A breakdown of the performance against targets can be found in **Appendix 2**.

Descriptions of each KPI are available in **Appendix 3**. Further detail around interpretation of Statistical Process Control (SPC) charts and "Making Data Count" icons can be found in **Appendix 4**.

The Income Statement for April 2025 is attached in **Appendix 5**.

The Trust has submitted a deficit plan of £28.7m before deficit support funding of £18.3m which reduces the deficit to £10.4m. There are several risks to the achievement of the planned deficit. The key risks are as follows:
- Delivery of the level 1 & 2 CIP plan (£21.5m).
- Delivery of system wide savings of £12m (level 3 CIP).
- Achieving the income plan through core capacity and risk of overperformance not being funded.
- Receipt of deficit support funding and potential new restrictions.
- Cash level and ability to access revenue cash support.
- Funding for recently announced pay award.

These risks also present a challenge to future sustainability if they are not addressed.

Cash
The cash balance at the end of April is £19.5m of which £7.3m relates to capital creditors. Given the current cash position and the planned deficit for 2024/25 the Trust will require cash support during 2025/26. The first drawdown is likely to be required during Q2 subject to receipt of deficit support funding. Increased cash management measures have been introduced in line with NHSE guidance. This has led to a deterioration in April 2025 of both creditor days (60 days from 52 days in March 2025) and BPPC (53% against a target of 95%, 88% cumulative position in March 2025). As a result, cash days are at 18 days which is an improvement from 15 days in March 2025. Debtor days has improved in April 2025 (63 days from 65 days in March 2025) due to even greater focus on debt collection.

CIP
At 30 April 2025, the Trust has delivered a CIP of £0.8m which is on plan. However, it should be noted that £0.3m has been achieved from non-recurrent central items. Full year CIP plans of £21.5m have been identified against the £21.5m levels 1 and 2 CIP target. Of the £21.5m identified £2.8m is non recurrent, presenting an ongoing challenge to finance sustainability. There is a significant risk to the Trust if it cannot deliver recurrent CIP in 2025/26 therefore further work is required to identify recurrent CIP.

Capital Programme
The Trust total capital funding consists of £10.44m CDEL and £18.24m external funding, a total of £28.68m. The Trust also has £1.49m IFRS16 CDEL.

The Trust capital spend for month 1 is £0.08m which is £0.27m below the Trust plan of £0.35m. This is due to timing and is expected to be fully delivered by year end.

Table 3 highlights the current contingency fund.

Table 3: Capital Contingency

DETAIL	£'000	£'000
Contingency balance start of month 1		500
Proposed changes in month		
VAT rebate		17
Emergency request		
Ducting redesign and installation for ventilated benches	- 110	
X Ray Detector	- 40	
Sub Total		- 150
Contingency as at end of month 1		367

The Trust Board is asked to:

- Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The KPIs that are underperforming are managed in line with the Trust's Performance Assurance Framework.

4. ASSURANCE COMMITTEE

The following committees provide assurance to the Trust Board:
- Finance and Sustainability Committee
- Quality & Assurance Committee
- Strategic People Committee

5. RECOMMENDATIONS

The Trust Board is asked to:
1. Note the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.
2. Note the contents of this report.

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Key:

- L / H — Special Cause Variation of a improving nature.
- Common Cause (Normal Variation).
- L / H — Special Cause Variation of a concerning nature.
- P — Consistently passes the target
- ? — Inconsistently passes and fail the target
- F — Consistently fails the target

	QUALITY	Latest				Previous		Assurance
		Plan/Target	Actual	Period	Variation	Actual	Period	
1	Incidents	0	9	Apr-25	(common cause)	19	Mar-25	F
2	Healthcare Acquired Infections (MRSA)	Thresholds not yet set for 2025/26	0	Apr-25	(common cause)	1	Mar-25	No SPC
3	Healthcare Acquired Infections (MSSA)	Thresholds not yet set for 2025/26	6	Apr-25	(common cause)	0	Mar-25	?
4	Healthcare Acquired Infections (CDI)	Thresholds not yet set for 2025/26	3	Apr-25	(common cause)	7	Mar-25	?
5	Healthcare Acquired Infections (Ecoli)	Thresholds not yet set for 2025/26	8	Apr-25	(common cause)	7	Mar-25	?
6	Healthcare Acquired Infections (Klebsiella)	Thresholds not yet set for 2025/26	3	Apr-25	(common cause)	3	Mar-25	?
7	Healthcare Acquired Infections (PA)	Thresholds not yet set for 2025/26	1	Apr-25	(common cause)	2	Mar-25	?
8	VTE Assessment	95.00% (quarterly position)	94.40%	Apr-25	(common cause)	94.01%	Mar-25	?
9	Inpatient Falls & harm levels	10% reduction from 2024/25	26	Apr-25	(common cause)	28	Mar-25	?
10	Pressure Ulcers	20% reduction from 2024/25	18	Apr-25	(common cause)	11	Mar-25	?
11	Medication Safety Reconciliation within 24 hours	80.00%	51.00%	Apr-25	(common cause)	45.00%	Mar-25	F
12	Staffing - Average Fill Rate	90.00%	N/A - grouped indicator	Apr-25	No SPC	90.43%	Mar-25	No SPC

Statistical Process Control - Assurance & Variation

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

Appendix 1

Key:

Special Cause Variation of a improving nature.

Common Cause (Normal Variation).

Special Cause Variation of a concerning nature.

Consistently passes the target

Inconsistently passes and fail the target

Consistently fails the target

#	Metric	Target	Value	Period	Variation	Prev Value	Prev Period	Assurance
13	Mortality ratio - HSMR	No target set	93.66	Apr-25	H (concerning)	93.10	Mar-25	No SPC
14	Mortality ratio - SHMI	No target set	103.47	Apr-25	H (concerning)	102.94	Mar-25	No SPC
15	Complaints	Zero complaints open over 6 months old/in the backlog	1	Apr-25	Common Cause	2	Mar-25	?
16	Friends and Family (Inpatients & Day cases)	95.00%	97.00%	Apr-25	Common Cause	97.00%	Mar-25	P
17	Friends and Family (ED and UCC)	87.00%	76.00%	Apr-25	Common Cause	74.00%	Mar-25	F
18	Mixed Sex Accommodation Breaches (Non ITU)	0	4	Apr-25	Common Cause	12	Mar-25	F
19	Sepsis - % screening for all emergency patients.	90.00%	54.00%	Apr-25	Common Cause	58.00%	Mar-25	F
20	Sepsis - % screening for all inpatients	90.00%	70.00%	Apr-25	Common Cause	68.00%	Mar-25	F
21	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag	90.00%	62.00%	Apr-25	Common Cause	54.00%	Mar-25	F
22	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90.00%	95.00%	Apr-25	H (improving)	84.00%	Mar-25	?
23	Acute Kidney Injury	Less than previous month	144	Apr-25	Common Cause	165	Mar-25	P
24	Maternity Postpartum Haemorrhage	3.70%	5.50%	Apr-25	Common Cause	3.80%	Mar-25	?
25	Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	48%	Apr-25	Common Cause	24%	Mar-25	No SPC
26	MUST nutritional assessment completion	above > 85%	68.43%	Apr-25	Common Cause	67%	Mar-25	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

- 🔵 L / 🔵 H — Special Cause Variation of a improving nature.
- ⚪ — Common Cause (Normal Variation).
- 🟠 L / 🟠 H — Special Cause Variation of a concerning nature.
- 🔵 P — Consistently passes the target
- ⚪ ? — Inconsistently passes and fail the target
- 🟠 F — Consistently fails the target

	ACCESS & PERFORMANCE	Latest Plan/Target	Latest Actual	Latest Period	Latest Variation	Previous Actual	Previous Period	Assurance
27	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (excluding WUTC).	78%	64.75%	Apr-25	⚪	64%	Mar-25	🟠 F
28	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (including WUTC).	78%	68.92%	Apr-25	⚪	68%	Mar-25	🟠 F
29	A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	20.08%	Apr-25	⚪	19.8%	Mar-25	🟠 F
30	Average time in department ED	No Target	479	Apr-25	⚪	562	Mar-25	No SPC
31	Ambulance Handovers within 15 minutes	65%	37.93%	Apr-25	⚪	41.33%	Mar-25	🟠 F
32	Ambulance Handovers within 30 minutes	95%	71.27%	Apr-25	⚪	75.52%	Mar-25	🟠 F
33	Ambulance Handovers within 60 minutes	100%	87.10%	Apr-25	⚪	90.71%	Mar-25	🟠 F
34	Type 5 attendances	No Target set	2262	Apr-25	🔵 H	2527	Mar-25	No SPC
35	Patients seen in the Fracture Clinic within 72 hours	95%	73.00%	Apr-25	🟠 L	96%	Mar-25	⚪ ?
36	Diagnostic Waiting Times 6 Weeks	95.00%	96.13%	Apr-25	🔵 H	96.66%	Mar-25	⚪ ?
37	Referral to treatment Open Pathways	92.00%	56.55%	Apr-25	⚪	58.41%	Mar-25	🟠 F
38	Referral to treatment - Number of patients waiting 52+ weeks	0	1528	Apr-25	⚪	1387	Mar-25	🟠 F

Statistical Process Control - Assurance & Variation

Key:

- Special Cause Variation of a improving nature.
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#	Indicator	Target	Value	Period	Variation	Value	Period	Assurance
39	28 Day Faster Cancer Diagnosis Standard	75%	74.20%	Mar-25	Common Cause	72.20%	Feb-25	F
40	Cancer 31 Day Wait	96%	98.80%	Mar-25	Common Cause	100.00%	Feb-25	P
41	Cancer 62 Day Wait	85%	73.40%	Mar-25	Common Cause	78.90%	Feb-25	F
42	Reduction in Outpatient Follow Ups compared to 19/20 activity	No Target set	87%	Apr-25	Common Cause	105%	Mar-25	No SPC
43	Elective Recovery Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC
44	Elective Recovery Diagnostic Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC
45	Elective Outpatient Activity	104%	94%	Apr-25	Common Cause	105%	Mar-25	?
46	Super Stranded Patients	Trajectory	131	Apr-25	Common Cause	154	Mar-25	No SPC
47	No Criteria to Reside (NCTR)	No Target set	172	Apr-25	Common Cause	212	Mar-25	No SPC
48	% Patients discharged to their usual place of residence	No Current Threshold	97%	Apr-25	Common Cause	96%	Mar-25	No SPC
49	Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicators was in progress at the time of reporting.	Less than 2%	1.04%	Apr-25	Common Cause	1.04%	Mar-25	P
50	Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Please note: Validation for this indicators was in progress at the time of reporting.	0	4	Apr-25	Common Cause	3	Mar-25	F
51	Capped Theatre Utilisation	85%	78.90%	Apr-25	Common Cause	76%	Mar-25	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Key:

 Special Cause Variation of a improving nature.

 Common Cause (Normal Variation).

 Special Cause Variation of a concerning nature.

 Consistently passes the target

 Inconsistently passes and fail the target

 Consistently fails the target

	WORKFORCE	Latest				Previous		Assurance
		Plan/Target	Actual	Period	Variation	Actual	Period	
52	Supporting Attendance	5.00%	5.86%	Apr-25		5.74%	Mar-25	
53	Turnover	Below 13%	11.68%	Apr-25		12%	Mar-25	
54	Core/Mandatory Training	85.00%	90.26%	Apr-25		90.17%	Mar-25	
55	PDR compliance	85.00%	79.00%	Apr-25		79.22%	Mar-25	

Statistical Process Control - Assurance & Variation

Key:

- Special Cause Variation of a improving nature.
- Common Cause (Normal Variation).
- Special Cause Variation of a concerning nature.
- Consistently passes the target
- Inconsistently passes and fail the target
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	FINANCE & SUSTAINABILTY	Latest				Previous		Assurance
		Plan/Target	Actual	Period	Variation	Actual	Period	
56	Trust Financial Position (£m)	-£4.69	-£4.69	Apr-25	No SPC	£2.45	Mar-25	No SPC
57	Cash Balance (£m)	£10.64	£19.48	Apr-25	No SPC	£16.21	Mar-25	No SPC
58	Capital Programme (£m)	£0.33	£0.09	Apr-25	L	£21.27	Mar-25	F
59	Better Payment Practice Code	>95%	53%	Apr-25	L	91%	Mar-25	F
60	Cost Improvement Programme - In year (£m)	90% of plan	100%	Apr-25	Common Cause	95%	Mar-25	P
61	Cost Improvement Programme (recurrent) – In year (£m)	90% of plan	57%	Apr-25	L	65%	Mar-25	F
62	Agency Reduction (£m)	£0.24	£0.32	Apr-25	Common Cause	£0.39	Mar-25	?
63	Bank Reduction (£m)	£2.34	£2.40	Apr-25	Common Cause	£2.91	Mar-25	?

Quality Improvement - Trust Position

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

| Trust Performance | Trend | Statistical Narrative | reasons for the | How are we going to improve the position (Short & Long Term)? |

Section 1: Incidents

1. Incidents (over 40 days)
Target: ZERO Open incidents outside 40 day timeframe and

There was 9 incident over 40 days old.

Charts
- **Open Incidents - 40 Days** (SOF / CQC) — Intervention: change in closure process for incidents. Target, Mean, UCL, Number of Incidents over 40 days old
- **Total Incidents Reported by month** — Total Number of Reported Incidents, Mean, LCL, UCL
- **Total PSIIs recorded in month** — PSIIs recorded in month, Mean, LCL, UCL
- **Never Events** — NEVER EVENTS, Mean, LCL, UCL

Statistical Narrative
Assurance: The Trust consistently fails the target.

Variation: Common cause (normal) variation

There was 1 PSII reported in April 2025, this was an interface incident relating to a deteriorating patient that had a cardiac arrest and passed away.

There were 9 incidents open over 40-days at the time of reporting.

How are we going to improve
A weekly Governance Dashboard is overseen by the Executive Team monitoring trends of reporting alongside triangulation of incidents, complaints, claims and inquests. Immediate actions are put in place following all Initial Safety Reviews and monitored via the weekly Executive Led Safety Oversight Meeting (SOM). Triangulation of learning is reported via the Learning from Experience Report to Quality Assurance Meeting each quarter.

Incidents overdue 40 days- The incident position is escalated daily to the Triumvirates for the relevant areas, and this work is being prioritised. This position is reviewed weekly at SOM.

Datix system alerts at an additional lower threshold (30 days) to enable further support to be provided and this will be monitored closely.
A daily report of learning response and action positions for Care Group Triumvirate's oversight is now in place.

PSII's
Weekly monitoring continues through the weekly Executive Led Safety Oversight Meeting with appropriate escalation to the CBU leads.

Section 2-7: Healthcare Acquired Infections (SOF / CQC / S)

2. Healthcare Acquired Infections (MRSA) — Target: not yet set for 2025/26
3. Healthcare Acquired Infections (MSSA) — Threshold: not yet set for 2025/26
4. Healthcare Acquired Infections (CDI) — Threshold: not yet set for
5. Healthcare Acquired Infections (Ecoli) — Threshold: not yet set
6. Healthcare Acquired Infections (Klebsiella) — Threshold: not yet set for 2025/26
7. Healthcare Acquired Infections (PA) — Threshold: not yet set for 2025/26

Trust Performance
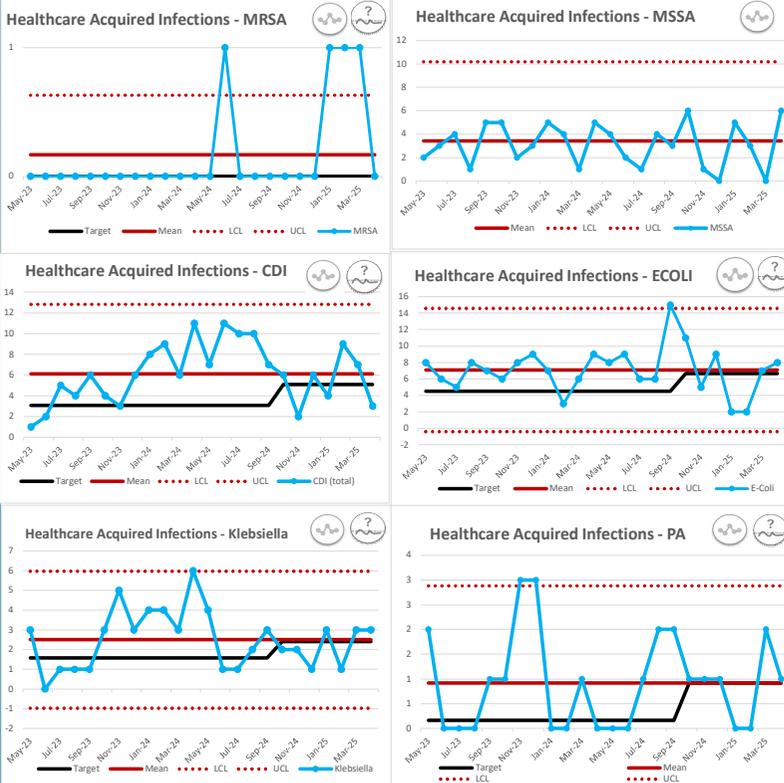MRSA cases YTD - annual threshold not yet set

MSSA 6 cases YTD - no threshold set

CDI 3 cases YTD - annual threshold not yet set

E. coli 8 cases YTD - annual threshold not yet set

Klebsiella spp. 3 cases YTD - annual threshold not yet set

P. aeruginosa 1 cases YTD - annual threshold not yet set

Charts
- **Healthcare Acquired Infections - MRSA** — Target, Mean, LCL, UCL, MRSA
- **Healthcare Acquired Infections - MSSA** — Mean, LCL, UCL, MSSA
- **Healthcare Acquired Infections - CDI** — Target, Mean, LCL, UCL, CDI (total)
- **Healthcare Acquired Infections - ECOLI** — Target, Mean, LCL, UCL, E-Coli
- **Healthcare Acquired Infections - Klebsiella** — Target, Mean, LCL, UCL, Klebsiella
- **Healthcare Acquired Infections - PA** — Target, Mean, LCL, UCL

Statistical Narrative
(MRSA) Assurance: The Trust consistently passes the target.
Variation: Common Cause (Normal) variation.

(CDI) Assurance: The Trust inconsistently passes/fails the target.
Variation: Common Cause (Normal) variation.

(ECOLI) Assurance: The Trust inconsistently passes/fails the target.
Variation: Common Cause (Normal) variation.

(K) Assurance: The Trust inconsistently passes/fails the target.
Variation: Common Cause (Normal) variation.

(PA) Assurance: The Trust inconsistently passes/fails the target.
Variation: Common Cause (Normal) variation.

reasons for the
Regional/national increase in C. difficile cases. The rise in cases has been declared as a national standard incident by UK Health Security Agency. The Trust remains a low outlier for C difficile cases.

Noted increase in MSSA cases nationally which NHSE are reviewing and further information awaited. The Trust is not flagging as an outlier on cases/rates of infection. There are multiple likely primary sources for these infections, some are deep seated infections and likely unavoidable.

How are we going to improve
MRSA: MSSA: There has been an increased focus on ANTT training and competency assessments this is monitored via the Infection Control Committee. More ANTT competency assessors have been trained to aid in improving Trust wide compliance.

Clinical Education Team are focusing on IV device care bundle training. The IV device audit schedule has now been revised to provide increased assurance on compliance with the care of invasive devices.

CDI: CDI prevention action plan in place. Model Ward programme ongoing now aligned to the Well Organised Ward annual plan. Review of patients with recurrent CDI is ongoing outputs expected in Q1. Swarm Huddles in place for all hospital onset healthcare associated cases. Trust-wide deep cleaning programme continues. Review of National Action Plan on Antimicrobial Stewardship in progress. Reviewing opportunities to look at using probiotics for prevention of CDI Q1/2.

ECOLI: Klebsiella: Pseudomonas aeruginosa: CAUTI surveillance commenced May 2025. Revision and relaunch of the Gram-Negative Blood Stream Infection (GNBSI) Prevention Group.

Quality Improvement - Trust Position

Appendix 2

Trust Performance	Trend	Statistical Narrative	reasons for the	How are we going to improve the position (Short & Long Term)?

VTE Assessment

8. VTE Assessment

Target: 95% (quarterly position)

The Trust did achieve the required target at 94.4% for VTE assessments in month.
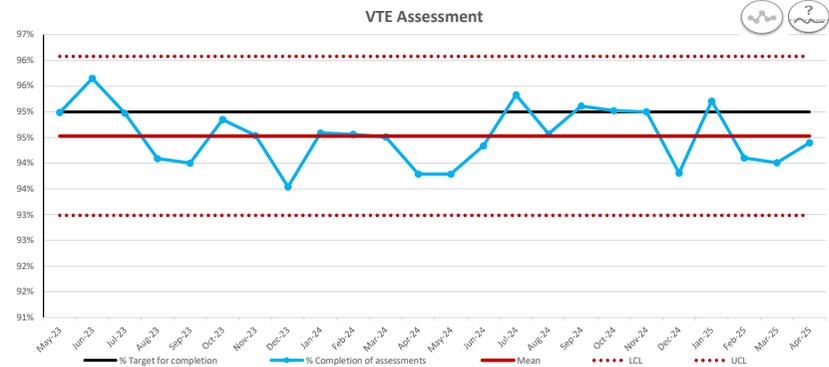
Assurance: The Trust inconsistently passes/fails the target.

Variation: Common Cause (Normal) variation.

VTE risk assessment (RA) performance target in April 2025 was just below the mandatory threshold at 94.40 %.

Ward-based team making use of real time data to complete outstanding VTE risk assessments using GIRFT Inpatient Ward Productivity Dashboard.
CBU discuss at each CBU Clinical Governance meetings actions to improve on non-compliance of VTE risk assessments in each CBU

Feedback sought from each CBU on improvement plans to meet the mandatory target > 95% at the Thrombosis Group

Monthly Report directly to Clinical lead/Clinical directors/CBU/care group to aim for improvement in respective clinical areas.

Thrombosis Group will continue to monitor the data trends to inform further improvement plans.

Full review of VTE governance processes taking place in Q1.

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9. Inpatient Falls & harm levels

Target: 10% reduction from 2024/25

34 total falls were reported in month. 26 of these were inpatient falls.
There was 0 fall(s) in month with harm.

There were 611 total falls in 2023/24. There have been 687 total falls YTD in 2024/25.
We are expecting a 41% decrease in falls from last year.

There were 378 inpatient falls in 2023/24. There have been 405 inpatient falls YTD in 2024/25.
We are expecting a 2% decrease in falls from last year.
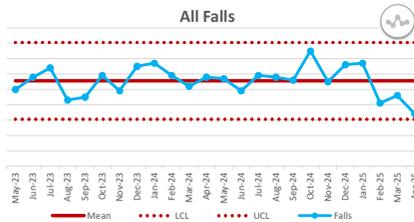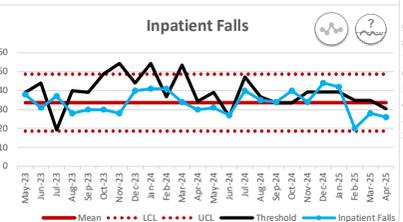
Inpatient Falls
All Falls
Falls - All harm inpatient and ED falls
Patient falls per 1000 Bed Days

Assurance: The Trust inconsistently passes/fails the target.

Variation: Common Cause Variation.

During April 2025 there were 26 inpatient falls which remains within expected variation. This is a 13% reduction from April 2024. There were no falls in April 2025 with moderate harm or above.

The lowest number of "all falls" since March 23 was noted in April 2025 (n=34) recorded as 3 falls above the lower control limit.

The PSIN completed data collection for the Trust wide falls audit in February 2025. The data remains with the Clinical Audit Team and is expected in Q1.

The bedside eyesight test was launched Trust wide in May 2025. Drop in sessions have been held with front line teams with an additional training video also being circulated.

The falls prevention leaflet has been updated and is now available on the extranet.

The updated falls policy was approved at the Policy Review Group in May 2025 and is now available on the extranet.

The PSIN have been asked to support with the re-launch of deconditioning prevention Trust wide. The initial scoping meeting took take place during May 2025.

Harm Free care processes are being reviewed in Q1/2 to ensure full alignment with PSIRF methodology.

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10. Pressure Ulcers (Category 2 and above)

Target: 20% reduction from 2024/25

In month there were 16 hospital acquired category 2 pressure ulcers, 2 Category 3 pressure ulcers and 0 Category 4 ulcers in month.

There were 58 community aquired pressure ulcers in month.
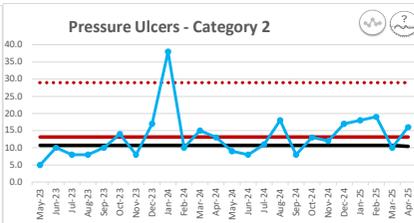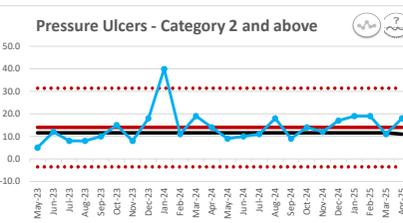
Pressure Ulcers - Category 2 and above
Pressure Ulcers - Category 2
Pressure Ulcers - Category 3 and 4
Community Acquired Pressure Ulcers

Assurance: The Trust inconsistently passes/fails the target.

Variation: Common Cause (Normal) variation.

In April 2025, there were 16 category 2 pressure ulcers and 2 category 3 pressure ulcers in April 2025.

There were 3 device related pressure ulcers in April 2025 these related to TED stockings, an orthopaedic brace and mattress which had high pressure.

After Action Reviews are taking place and lessons are shared with ward teams and via Operational Patient Safety Group.

Minimum category 3 and above will have an MDT review completed. Improvement plans in place for both Unplanned Care and Planned Care Groups overseen by the Associate Chief Nurses.

Compliance/review meetings are taking place with the Deputy Chief Nurse/Director of Governance. Lessons learned shared.

Purpose T (pressure ulcer risk assessment) launched 07 May 2025. Quality walk abouts are in place with the Chief Nurse, Deputy Chief Nurse/Director of Governance and associate Chief Nurses to assure on the quality of pressure ulcer prevention care.

Quarterly Quality Summits in place with Chief Nurse, Deputy Chief Nurse/Director of Governance to monitor plans to improve quality metrics.

Corporate Reviews initiated with Chief Nurse, Deputy Chief Nurse/Director of Governance for wards with higher incidence.
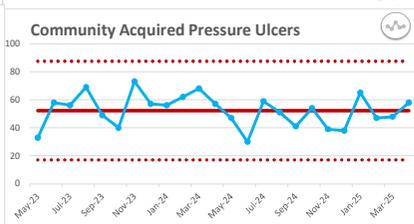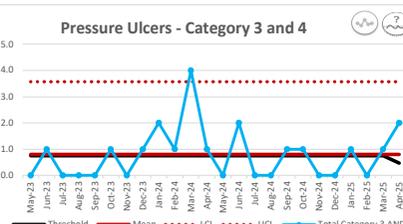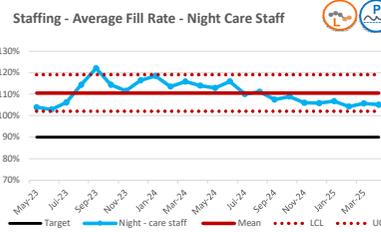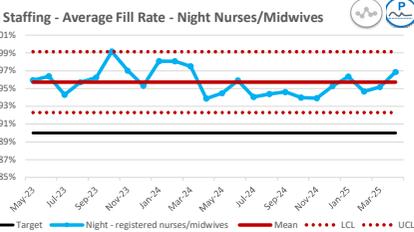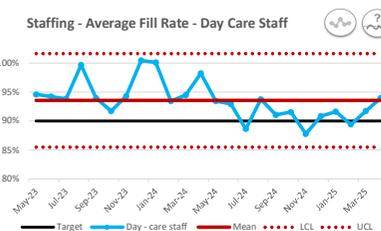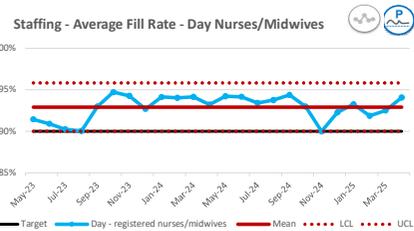
NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

Quality Improvement - Trust Position

| Trust Performance | Trend | Statistical Narrative | reasons for the | How are we going to improve the position (Short & Long Term)? |

Medication Safety - Reconciliation - 24 hours
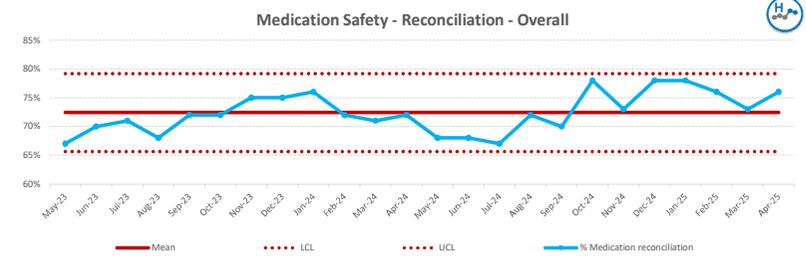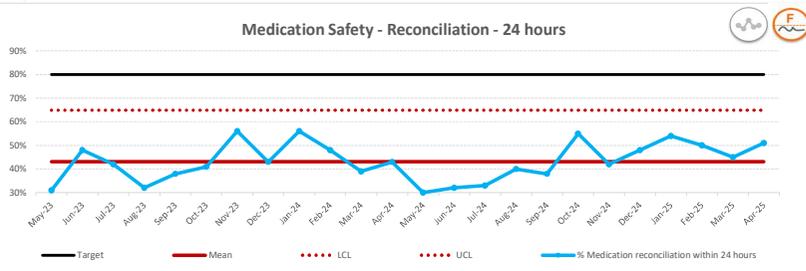
11. Medication Safety

Reconciliation within 24 hours
Target: 80%

Medicines reconciliation was completed within 24 hours of admission for 51% of patients. 76% of patients had MR completed during inpatient stay.

Medication Safety - Reconciliation - Overall

Assurance: The Trust consistently fails the target.

Variation: Common Cause (Normal) variation.

Performance varies between care groups
• 65% in 24 hours and 96% total for a patients in Unplanned Care,
• 37% in 24 hours and 54% total for patients in Planned Care.

Pharmacy staffing levels do not permit all inpatient areas to be covered, with workforce deployed according to risk stratification, activity and acuity of patients.

45% of patients who did not receive medicines reconciliation were in the W&C CBU, primarily Maternity patients in Birth Suite and Midwifery Led Unit. Previous analysis of this cohort has shown 90% of women were on no regular medication.

Team working pilot underway in Surgical Specialties/Digestive Diseases to review alternative deployment options for Pharmacy staff.

Maternity SOP in place for patients on no regular medicines/pregnancy supplements only. Plan Midwives are being encouraged to record medicines reconciliation status in line with Standard Operating Procedure.

Compliance with this will be monitored During Q1/2 via Medicines safety and Optimisation Group (MSOP).

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12. Staffing - Average Fill Rate

Target: 90%

In month, the average staffing fill rates were:

Day (Nurses/Midwife) 94.06%
Day (Care Staff) 93.94%
Night (Nurses/Midwife) 96.86%
Night (Care Staff) 105.12%

Staffing - Average Fill Rate - Day Nurses/Midwives

Staffing - Average Fill Rate - Day Care Staff

Staffing - Average Fill Rate - Night Nurses/Midwives

Staffing - Average Fill Rate - Night Care Staff

Assurance: N/A Grouped Indicator

Variation: N/A Grouped Indicator

Fill rates improved in April 2025 for registered staff days and nights and for Health Care Support Worker staff on days following a decrease in vacancies for both registered and unregistered staff, and a reduction in sickness and turnover for registered staff.

Additional beds did remain in use across the Trust due to increased demand in the Emergency Department, in addition to a large number of patients who have no criteria to reside and escalated beds open.

The current percentage vacancy for April 2025 for registered staff is 8.05% against a Trust target of 9%. This is mainly due to ED increased establishment of 32.51 WTE at Band 5. The remaining vacancy is being readvertised. Specialist recruitment is ongoing within areas with remaining vacancy.

There currently 23 HCA's that have been appointed to the Trust and are now being supported through the recruitment process with an additional 15 x NHSP CSWD's who commenced in April 2025. An RN open event took place on 14 for May 2025 to support 3rd year students qualifying this summer to apply for posts, there were 32 attendees who are being encouraged to apply for vacant positions.

The current percentage vacancy for April 2025 for unregistered staff is 12.0% against a Trust target of 9%. Monthly recruitment is taking place alongside specialist recruitment. Staffing is reviewed twice daily by the Senior Nursing Team and acuity and activity are monitored to ensure safe patient care at all times. All wards have senior nurse oversight by a Matron and Lead Nurse.

Ward Managers work clinically 2 days per week.

Quality Improvement - Trust Position
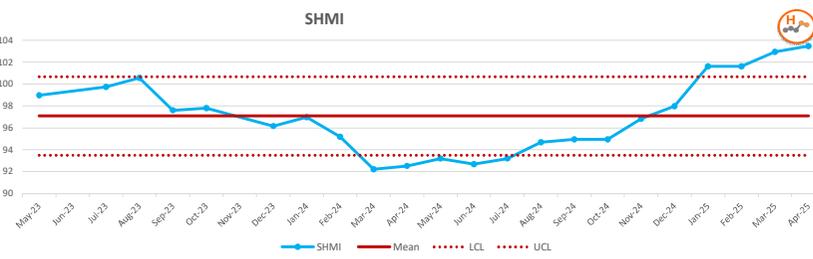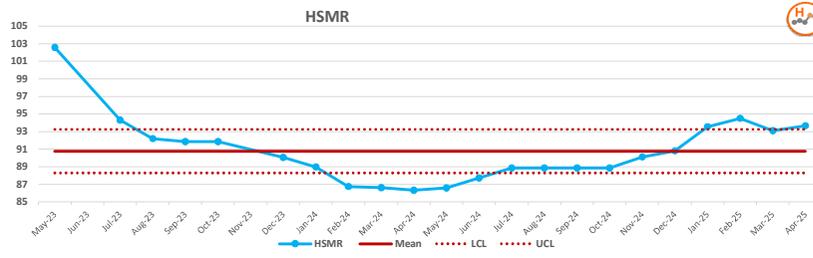
| Trust Performance | Trend | Statistical Narrative | reasons for the | How are we going to improve the position (Short & Long Term)? |

13. Mortality ratio - HSMR

Target: Plan

14. Mortality ratio - SHMI

Target: Plan

SHMI and HSMR are within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 93.66. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 103.47.

HSMR

SHMI

(HSMR) Assurance: NA - no target

Variation: Common Cause Variation.

(SHMI) Assurance: NA - no target

Variation: Special Cause Variation of a concerning nature.

SHMI and HSMR continue to rise

Since November 2023, Warrington's Same Day Emergency Care (SDEC) activity is reported as Emergency Care Data Set (ECDS) activity.

This means the remaining patient population is likely to comprise of the more complex cases, and mortality ratios for Warrington may increase slightly until Trusts are aligned with reporting SDEC in ECDS. The national deadline for reporting SDEC as ECDS activity using ECDS version 4 was July 2024, but it has been delayed to July 2025.

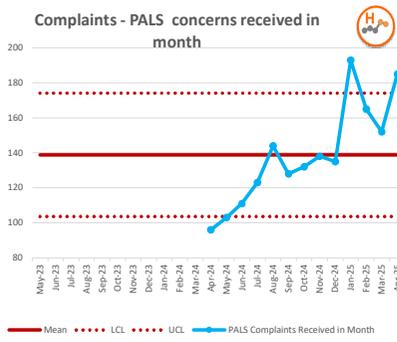Although Trusts have been expected to submit SDEC to ECDS using version 3 since July 2024, many are not yet achieving this, and so inconsistencies between Trusts continue.
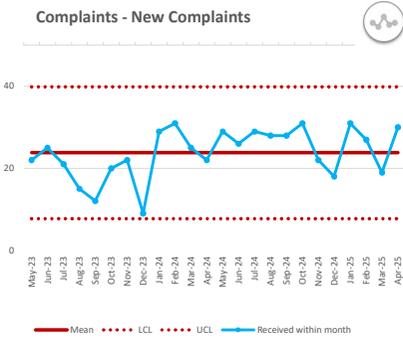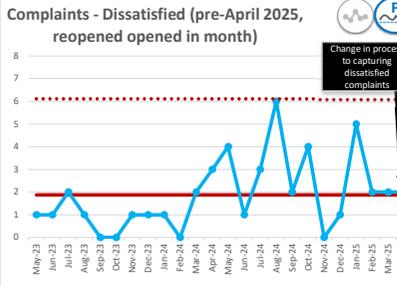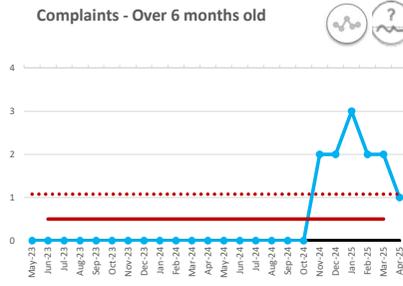
SJR backlog is being addressed via Mortality Review Group (MRG) and with individual's discussions has with the reviewers. Additional support with completion is being provided where required. There has been a considerable improvement in the reduction of overdue SJRs, this is monitored via Patient Safety and Clinical Effectiveness reporting to Quality assurance Committee.

The importance of timely closures was again re-iterated in April's MRG this will continue to be closely monitored.

15. Complaints

Target: Zero complaints open over 6 months old/in the backlog

In month, 30 new complaints were received to the Trust which was an increase of 11 from the previous month. There were 2 cases reopened in month, which is the same as the previous month.

7 PHSO cases were open at the time of reporting, these were not linked to a specific area or theme.

Complaints - Over 6 months old

Complaints - Dissatisfied (pre-April 2025, reopened opened in month)

Change in process to capturing dissatisfied complaints

Complaints - New Complaints

Complaints - PALS concerns received in month

Assurance: The Trust inconsistently passes/fails the target.

Variation: Common cause (normal) variation.

Please note: Prior to April 2025, the Complaints 'dissatisfied' graph reported 'reopened complaints'.

The Trust continues to sustain performance in the timely completion of complaints at 100% in time.

At the time of reporting, there was 1 complaint over 6 months old. This was due to the patient's wishes to add further questions following review of patient records.

2 complaints were reopened, both of which have asked further questions and challenged the previous response.

Increases are being seen in the number of Pals enquiries following the introduction of new processes in December 2024 to encourage informal resolution and meetings with clinicians wherever possible supporting a more timely resolution for those raising concerns.

There were 79 open complaints at the time of reporting. All complaints continue to be closely monitored to ensure that a timely response is completed.

All complainants are offered an initial meeting with the Clinical Teams, as well as follow up meetings upon receipt of the initial response letter.

All CBUs have a designated complaints case handler to ensure consistency.

The Complaints Policy has been updated and is currently about to be circulated for consultation in Q1. This policy Is expected to be ratified and Policy Review Group in early Q2.
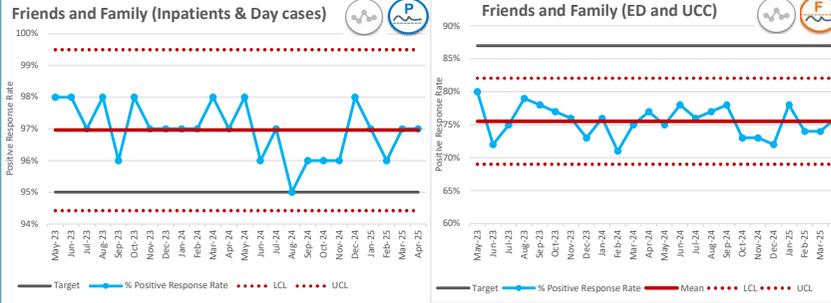
Quality Improvement - Trust Position

| Trust Performance | Trend | Statistical Narrative | reasons for the | How are we going to improve the position (Short & Long Term)? |

16. Friends and Family (Inpatients & Day cases)
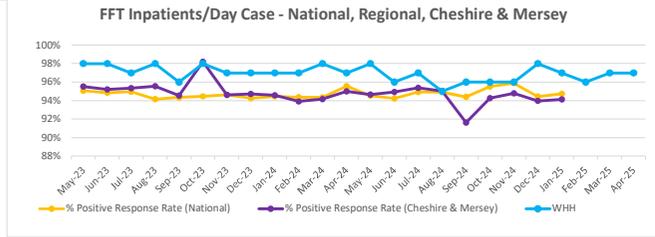
17. Friends and Family (ED and UCC)

Target: 87%

The Trust achieved 97% in month for Inpatient & Day case FFT and 76% for ED/UCC FFT.

Friends and Family (Inpatients & Day cases)

Friends and Family (ED and UCC)

FFT Inpatients/Day Case - National, Regional, Cheshire & Mersey

(IP/DC) Assurance: The Trust consistently passes the target.

(IP/DC) Variation: Common Cause (Normal) variation.

(ED/UCC) Assurance: The Trust consistently fails the target.

(ED/UCC) Variation: Common Cause (Normal) variation

Inpatients - WHH achieved a 97% positive recommendation rate in April 2025. Reflecting on the previous 12 months comparable data, WHH continues to achieve higher positive response rates in comparison to regional and national figures.

ED/UCC - The Trust increased to a 76% positive feedback in Friends and Family Test results for April 2025. The main negative feedback theme continues to be waiting time, staff attitude and the environment. It is acknowledged these themes are also noted as areas for positive feedback also from a large volume of patients.

Monitoring of themes trust wide and at CBU level, through the FFT Dashboard to identify areas for improvement and share best practice at the Patient Experience and Inclusion Sub-Committee (PEISC).

Actions are identified for each area and also monitored via PSEISC Trust Board, Governors, Senior Leaders, PLACE and Patient Experience Team observations are fed back to wards/department with action plans initiated and monitored via governance structures.

Quality Priority set for 2025 to achieve Accessible Information Standards to support patients and reasonable adjustments required.

Patient Experience and Inclusion Team continuing FFT improvement programme to increase response rates, enhance reporting functions, and encourage learning with additional training to support CBUs.

Plan in place to reduce paper surveys moving to more digital responses in a bid to aid real time feedback.

18. Mixed Sex Accommodation Breaches (ITU Only)
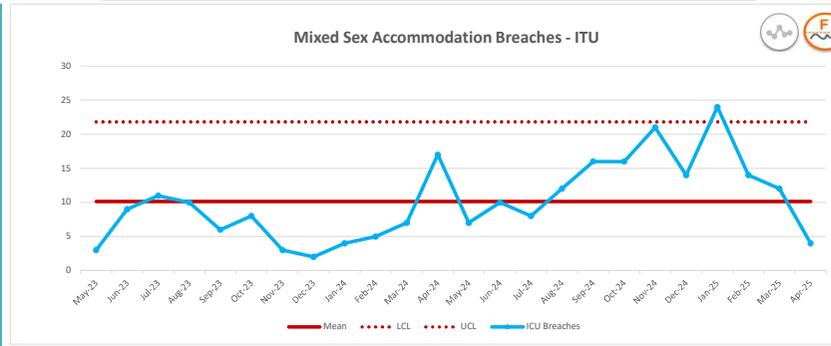
Target: Zero

There were 0 mixed sex accommodation (MSA) incident(s) outside of the ITU in month. There were 4 MSA incident(s) within the ITU.

Mixed Sex Accommodation Breaches - ITU

Assurance: The Trust consistently fails the target.

Variation: Common Cause (Normal) variation

There were 4 mixed sex breaches in April 2025, this is a decrease of 8 compared to March 2025. These were all within the Intensive Care Unit.

Any delays in discharges are escalated to patient flow Team and the Tactical Manager of the day. They are also discussed at each Bed Meeting throughout the day.

There were 0 breaches within any other ward areas.

Work continues within the Care Group and with Patient Flow to ensure prioritisation is given to ITU to step down level 1 patients to the appropriate areas.

As there are a high number of super stranded patients across the hospital this greatest additional challenges in stepping patients down to wards. Mixed Sex accommodation policy is currently being updated, this will be ratified in Q2.

Quality Improvement - Trust Position

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Performance	Trend	Statistical Narrative	reasons for the	How are we going to improve the position (Short & Long Term)?

19. Sepsis - % screening for all emergency patients.

Target: 90%

20. Sepsis - % screening for all inpatients

Target: 90%

The Trust achieved:

• 54% Sepsis screening for all emergency patients with suspected sepsis within 1 hour.

• 70% screening for all inpatients with suspected sepsis within 1 hour.
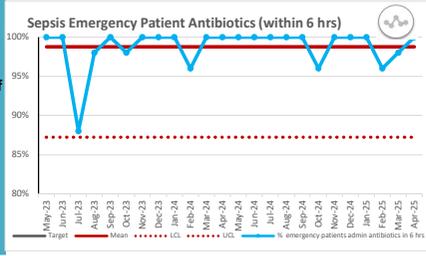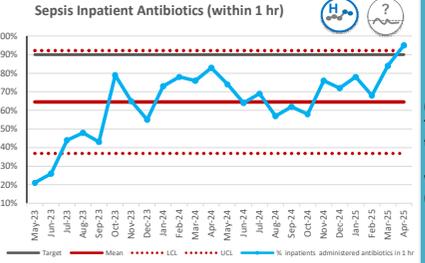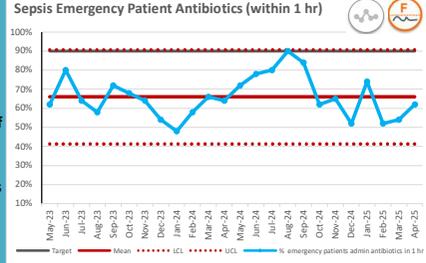
Blood Cultures:

• 56% screening for Emergency patients with suspected sepsis within 1 hour.

• 75% screening for Inpatients with suspected sepsis within 1 hour.

Lactate:

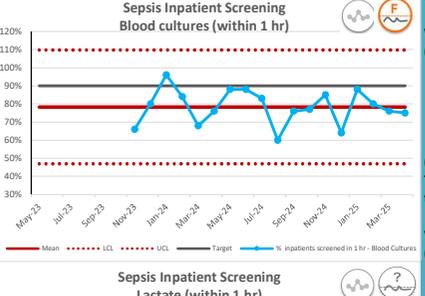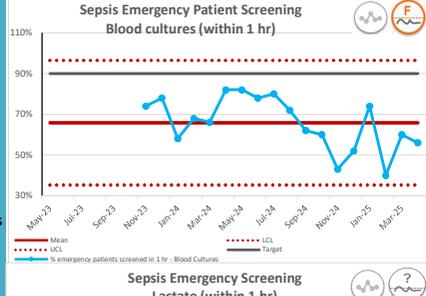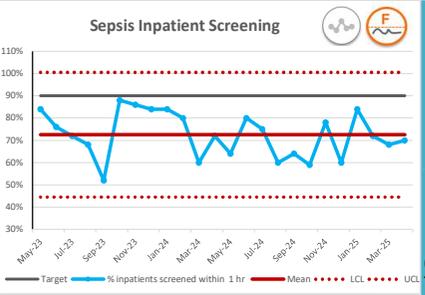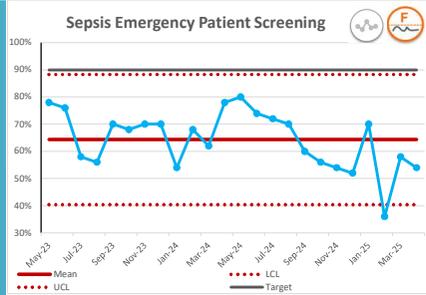• 94% screening for Emergency patients with suspected sepsis within 1 hour.

• 95% screening for Inpatients with suspected sepsis within 1 hour.

Sepsis Emergency Patient Screening

Sepsis Inpatient Screening

Sepsis Emergency Patient Screening Blood cultures (within 1 hr)

Sepsis Inpatient Screening Blood cultures (within 1 hr)

Sepsis Emergency Screening Lactate (within 1 hr)

Sepsis Inpatient Screening Lactate (within 1 hr)

(Emergency) Assurance: The Trust consistently fails the target.

Variation: Common Cause (Normal) variation

(Inpatient) Assurance: The Trust consistently fails the target.

Variation: Common Cause (Normal) variation.

The new NICE Guideline 51 was implemented in September 2024. This changed the guidance for the time at which the one-hour clock starts counting, is now taken from when the patient observations (NEWS2 score) resulting in the identification of level of risk e.g. moderate or high risk as opposed to red and amber flags which was previously later in the pathway. Previously this was from when clinical staff document that Sepsis is suspected, and the Sepsis Tool was launched on Lorenzo.

Clinical Education have prioritising training for HCAs in ED throughout Q1. Patient Safety Improvement Nurses have devised a visual prompt sticker for use for patients with suspected sepsis in ED. Regular training sessions are being held with frontline staff. Single Point Lessons are being provided on how to access the Sepsis Tool , these continue to be promoted across all areas, as well as completion of e learning package.

ED commenced a Test of Change in Q1 relating to launch of the Sepsis Tool and prioritisation of blood cultures. HCSWs in ED training to undertake blood cultures more training planned throughout Q2 for new staff members.

ED blood trollies have been adapted with the bottom two drawers now containing sepsis screening equipment/consumables. Department Manager undertaking two weekly reviews on completion of the sepsis pathway and daily checks on sepsis bundles in notes. Manager attends daily safety huddles to remind staff regarding escalation pathway and process.

Compliance data is shared monthly with Lead Nurses and discussed at Operational Patient Safety Group. Updated draft Sepsis Policy has been completed and is being reviewed with maternity/obstetrics for ratification in Q2..

21. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag

Target: 90%

22. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis

The Trust achieved:

• 62% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made.

• 100% of emergency patients with suspected sepsis were administered antibiotics within 6 hours of a diagnosis of sepsis being made.

• 95% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.

• 100% of inpatients had antibiotics administered within 6 hours of a diagnosis of sepsis being made.

Sepsis Emergency Patient Antibiotics (within 1 hr)

Sepsis Inpatient Antibiotics (within 1 hr)

Sepsis Emergency Patient Antibiotics (within 6 hrs)

Sepsis Inpatient Antibiotics (within 6 hrs)

(Emergency 1hr) Assurance: The Trust consistently fails the target.

Variation: Common cause (normal) cause variation.

(Inpatient 1hr) Assurance: The Trust consistently fails the target.

Variation: Special Cause Variation of a concerning nature.

Compliance with antibiotics prescription and administration has improved within inpatient wards.
100% of patients received antibiotics within 6 Hours

The main challenge is due to the changes in the time the clock starts counting which is now when the NEWS triggers a moderate or high risk. This is following the change to the N51 guidance in September 2024. For many patients this can be at Triage or early on in the care pathway.

To continue education and training regarding the importance of timely antibiotics prescription and administration. From the audit done by PSIN Team, doctors who did not prescribe the initial dose of antibiotics have been contacted directly to make them aware of the importance of the initial stat dose.

Services have been encouraged to launch the Sepsis Tool on suspicion of Sepsis to support timely decision making. A single point lesson on how to access the tool continues to be promoted Trust-wide. The new e-learning package continues to be promoted for completion. Laptop aids providing information about launching the tool have been recirculated.

Compliance data is shared monthly with Lead Nurses and discussed at Operational Patient Safety Group.

Quality Improvement - Trust Position

Trust Performance

Trend

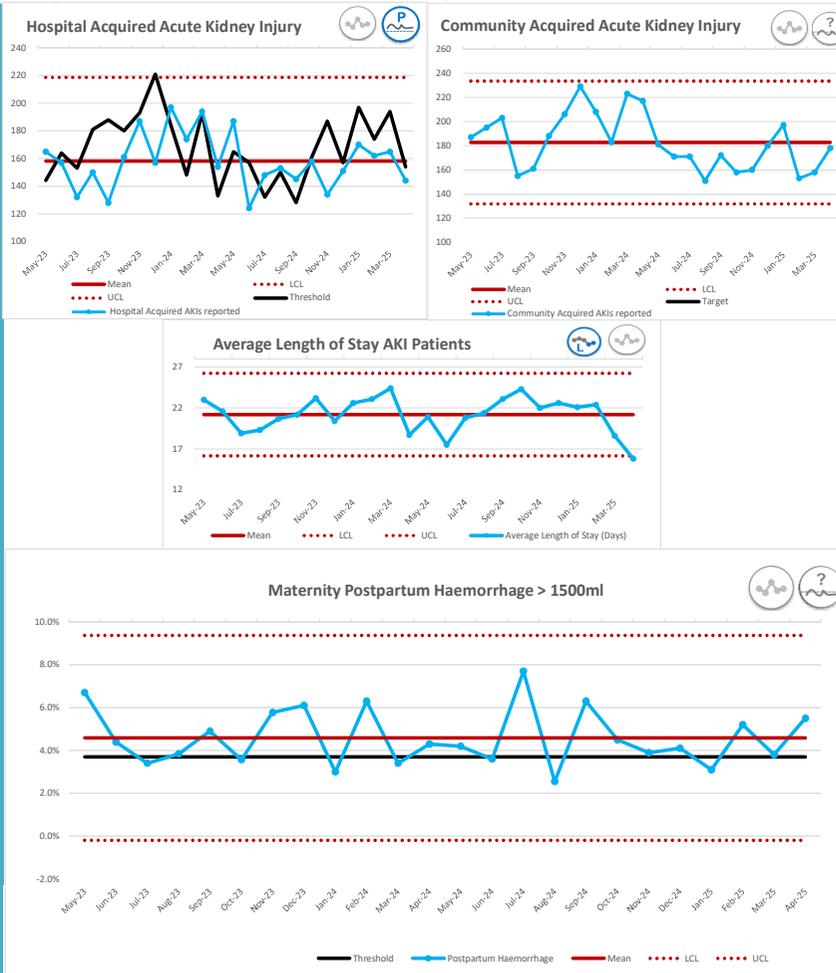**Statistical Narrative**

reasons for the

How are we going to improve the position (Short & Long Term)?

23. Acute Kidney Injury

Target: Less than month in previous year

There were 144 acute kidney injuries reported in month compared to 165 last month.

Hospital Acquired Acute Kidney Injury

Legend: Mean | LCL | UCL | Threshold | Hospital Acquired AKIs reported

Community Acquired Acute Kidney Injury

Legend: Mean | LCL | UCL | Target | Community Acquired AKIs reported

Average Length of Stay AKI Patients

Legend: Mean | LCL | UCL | Average Length of Stay (Days)

Assurance: The Trust Consistently passes the target.

Variation: Common Cause (Normal) variation.

No Variation with LOS and HA-AKI with both being below the mean and HA-AKI below target.

Length of stay has significantly reduced .

There is Trust wide focus on accurate and appropriate fluid balance chart completion. This does not just impact AKI but supports the early recognition of the deteriorating patient. AKI e-learning package simplifies understanding of AKI and promotes increased awareness to complete fluid balance charts. Updated fluid balance guidelines now more clearly define roles and responsibilities.

The AKI lead presented at Chief Nurse Check In February 2025 to raise awareness

Day to day ward-based AKI education by the AKI lead.

24. Maternity Postpartum Haemorrhage >1500ml

Threshold: < 3.7%

There were 5.5% Postpartum Haemorrhages >1500ml in month.

Maternity Postpartum Haemorrhage > 1500ml

Legend: Threshold | Postpartum Haemorrhage | Mean | LCL | UCL

Assurance: The Trust inconsistently passes/fails the target.

Variation: Common cause variation.

Rates for PPH >1500ml continue to fluctuate. The service has received comparator data from the Cheshire and Mersey (C&M) Local Maternity and Neonates System which notes an average rate for C&M of 34/1000 births. The WHH rate is 46.3 cases per 1000 births.

PPH >1500mls will continue to be reviewed on an individual basis via governance processes but will also be subject to additional review through the Intrapartum Incident Review Group which meets regularly to review patterns and themes from incidents of PPH >1500ml. In addition a PPH QI Group has been working through processes. Several actions are now underway including sharing of good practice and the implementation of bespoke training package for resident doctors in relation to management of the 3rd stage of labour. A new regional guideline re PPH is due to be published shortly. Colleagues from WHH have participated in the regional working groups tasked with developing this guideline and many of the change ideas advocated by WHH will be included within the guideline.

The PPH QI working group have acknowledged there are limitations to the change ideas which can be trialled as a PDSA cycle whilst awaiting the guideline publication. Accordingly, it has been agreed to stand down the formal QI project. The working group will continue but change its focus to the implementation of new standards. The PPH action plan is reported monthly to QAC alongside an SPC chart which currently shows common cause variation but with some stability.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Quality Improvement - Trust Position

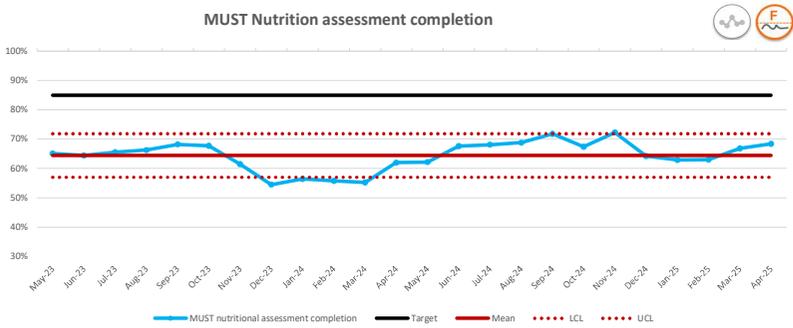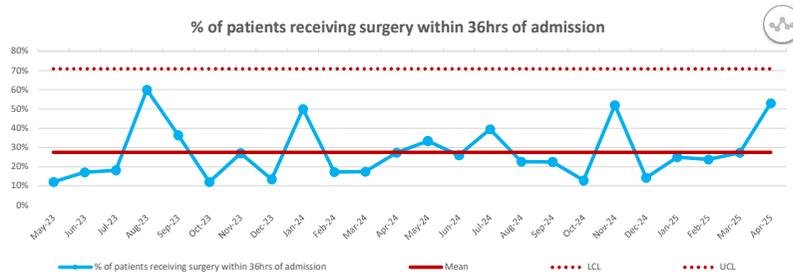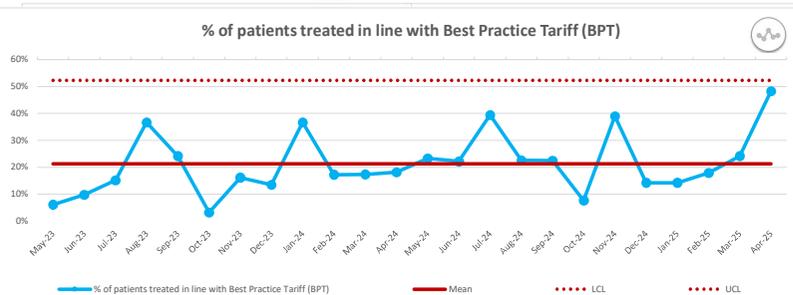| Trust Performance	Trend	Statistical Narrative	reasons for the	How are we going to improve the position (Short & Long Term)?

25. Fractured Neck of Femur

Target: Best Practice Tariff

48.28% of patients were treated in line with Best Practice Tariff (BPT) in Apr-25.

% of patients treated in line with Best Practice Tariff (BPT)

Legend: % of patients treated in line with Best Practice Tariff (BPT) — Mean — LCL — UCL

% of patients receiving surgery within 36hrs of admission

Legend: % of patients receiving surgery within 36hrs of admission — Mean — LCL — UCL

Variation: Common Cause (Normal) variation.

In April a total of 32 patients were included on the National Hip Fracture Database, of which a total of 28 would qualify for best practice tariff (BPT). Most of these patients were admitted either in March or April (29 patients out of 32 in total). 69% of the patients were admitted directly from A&E to the Orthopaedic Ward and all the outlying patients in this time period at some point to A6.

There was an improvement in waiting times for patients in A&E suggesting better bed availability on the acute ward and the average acute ward length of stay fall from 22 days in March to 15 in April, again suggesting that better bed availability was available for waiting patients.

April discharges noted improvements on BPT performance for a third consecutive month. Five of the eight BPT measurements achieved 100% whilst a further BPT measurement was 96% for post-op delirium screening.
Access to Theatre capacity remains a challenge, however improvements were noted in April 2025.

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April discharges noted improvements on BPT performance for a third consecutive month. Five of the eight BPT measurements achieved 100% whilst a further BPT measurement was 96% for post-op delirium screening. Access to Theatre capacity remains a challenge, however improvements were noted in April 2025.

26. MUST nutritional assessment completion

Target: above 85%

MUST Nutrition assessment completion was 68.43% in month.

MUST Nutrition assessment completion

Legend: MUST nutritional assessment completion — Target — Mean — LCL — UCL

Assurance: The Trust consistently fails the target.

Variation: Common cause (normal) variation.

MUST compliance continues to improve slowly, with work ongoing with clinical teams to improve this.

Work is been completed to improving the clinical indicators function on Lorenzo to enable teams to see that the compliance is about to turn red (amber status) giving teams the chance to complete and meet compliance. All EAU staff are receiving training as this area did not previously use the Risk assessment tool but now are required to due to patients having longer length of stay.

The Chief Nurse is holding Quality Summits with each ward to review compliance and plans for improvement. Wards are using test of change to utilise Ward Clarks to track performance and prompt staff daily these quality Initiatives are yielding positive results in the wards utilising this approach. This initiative has been shared with all wards.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Performance		Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	Term)?

27. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Not including WUTC)

Target: 78%

The Trust achieved 64.75% excluding Widnes UTC in month.

The target is set at 78%, which is the national aspiration for 2025/26

A&E Waiting Times - Under 4 hour wait (% excluding WUTC)

Assurance: The Trust consistently fails the target.

Variation: Common cause (normal) variation

28. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Including WUTC)

Target: 78%

The Trust achieved 68.92% excluding Widnes UTC in month.

The target is set at 78%, which is the national aspiration for 2025/26

A&E Waiting Times - Under 4 hour wait (% including WUTC)

Assurance: The Trust consistently fails the target.

Variation: Common cause (normal) variation

Performance continues to be negatively impacted by long length of stay and a overall high bed occupancy.
The target of 78% includes Widnes Type 3 activity which typically contributes a further 4.5%

• System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity in order to support flow.
• System resource investment in order to support Pathway 1 discharges.
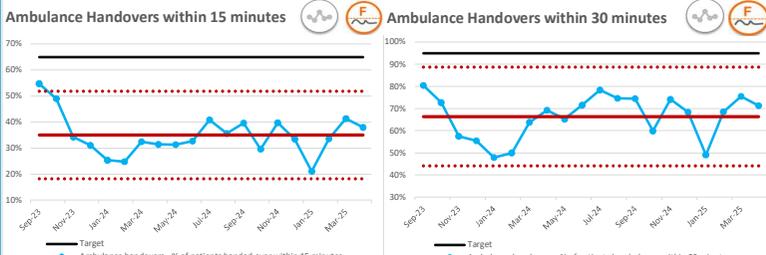• 21 Additional beds were opened on ward B4 in Feb to support the position, A10 remains open.
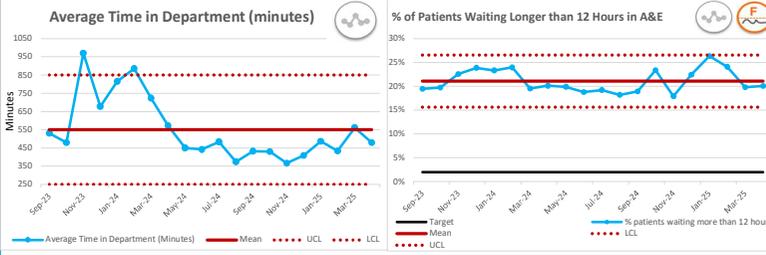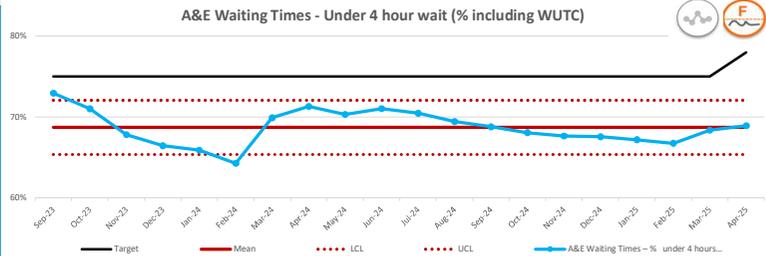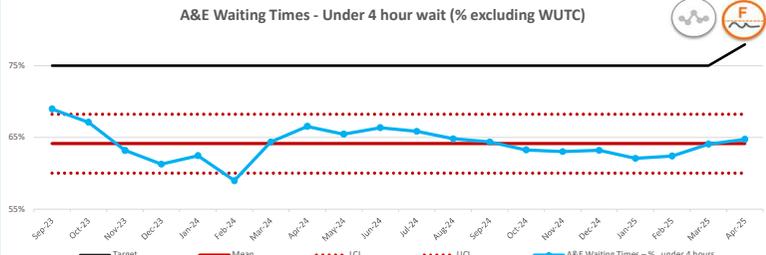
29. Average time in department ED
No Target

20.08% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 479 minutes.

Average Time in Department (minutes)

% of Patients Waiting Longer than 12 Hours in A&E

Assurance: No Target set

Variation: Common cause (normal) variation

Assurance: The Trust consistently fails the target.

Variation: Common Cause (Normal) Variation.

12 hour performance continues to be monitored. A key theme for the breaches is the high bed occupancy restricting flow through ED and Patients waiting Mental health assessment and placement comprises our longest delays in ED.

The Trust will continue to monitor and manage compliance around the 12 hour standard and is now one of 4 key indicators in the 2024/25 tiering of Urgent Care performance for ICBS. A service improvement for group for ED for 2024/25 is set up to support improvement.

30. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.

Target: 2% or less

In month the Trust achieved:

- 37.9% Ambulance Handovers within 15 minutes (65% target)

- 71.3% Ambulance Handovers within 30 minutes (95% target)

- 87.1% Ambulance Handovers within 60 minutes (100% target)

31. Ambulance Handovers within 15 minutes

Target: 65%

32. Ambulance Handovers within 30 minutes

Target: 95%

Ambulance Handovers within 15 minutes

Ambulance Handovers within 30 minutes

(15) Assurance: The Trust consistently fails the target.

Variation: There is Common Cause (normal) Variation.

(30) Assurance: The Trust consistently fails the target.

Variation: There is Common Cause (normal) Variation.

The Trust continues to work with NWAS to support improving this metric. A QA project has been initiated to support improving this metric, areas of concern are mainly out of hours

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	Term)?

Ambulance Handovers within 60 minutes

33. Ambulance Handovers within 60 minutes

Target: 100%

(60) Assurance: The Trust consistently fails the target.

Variation: There is Common Cause (normal) Variation.

Type 5 activity

34. Type 5 activity

No Target

Pre-November 2024 activity has been estimated as attendances that would be considered a 'Type 5' attendance.

In month there were 2262 Type 5 Attendances.

Assurance: N/A Trajectory Not Agreed.

Variation: Special Cause variation of an improving nature.

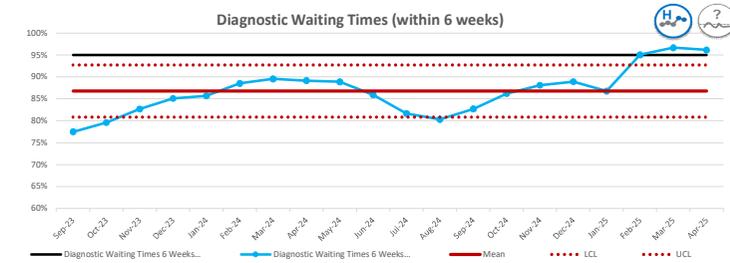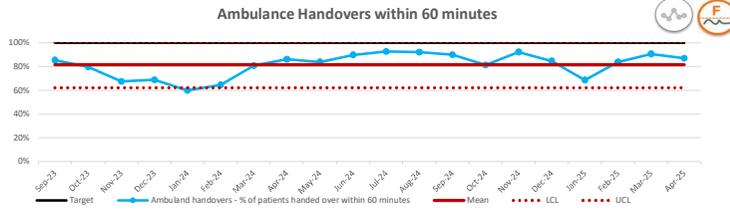As SDEC becomes more established the service is maturing and an increase in zero day admissions is seen.

Fracture Clinic - 72 Hours

35. Patients seen in the Fracture Clinic within 72 hours

Target: 95%

In monthy, the fracture clinic saw 73% of patients within 72 hours.

Assurance: The Trust inconsistently passes/fails the target.

Variation: Special cause variation of a concerning nature.

Compliance reduced to the number of bank holidays, this is being addressed to support creating additional capacity to avoid this in the future

This improvement is being sustained by the introduction of the Virtual Fracture clinic (VFC) and will be further improved with the introduction of e-trauma software to support the VFC implementation.

Diagnostic Waiting Times (within 6 weeks)

36. Diagnostic Waiting Times 6 Weeks

Target: 95%

The Trust achieved 96.13% in month.

Assurance: The Trust inconsistently passes and fails the target.

Variation: There is special cause variation of an improving nature.

The diagnostic target has been maintained for 3 consecutive months

This recovered position will continue to be monitored through Performance review group to ensure continued achievement.
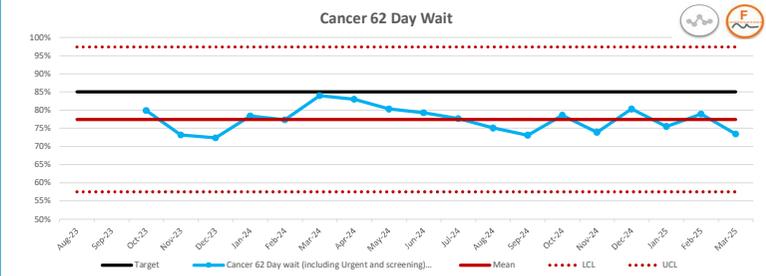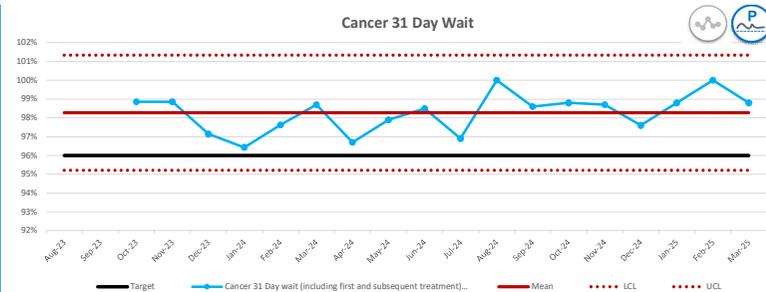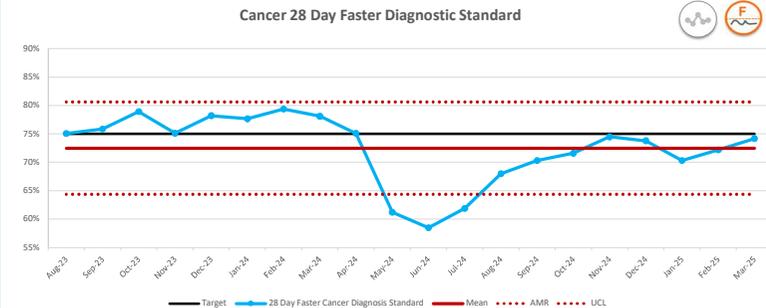
Trust Performance

Trend

Statistical Narrative

What are the reasons for the variation and what is the impact?

Term)?

37. Referral to treatment Open Pathways

Target: 92%

38. RTT - Number of patients waiting 52+ weeks

Target: 0

The Trust achieved 56.55% in month. There were 1528, 52 week breaches, 8, 78 week breaches and 124, 65 week breaches.

Referral to Open Pathways

Intervention: service improvement work and additional funding

Referral to Treatment - 52 + Week Waiters

Referral to Treatment - 65 + Week Waiters

Referral to Treatment - 78 + Week Waiters
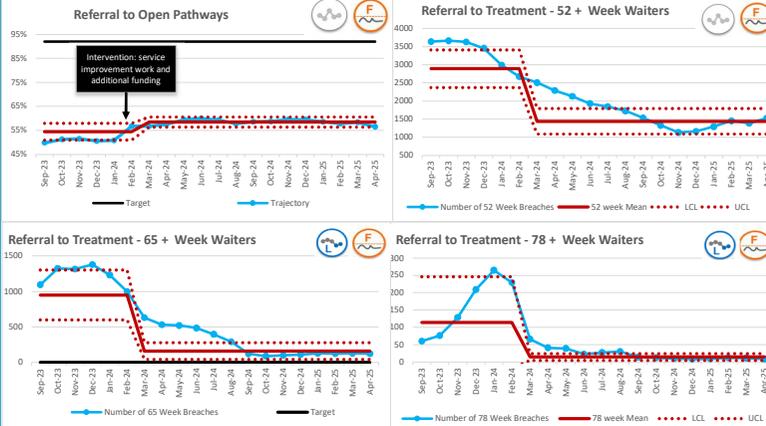
(Open Pathways) Assurance: The Trust consistently fails the target.

Variation: There is common cause variation.

(52+) Assurance: The Trust consistently fails the target.

Variation: There is common cause (normal) variation.

RTT performance - 52 weeks is behind trajectory, mainly in planned care. 65 weeks has a small residual number of patients remaining with 126 submitted for April. This continues to be within a few specialties, T&O, Gynae, Pain and Max Fax.

Recovery of the elective programme is taking place with:
• Elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of patients.
• Restoration and recovery plans for 2024/25 have been drawn up in line with current Operational Planning Guidance.
• Commencement of the TIF elective project has necessitated the closure of theatres 1 and 2 at Nightingale, Halton, sessions have been redistributed across both sites, once works have completed this will give an additional theatre at Halton Nightingale.

39. 28 Day Faster Cancer Diagnosis Standard

Target: 75%

The Trust achieved 74.2% in month.

Cancer 28 Day Faster Diagnostic Standard

Assurance: The Trust consistently fails the target.

Variation: Common Cause (Normal) variation.

Performance for the Faster Diagnosis Standard for March was 74.2%. The Trust is not currently meeting the 28 Day FDS. This has been due to specific issues with breast first appointment capacity which has affected performance. The capacity issue has resolved mid-July but the effect has continued into following months. This is a resolving position and a trajectory to reach the 77% stretch target by March 25 has been put in place. The trajectory has underperformed in January due to activity loss and patient choice over the Christmas period. The position in March remains under trajectory but is improving. There are longer term plans to achieve a sustained improvement in performance in gynae and lower GI pathways which will see significant improvement in Q2

Under the changes to Cancer Waiting Times standards that come into force on 1st October 2023 the operational standard will remain at 75% with a view to delivering 80% by March 2026 and an interim target of 77% by March 25.

The Trust will continue to monitor and review performance of this standard via the Performance Review Group (PRG). A recovery trajectory has been developed to monitor recovery.

40. Cancer 31 Day wait

Target: 96%

The Trust achieved 98.8% in month for Cancer 31 Day Wait.

Cancer 31 Day Wait

Assurance: Target met consistently.

Variation: There is Common Cause (normal) Variation.

The Trust achieved the 31 day target.

41. Cancer 62 Day wait

Target: 85%

The Trust achieved 73.4% in month for Cancer 62 Day Wait.

Cancer 62 Day Wait

Assurance: The Trust consistently fails the target. There is a commitment to achieveing 70% at March 25 required nationally. This is currently being met.

Variation: There is Common Cause (normal) Variation.

62-day wait for first treatment performance for March was 73.4%. The 62-day referral to treatment target remains challenging but is seeing some improvement due to the combined standards. From 1st October 2023 this standard was combined with 62-day screening and 62-day Consultant Upgrades. Whilst the operational standard remains at 85% there is a commitment to reach 70% by March 2025. The Trust is currently achieving this.

Operational Planning guidance for the next financial year indicates a commitment to reach 75% by March 2026 and a trajectory has been developed with the Cancer Alliance to achieve this.

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	Term)?

42. Reduction in Outpatient Follow Ups compared to 19/20 activity Target: 75% or less based on 2019/20 activity

Outpatient follow ups have reduced to 87.41% of 19/20 activity in month.

Reduction in Outpatient Follow Ups

Assurance: N/A Trajectory Not Agreed.

Variation: Common Cause (Normal) variation.

Outpatient follow ups is in line with the agreed trajectory as part of annual planning.

---

43. Elective Recovery Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20

In month, the Trust achieved the following % of activity against 2019. This included 99% of Daycase Procedures and 99% of Inpatient Elective Procedures.

Elective Recovery Daycase

Elective Recovery Inpatient

N/A - Grouped indicator.

Day case and inpatient elective activity continues to be managed in line

The Trust monitors progress weekly via Performance Review Group. Additional activity via Waiting List Initiative and Insourcing methods to undertake additional activity is being undertaken.

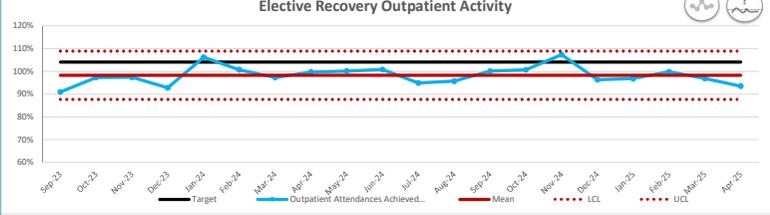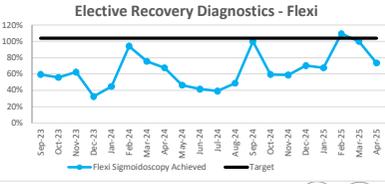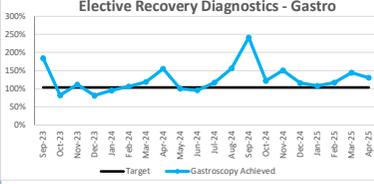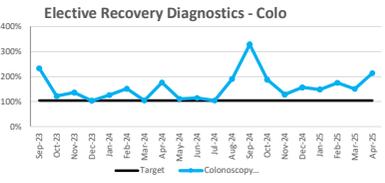**44. Elective Recovery Diagnostics Aggregate Target: 104% % activity is against activity in the same month in 2019/20**

In month, the Trust achieved the following % of activity against 2019.

This included:
134.2% of MRI
123.31% of CT
113.18% of Non-Obstetric Ultrasound
73.53% of Flexi Sigmoidoscopy
213.13% of Colonoscopy
130.04% of Gastroscopy

Elective Recovery Diagnostics - MRI

Elective Recovery Diagnostics - Ultrasound

Elective Recovery Diagnostics - CT

Elective Recovery Diagnostics - Colo

Elective Recovery Diagnostics - Gastro

Elective Recovery Diagnostics - Flexi

N/A - Grouped indicator.

Radiology modalities remain fully recovered, Challenges in Endoscopy due to the delay in the hub being operational which have now been resolved and on-going pressure within cardiorespiratory remain.

Challenges remain in Echo, mainly Stress Echo capacity.

The Trust continues to restore clinical services in line with the national operating guidance.

Additional insourcing support for Echo is being progressed to help reduce waiting times.

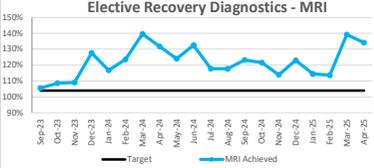Underperformance modalities are monitored at PRG with recovery trajectories in place for each service

---

45. Elective Recovery Outpatient Activity Aggregate Target: 104%

In month, the Trust achieved 93.54% of Outpatient activity.

Elective Recovery Outpatient Activity

Assurance: The Trust inconsistently passes/fails the target.

Variation: Common Cause (normal) variation

The Trust continues to deliver Outpatient activity in line with operational planning guidance

The Trust continues to restore clinical services in line with the national operating guidance.

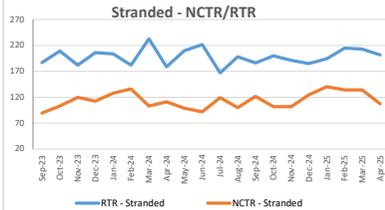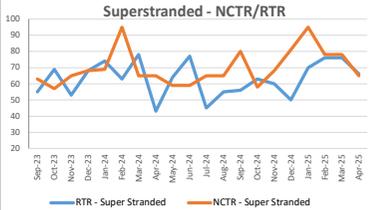The position will improve following completion of coding of OPD procedures.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Performance

Trend

Statistical Narrative

What are the reasons for the variation and what is the impact?

Term)?

46. Super Stranded Patients
Target: Trajectory

47. No Criteria to Reside (NCTR)

There were 309 stranded and 131 super stranded patients at the end of month. A Superstranded Patient Trajectory has not yet been agreed for 2023/24.

Super Stranded Patients
Number of Super Stranded Patients — Mean ···· LCL ···· UCL

Stranded Patients
Number of Stranded Patients — Mean ···· LCL ···· UCL

No Criteria to Reside
NCTR — Mean ···· LCL ···· UCL

Right to Reside
RTR — Mean ···· LCL ···· UCL

Superstranded - NCTR/RTR
— RTR - Super Stranded — NCTR - Super Stranded

Stranded - NCTR/RTR
— RTR - Stranded — NCTR - Stranded

(Super Stranded) Assurance: N/A Trajectory Not Agreed.

Variation: Common Cause (normal) variation.

(Stranded) Assurance: N/A Trajectory Not Agreed.

Variation: Common Cause (normal) variation.

(NCTR) Assurance: N/A Trajectory Not Agreed.

Variation: Common Cause (normal) variation.

(RTR) Assurance: N/A Trajectory Not Agreed.

Variation: Common Cause (normal) variation.

The Trust continues to monitor this inline with the operational planning guidance

The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available.

Trust Performance

Trend

Statistical Narrative

What are the reasons for the variation and what is the impact?

Term)?

48. % Patients discharged to their usual place of residence

Target: No Current Threshold

96.7% patients in month were discharged to their usual place of residence.

% Patients Discharged to usual place of residence

Legend: % Patients discharged to their usual place of residence — Mean ---- LCL ---- UCL
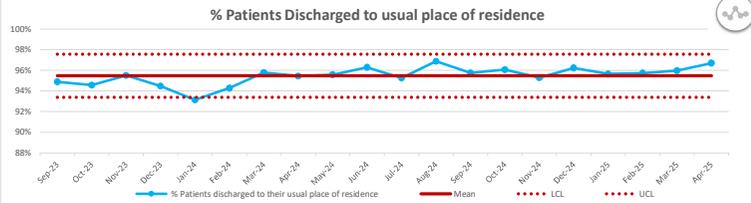
Assurance: N/A Trajectory Not Agreed.

Variation: Common Cause (normal) variation.

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49. Cancelled Operations on the day for a non-clinical reason

Target: Less than 2%

Cancelled operations for a non-clinical reason was 1.04% in month. 4 cancelled operation wss not offered a date for readmission within 28 days.

Cancelled Operations on the day for a non-clinical reason

Legend: Target — % of Cancelled Operations for a non-clinical reason — Mean ---- LCL ---- UCL
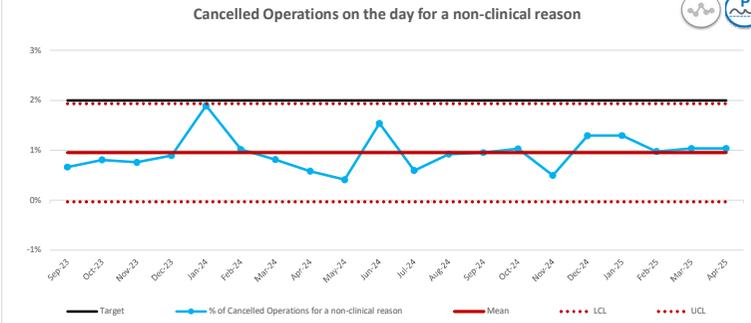
(Cancelled - non-clinical reason) Assurance: The Trust consistently passes the target.

Variation: Common Cause (normal) variation.

(Urgent Ops cancelled 2nd time) Assurance: The Trust consistently passes the target.

Variation: Common Cause (normal) variation.

A change in reporting following identification of a DQ issue has caused the variation in numbers, this remains inline with Peers.

Recovery of elective activity continues to be monitored via Performance review group. A discrepancy in reporting has been identified by analytics this will mean an increase in reporting, it is anticipated that this will keep us in line with peers, this is reflected in the increase in position.

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50. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation

Target: ZERO

Number of Cancelled operations on the day for non-clinical reason - Not offered date for readmission within 28 days

Legend: Target — Not offered a date for readmission within 28 days of the cancellation... — Mean ---- LCL ---- UCL

(Not offered 28 days) Assurance: The Trust consistently fails the target.

Variation: Common Cause (normal) variation.

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51. Capped Theatre Utilisation

Target: 85%
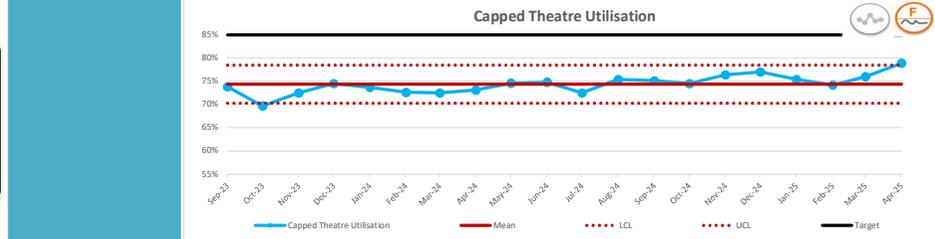
Capped Theatre Utilisation

Legend: Capped Theatre Utilisation — Mean ---- LCL ---- UCL — Target

Assurance: The Trust consistently fails the target.

Variation: Common Cause (Normal) Variation.

The Planned Care Transformation Group is working on aligning the activity to the British Association of Day Surgery and the opportunities to increase day case rates.

Areas of focus are on Urology, Breast Surgery & Gynaecology. The transformation team is working with the CBUs and clinical teams to increase the rates.
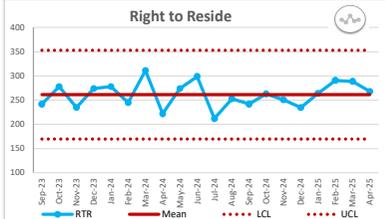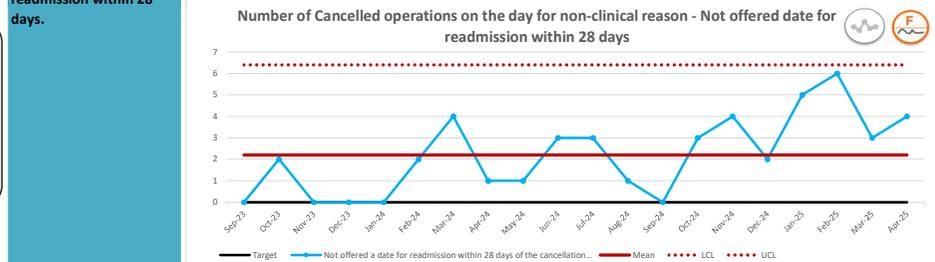
NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?

52. Supporting Attendance
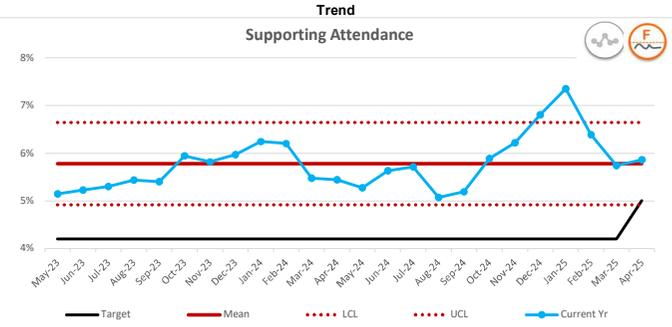Target: Below 5%

The Trust's sickness rate was 5.86% in month.

Supporting Attendance

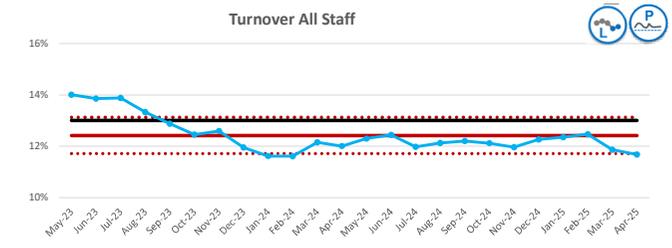**Assurance:** The Trust consistently fails the target.

Variation: Common cause (normal) variation.

Sickness absence consistently fails to meet the 5% target, and is showing a variation of a concerning nature, but recently reduced to the monthly average and therefore within the upper and lower limits.

From further analysis, long term sickness is showing an improving nature however short term sickness is showing a concerning nature.

The Trusts pro-active health interventions and wellbeing offers continue to be well utilised and the Trust has received both national and local recognition the initiatives in place. The Trust has seen a significant improvement in long term sickness absence rates following transition on to the new Supporting Attendance policy, reducing from 4.39% in April 2022 to a monthly average of 3.8% which continues to improve.
Actions to improve the position include:
Support continues within areas of high sickness. Providing coaching support to managers, compliance audits and communication campaigns.
New stage 3 absence process has been successfully piloted to provide a compassionate and dignified exit out of the organisation on the grounds of ill health capability.
Reviewing health inequalities data to inform proactive health interventions for staff.

53. Turnover
Target: Below 13%

The Trust's turnover of all staff was 11.68% in month.

Turnover All Staff

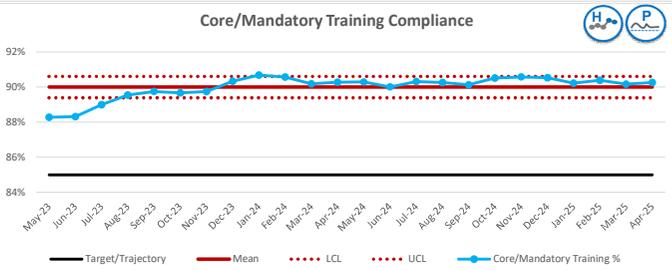**Assurance:** The Trust consistently passes the target.

Variation: Special Cause Variation of an improving nature.

Turnover is showing an improving nature and performing in line with Trust target and monthly average. It consistently passes the Trust target of 85%.

The latest Staff Survey results demonstrate that all 9 measures scored above national average and the Health Service Journal (HSJ) reported that WHH scored in the top five Trusts in the North West for recommending the organisation as a place to work. Service leads are developing key priorities against their local staff survey results to deliver during 2025/26 supporting areas to make further improvements based on the results.

Work/life balance remains the main reason people leave WHH. The #MyFlex campaign continues to be promoted, and following successfully launching a preference rostering approach in two ward areas, options to further rollout this approach are being developed.

54. Core/ Mandatory Training
Target: 85%

Core/Mandatory training compliance was 90.26% in month.

Core/Mandatory Training Compliance

Assurance: The Trust consistently passes the target.

Variation: Special Cause Variation of a improving nature.

In April 2025, CSTF Mandatory Training compliance was 90.26%.

Care Groups report compliance at Operational People Committee with actions required to ensure targets are met.

National changes have been mandated regarding how Trusts deliver CSTF training. There are limited changes to WHH as the Trust has always closely followed the national guidance using the systems provided. Where there is variation, the Trust has made submissions nationally referencing the relevant legislation for consideration.

55. PDR
Target: 85%

Annualised PDR compliance was 79% in month.
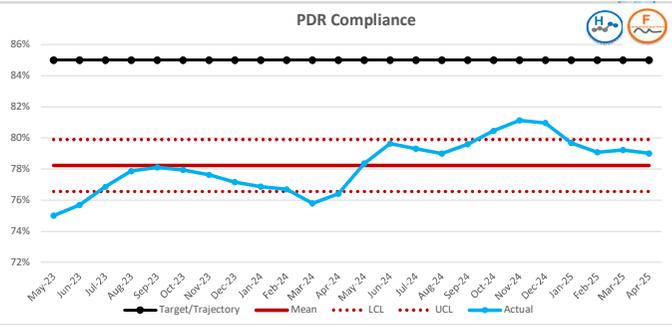
PDR Compliance

Assurance: The Trust consistently fails the target.

Variation: Special Cause Variation of a improving nature.

PDRs continue consistently to fail to meet the 85% target. Upon further analysis, this is mirrored across all staff groups.

A number of corporate areas are now achieving PDR target following achievement of the trajectories set, and a number of CBUs have improved significantly over the last 12 months, but still perform below target.

OPC continues to focus on PDR compliance with Care Groups reporting actions to address the below target compliance. The Trust has now set PDR compliance as one of the key workforce priorities for 2025/26.

Trend

Trust Financial Position - In Month

Trust Financial Position - Cumulative

Statistical Narrative

At month 1 the Trust has recorded a deficit position of £4.7m (before deficit support) which is in line with plan.

What are the reasons for the variation and what is the impact?

There is no variation at month 1, the deficit position is in line with plan.

How are we going to improve the position (Short & Long Term)?

Work is ongoing to identify additional CIP schemes, reduce cost pressures and increase activity delivery.

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56. Trust Financial Position

Target: Plan

Cash Balance

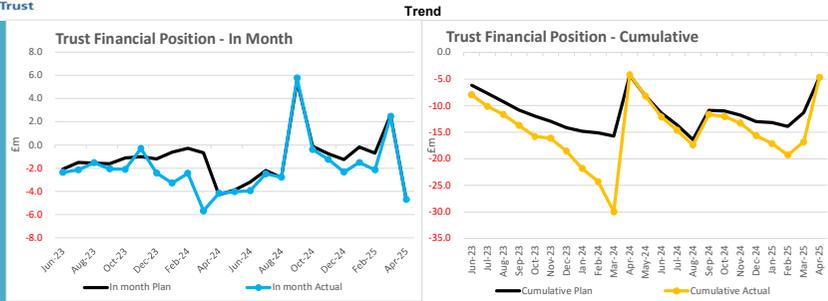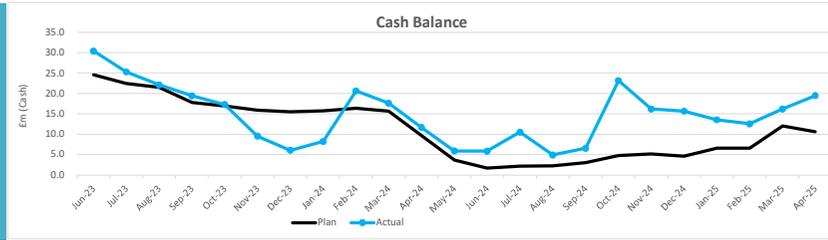**The cash balance at 30 April 2025 is £19.5m.**

The current cash balance is £19.5m which is £8.8m higher than the cash plan. This is predominantly due to an increase in unpaid creditors in April. Of the £19.5m cash, £7.3m is related to capital creditors.

The finance team produces a daily cashflow and before payment runs are made a senior review is undertaken. Weekly reviews of non-NHS and NHS payments are being undertaken to determine whether payments can be deferred without incurring late payment interest charges.

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57. Cash Balance

Target: On or better than plan

Capital Programme

Assurance: The Trust consistently fails the target.

Variation: Special Cause Variation of a declining nature.

Capital expenditure at the end of month 1 is £0.1m against a plan of £0.3m. This is due to timing and is expected to be fully delivered by year end.

The reason for the year to date variance is due to timing and is expected to be fully delivered by year end. The risk associated with delivering the 2025/26 capital plan is being monitored at CPG and reported to FSC.

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58. Capital Programme

Target: On plan 90%-100%

Better Practice Payment Code (Month)

Better Practice Payment Code (Cumulative)

Assurance: The Trust consistently fails the target.

Variation: Special Cause Variation of a declining nature.

Cumulative BPPC performance is 53% which is below the national target of 95%.

The main reason for this is due to cash management measures put in place to mitigate against the Trust's worsening cash position. £2m income from C&M ICB was not received in April 2025 as planned. This related to deficit support funding and the late changes to the contract position for convergence and deficit repayment and has subsequently been received in May 2025. The delay in payment reduced the cash available to meet payment commitments during April 2025.

BPPC is being closely monitored, especially due to cash shortages. This includes daily cash monitoring, ensuring wherever possible we pay SME. BPPC is unlikely to reach the 95% target given the cash position of the Trust.

---

59. Better Payment Practice Code

Target: Cumulative performance 95%

Trend   **Statistical Narrative**   **What are the reasons for the variation and what is the impact?**   **How are we going to improve the position (Short & Long Term)?**

60. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date

Target: >90% plan delivered YTD

CIP - In Year (% Delivered against plan)

CIP - In Year

Assurance: The Trust consistently passes the target.

Variation: Common cause (normal) variation.

At month 1 £0.8m has been delivered which is in line with plan.

CIP progress is reviewed internally and externally on a weekly and monthly basis. The Medical Director and Director of Strategy and Partnerships are leading the Improvement programme with the Operational Teams supported by Finance and the Improvement Leads to drive greater efficiency across the Trust. Work continues on QIA and PID completion of identified schemes as well as identification of additional schemes.

61. Cost Improvement Programme (recurrent) – In year performance to date

Target: >90% plan delivered YTD

CIP recurrent- In Year (% Delivered against plan)

Recurrent CIP - In Year
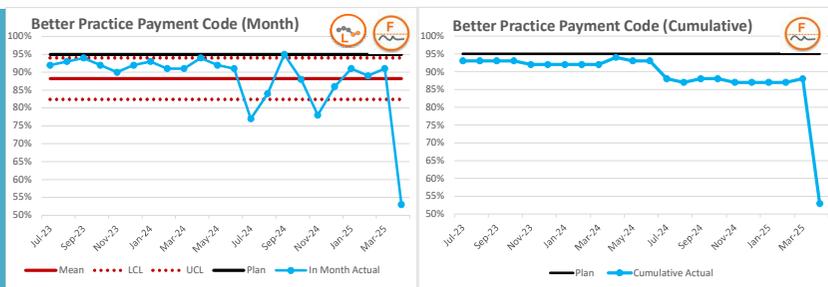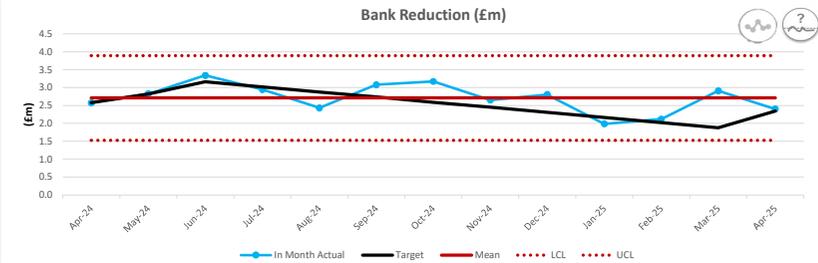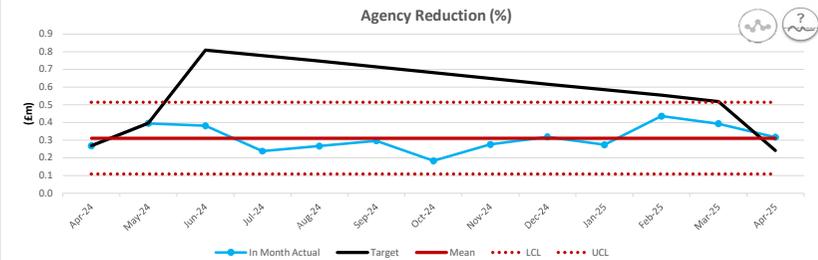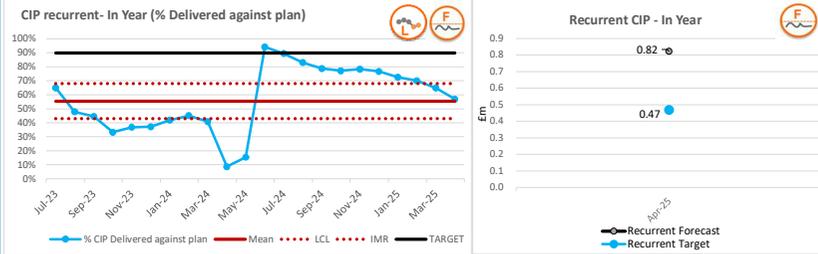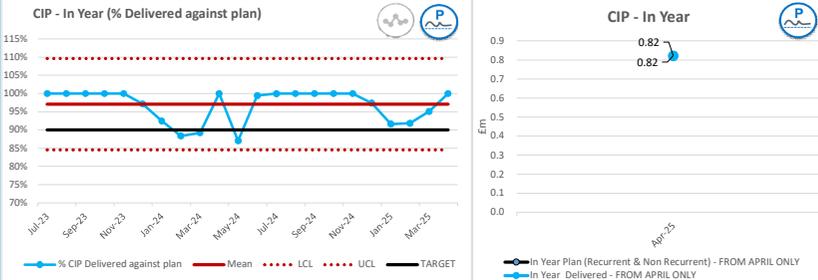

Assurance: The Trust consistently fails the target.

Variation: Special Cause Variation of a declining nature.

£0.5m CIP has been delivered recurrently against the target of £0.8m.

The Trust aims to deliver CIP recurrently wherever possible and challenges if CIP is not recurrent.

Where recurrent CIP has not been realised, efforts have been made to deliver the CIP on a non-recurrent basis rather than not achieving at all.

Work continues to identify recurrent CIP schemes. To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Health and GIRFT are being used.

62. Agency Reduction

Target: 30% reduction of 2024/25 plan

Agency Reduction (%)

Assurance: The Trust inconsistently passes/fails the target.

Variation: Common cause (normal) variation.

In line with operational planning guidance the agency reduction requirement is 30% of the 2024/25 plan (£5.1m). The annual budget has been set at a lower value (£2.9m).

At month 1, agency expenditure is overspent by £0.1m compared to budget however remains below the £5.1m target set by the ICB. The main booking reason for agency usage is vacancies. April expenditure is lower than February and March.

Significant progress has been made on agency reduction and agency expenditure will continue to be reviewed throughout the year to ensure that it stays below the target set.

63. Bank Reduction

Target: 10% reduction of 2024/25 plan

Bank Reduction (£m)

Assurance: The Trust inconsistently passes/fails the target.

Variation: Common cause (normal) variation.

In line with operational planning guidance the bank reduction requirement is 10% of the 2024/25 plan which is the same as the annual budget (£27.6m). At M1 bank expenditure is overspent by £0.1m, however, expenditure is below month 12.

Actions have been taken to reduce bank spend. Medical bank has decreased by £0.1m and nursing has reduced by £0.2m compared to the 2024/25 average. However, the reduction in usage has not been sufficient to achieve the plan in month 1 in particular Adult A&E Nursing due to short term sickness, A&E Medical due to vacancies and Ward A9 due to enhanced care requirements.

A number of additional controls have been put in place as a result of the PwC work including bank sign off by the Chief Nurse and Deputy Chief Nurse. The nurse bank rate was reduced during 2024/25 and has reduced again from 1 May 2025.

Appendix 3 – Trust IPR Indicator Overview

Indicator	KPI	Detail	Target	Additional Context
		Number of incidents reported in month.		Nationally incidents are no longer referred to as SIs. This has been replaced by PSIIs in accordance with the nationally mandated Patient Safety Incident Response Framework.
Incidents	**1**	Number of incidents open over 40 days.	0	
		Total PSIIs recorded in month.		
		Number of PSII Actions Breached.		
		Number of never events reported in month.		
		Number of 'prevention of future death' orders.		
Healthcare Acquired Infections (MSSA, MRSA, Ecoli, Klebsiella, CDI and PA Gram Negative)	**2**	Meticillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans.	Threshold not yet set for 2025/26	
	3	MSSA, or methicillin-susceptible Staphylococcus aureus, is an infection caused by a type of bacteria commonly found on the skin.		
	4	Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel.		
	5	Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections.		
	6	Klebsiella is a type of Gram-negative bacteria that can cause different types of healthcare-associated infections, including pneumonia, bloodstream infections, wound or surgical site infections, and meningitis.		
	7	Pseudomonas aeruginosa can cause infections in the blood, lungs (pneumonia), or other parts of the body after surgery.		
VTE Assessment	**8**	Venous thromboembolism (VTE) is the formation of blood clots in the vein. This data looks at the % of assessments completed in month, however this indicator is reported quarterly.	>= 95%	
Inpatient Falls & Harm Levels		Total number of falls which have occurred in month.		
		Falls per 1000 bed days in month.		
	9	Total number of inpatient falls which have occurred in month.	10% decrease from previous year	
		Levels of harm reported as a result of a fall in month for inpatient and ED falls.		
	10	Pressure Ulcers (Categories 2, 3 and 4)	20% reduction on previous year	Pressure ulcers, also known as pressure sores, bedsores and decubitus ulcers, are localised damage to the skin and/or underlying tissue that usually

				occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction. Pressure ulcers are reported by Category (2,3 & 4).
		Community Acquired Pressure Ulcers		
Medication Safety	**11**	Medication reconciliation within 24 hours.	>=80%	Overview of the current position in relation to medication, to include:
		Medication reconciliation throughout the inpatient stay.		
Staffing Average Fill Levels	**12**	Staffing - Average Fill Rate - Day nurses/midwives		Percentage of planned verses actual fill rates for registered and non-registered staff by day and night. The data produced excludes CCU, ITU and Paediatrics.
		Staffing - Average Fill Rate - Day care staff		
		Staffing - Average Fill Rate - Night nurses/midwives		
		Staffing - Average Fill Rate - Night care staff		
		Staffing - CHPPD Benchmarking		
HSMR Mortality Ratio	**13**	Hospital Standardised Mortality Ratio (HSMR 12 month rolling). 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 Clinical Classification System (CCS) groups.	Plan	
SHMI Mortality Ratio	**14**	Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	Plan	
Complaints	**15**	Number of new complaints.		
		Total number of cases over 6 months old in month.	0	
		Dissatisfied complaints in month (pre April 2025 classed as 'reopened in month')		
		Number of PALS complaints received and closed in month.		
Friends and Family Test (Inpatient & Day Cases)	**16**	Percentage of Inpatients and day case patients responding as "Very Good" or "Good". Patients are asked - Overall, how was your experience of our service?	95%	
		National, Regional, Cheshire & Mersey positive response rates for Benchmarking		
Friends and Family (ED and UCC)	**17**	Percentage of AED (Accident and Emergency Department) patients responding as "Very Good" or "Good". Patients are asked - Overall, how was your experience of our service?	87%	
Mixed Sex Accommodation Breaches (ITU)	**18**	Number of MSA Breaches in month (ITU).	0	Due to no Mixed Sex Accommodation breaches being recorded outside of ITU over the past 24 months, it will be more effective to monitor ITU breaches.

	19	Sepsis Emergency Patient Screening	>=90%	
	20	Sepsis Inpatient Screening	>=90%	
		Sepsis Emergency Patient Screening Blood cultures (within 1 hr)	>=90%	
		Sepsis Inpatient Screening Blood cultures (within 1 hr)	>=90%	
		Sepsis Emergency Screening Lactate (within 1 hr)	>=90%	
Sepsis		Sepsis Inpatient Screening Lactate (within 1 hr)	>=90%	To strengthen oversight of sepsis management in regard to treatment and screening. All patients should be screened within 1 hour and if necessary administered anti-biotics within 1 hour.
	21	Sepsis Emergency Patient Antibiotics (within 1hr)	>=90%	
		Sepsis Emergency Patient Antibiotics (within 6hrs)		
	22	Sepsis Inpatient Screening (within 1hr)	>=90%	
		Sepsis Inpatient Screening (within 6hrs)		
		Monthly out of hour (10pm-6am) ward moves		
		Average qty of Ward moves per patient with an alert		
Acute Kidney Injury	**23**	Number of hospital acquired Acute Kidney Injuries (AKI) in month.	Less than month in previous year	
		Number of community acquired Acute Kidney Injuries (AKI) in month.		
		Average Length of Stay (LoS) of patients within a AKI.		
Postpartum Haemorrhage >1500ml	**24**	To monitor rates of PPH (Postpartum haemorrhage) >1500mls against North West Coast Regional Dashboard.	<3.7%	To monitor rates of PPH (Postpartum haemorrhage) >1500mls against North West Coast Regional Dashboard. PPH>1500ml is a significant obstetric emergency with potential for harm. WHH is currently an outlier for PPH>1500mls when compared to the North West Coast Maternity Dashboard.
Fractured Neck of Femur	**25**	The % of patients treated in line with Best Practice Tariff (BPT).		The Best Practice Bundle has been shown to significantly improve outcomes (set out by The National Hip Fracture Database (nhfd.co.uk)). Shorter time to theatres significantly reduces risk of mortality and improves pain.
		% of patients receiving surgery within 36hrs of admission		
MUST nutritional assessment completion	**26**	MUST Nutrition assessment completion	>85%	To monitor completion of the MUST assessment tool to reduce risk of malnutrition on admission to hospital (NICE). In hospital, disease-related malnutrition has been shown to result in increased wound infections, chest infections and pressure ulcers; increased length of admission; increased numbers of re-admissions; and increased overall morbidity

Access & Performance

Under 4 hour A&E Wait time Target and ICS Trajectory (excluding WWIC)	27	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge.	>78% (national objective)	
Under 4 hour A&E Wait time (including WWIC)	28	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge.	>75%	because of the pandemic, the commissioning changes didn't happen. As such, it has been confirmed that WHH's 4-hour position is to still benefit from the Widnes UTC 50% split. This gives WHH's "All Type 4 hour" position is to still a c5% positive increase. Now this has been confirmed, we have re-formatted the 4-hour performance reports to show an including and excluding Widnes UTC position.
Average Time in Department (ED)	29	How long on average a patient stays within the emergency department (ED).		
A&E Waiting Times – % patients waiting under 12 hours from arrival to admission, transfer or discharge.	30	% of patients who has experienced a wait in A&E longer than 12 hours from arrival to admission, transfer or discharge.	<=2%	
Ambulance Handovers 15	31	% of ambulance handovers that took place within 15 minutes (based on the data recorded on the HAS system).	>65%	
Ambulance Handovers 30–60 minutes	32	% of ambulance handovers that took place within 30 minutes (based on the data recorded on the HAS system).	>95%	
Ambulance Handovers – more than 60 minutes	33	% of ambulance handovers that took place within 60 minutes (based on the data recorded on the HAS system).	100%	
% of zero-day length of stay admissions (Type 5)	34	Type 5 activity		Following guidance from NHS Digital, since November 2023 we have been recording 'SDEC attendances' as a Type 5 A&E attendance instead, to include within ECDS. Type 5 attendances are for same day emergency care, they are not the same as an attendance at an Urgent Care Centre or Accident and Emergency department.
Fracture Clinic	35	Fracture Clinic - patients seen within 72 Hours	>95%	The British Orthopaedic Association recommends that patients referred to fracture clinic are thereafter reviewed within

				72 hours of presentation of the injury.
Diagnostic Waiting Times – 6 weeks	36	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made.	>95%	
RTT Open Pathways and 52 & 65 week waits	37	Referral to open pathways	>92%	The elective recovery plan was published in February 2022 and sets targets to reduce long waits for elective treatment – namely, to eliminate waits of over 104 weeks by July 2022, waits of over 78 weeks by April 2023, 65 week waits by March 2024, and 52 week waits by March 2025.
	38	Number of patients waiting over 52 weeks.	0	
		Number of patients waiting over 65 weeks.	0	
		Number of patients waiting over 78 weeks.	0	
Cancer 28 Days	39	Cancer 28 Day Faster Diagnostic Standard	>75%	All patients need to receive their first appointment for cancer within 14 days of urgent referral. All patients who are referred for the investigation of suspected cancer find out, within 28 days, if they do or do not have a cancer diagnosis. All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.
Cancer 31 Day wait	40	Cancer 31 Day wait	>96%	All patients to receive treatment for cancer within 31 days of decision to treat.
Cancer 62 Day wait	41	Cancer 62 Day wait	>85%	All patients to receive treatment for cancer within 62 days of decision to treat.
Reduction in Outpatient Follow Ups	42	% reduction in Outpatient follow ups compared to 19/20 activity.	<=75%	
Elective Recovery Activity	43	% of Elective Activity (Inpatients)	104%	
		% of Elective Activity (Day cases)	104%	
Elective Recovery Diagnostics	44	% of Elective Diagnostic Activity - MRI	month in previous year	
		% of Elective Diagnostic Activity - Non-Obstetric Ultrasound	month in previous year	
		% of Elective Diagnostic Activity - CT scans	month in previous year	
		% of Elective Diagnostic Activity - Flexi Sigmoidoscopy	month in previous year	
		% of Elective Diagnostic Activity - Gastroscopy	month in previous year	
		% of Elective Diagnostic Activity - Colonoscopy	month in previous year	

Elective Recovery Outpatients	**45**	% of Elective Recovery Outpatient Activity	104%	
Super Stranded Patients		Stranded Patients are patients with a length of stay of 7 days or more.		
	46	Super stranded patients are patients with a length of stay of 21 days or more. The number relates to the number of inpatients on the last day of the month.		
No criteria to reside (NCTR)	**47**	Number of patients with no criteria to reside		
		Number of patients with right to reside		
		Superstranded - qty of NCTR vs CTR		
		Stranded - qty of NCTR vs CTR		
% Patients discharged to their usual place of residence	**48**	% of patients who were discharged to their usual place of residence.		
Cancelled operations on the day for non-clinical reasons	**49**	% of operations cancelled on the day or after admission for non-clinical reasons.	<=2%	
Cancelled operations on the day for non-clinical reasons, not rebooked in within 28 days	**50**	Number of Cancelled operations on the day for non-clinical reason - Not offered date for readmission within 28 days	0	All service users who have their operation cancelled on the day or after admission for a non-clinical reason, should be offered a binding date for readmission within 28 days.
Capped Theatre Utilisation (measured as productive operating time only)	**51**	Capped theatre utilisation	>85%	Increase productivity and meet the 85% day case and 85% theatre utilisation expectations using Getting it Right First Time (GIRFT) and moving procedures to the most appropriate settings. Aim is to support providers and systems to maximise the effectiveness and throughput of their surgical theatres through improvements across the surgical elective pathway. As part of the High-Volume Low Complexity (HVLC) programme, GIRFT has set a target for Integrated Care Systems and providers to achieve 85% theatre touch time utilisation by 2024/25.

Workforce

Supporting Attendance	52	the monthly sickness absence % with the Trust Target (4.2%) previous year.	<5%	
Turnover	53	of the turnover % over the last 12 months.	<13%	
Core / Mandatory Training	54	of the Core/Mandatory Training Compliance, this includes:	>85%	Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation and most recently, safeguarding
Performance & Development Review (PDR)	55	of the PDR compliance rate.	>85%	

Finance

Trust Financial Position	56	Cumulative operating surplus or deficit compared to plan.	Plan	
		In month operating surplus or deficit compared to plan.	Plan	
Cash Balance	57	The cash balance at month end compared to plan.	Plan	
Capital Programme	58	Capital expenditure compared to plan.	Plan	
Better Payment Practice Code	59	Payment of non NHS trade invoices within 30 days of invoice date compared to target.	>95%	
Cost Improvement Programme – Plans in Progress in Year	60	Cost savings schemes in-year compared to plan.	>90% of annual target	
		CIP - In Year	plan	
Cost Improvement Programme – Recurrent	61	Cost savings schemes recurrent compared to plan.	>90% of annual target	
		Recurrent CIP - In Year	Plan	
Agency Reduction	62	Agency Reduction	30% reduction of 24/25 plan.	
Bank Reduction	63	Bank Reduction	10% reduction of 24/25 plan.	

Appendix 4 - Statistical Process Control

1.0 What is SPC?

Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes and both common cause (normal) and special cause (unexpected) variation.

2.0 SPC Charts

In addition to the process/metric being measured, SPC charts on the IPR have 3 additional lines.

- Mean – is the average of all the data points on the graph. This is used a basis for determining statistically significant trends or patterns.
- Upper Control Limit – the upper limit that any data point should statistically reach within expected variation. If any one datapoint breaches this line, this is what is known as special cause variation.
- Lower Control Limit – the lower limit than any data point should statistically reach within expected variation. If any one datapoint breaches this line, this is what is known as special cause variation.

Graph 1: SPC Chart
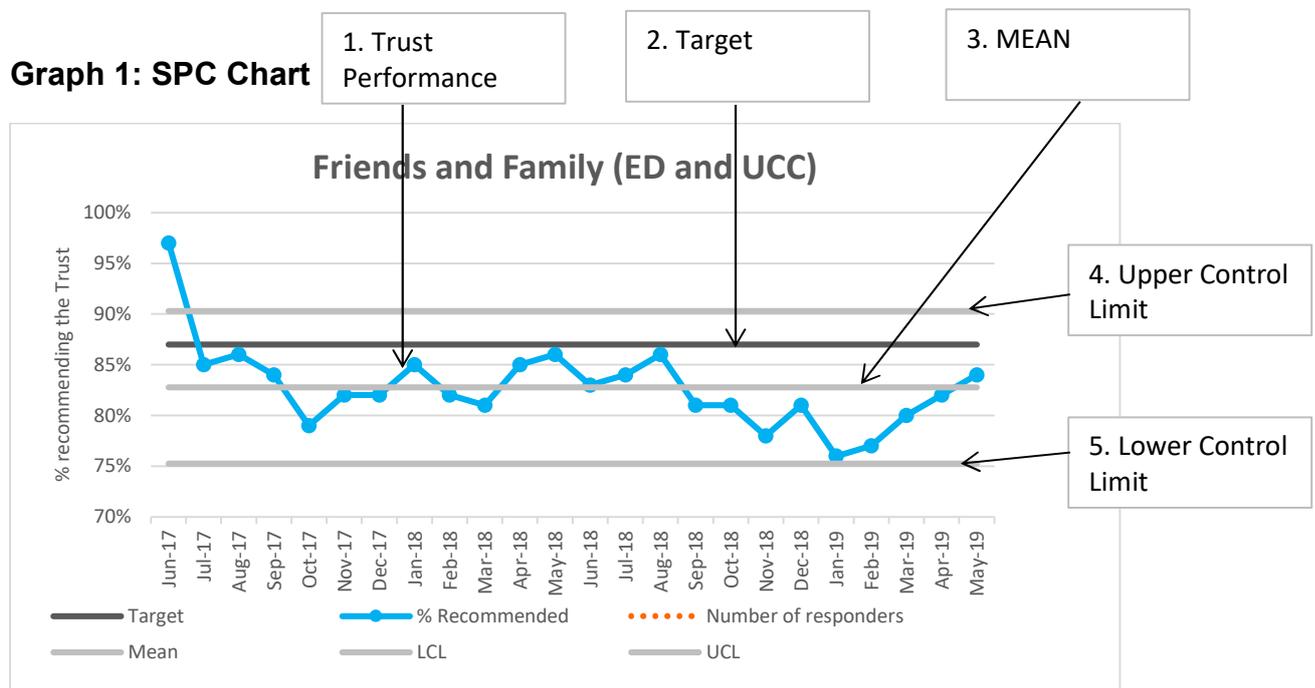
2.1 Interpreting a SPC Chart

There are 3 main rules to interpreting a SPC chart, if one of these rules is broken, this means that there is special cause variation present and that the process is not in control and requires investigation. Please note that breaching a rule does not necessarily mean the process needs to be changed immediately, but it does need to be investigated to understand the reasons for the variation.

1. All data points should be within the upper and lower control limits.
2. No more than 6 consecutive data points are above or below the mean line.
3. There are more than 5 consecutive points either increasing or decreasing.

Graph 2: Outlining Special Cause Variation
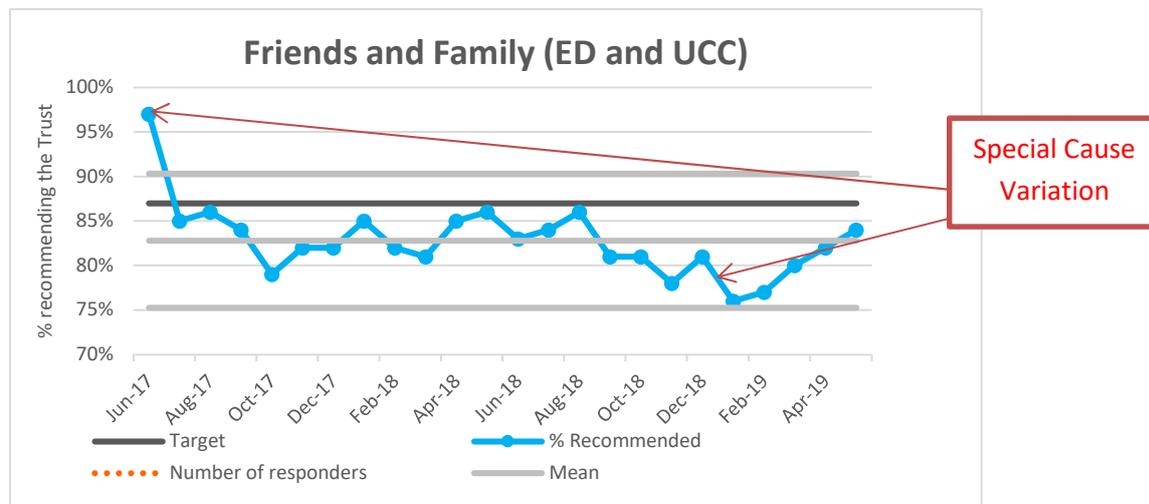
In the example above, there are two instances of special cause variation; in June 2017 the data point was outside of the upper control limit. Between September 2018 and April 2019, the data points all fall below the mean line.

For high targets (e.g. above 90%) if the upper control limit is below the target, it's unlikely the Trust will achieve the target using the current process.

For low targets (e.g. below 10%) if the lower control total is above the target, it's unlikely the Trust will achieve the target using the current process.

For the purposes of the Trust IPR, the RAG ratings (Red, Amber, Green) will be maintained to understand the Trusts current performance against the outlined targets. SPC should be considered side by side with the RAG rating as it is possible for a process to be within control but not meeting the target.

3.0 Making Data Count Assurance & Variation Icons

For 2022/23 the Trust has introduced the "Making Data Count" variation and assurance icons. These can be found in Appendix 2. Each indicator (where relevant) has been given one of the three assurance icons and one of the five

variation icons which is based solely on the data and the SPC rules. Ideally the assurance icon should be blue "P" icon which notes the indicator is consistently passing its target over the last 6 months. Again, ideally the variation icon should be either the grey "common cause variation" icon or a blue "H" or "L" icon noting improving variation. The orange icons note potential concern.

Table 1: Making Data Count Assurance & Variation Icons

Assurance			Variation		
Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target	Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values

3.1 Business Rules

- Where there are not enough data points for an SPC chart, the target is based on a cumulative position (e.g. an annual target) or SPC is not appropriate, a "No SPC" icon is utilised as outlined below.

- Assurance icons are based on the last 6 months. E.g. if the Trust has consistently passed a target in the last 6 months the blue "P" icon will be used.
- The Variation icon is based on the last data point. If the last data point means that the one of the SPC rules described in section 2.1 of this appendix is broken, the appropriate coloured "H" or "L" icons will be used to indicate special cause variation. The variation is common cause, the grey common cause variation icon will be used.

Income Statement at 30th April 2025

Income Statement	Annual	Month		
	Budget £000	Budget £000	Actual £000	Variance £000
Operating Income				
NHS Clinical Income	366,093	29,652	29,193	-459
Non NHS Clinical Income				
Private Patients	8	1	0	-1
Non NHS Overseas Patients	70	6	5	-1
Other non protected	750	63	99	37
Notional Pension Income	0	0	0	0
Sub total	**828**	**69**	**104**	**35**
Other Operating Income				
Training & Education	10,663	889	889	0
Donations and Grants	0	0	0	0
Miscellaneous Income	14,919	1,239	1,368	129
Sub total	**25,583**	**2,128**	**2,256**	**129**
Total Operating Income	**392,504**	**31,849**	**31,553**	**-296**
Operating Expenses				
Employee Benefit Expenses	-281,958	-24,790	-24,726	63
Drugs	-23,121	-1,951	-1,937	14
Clinical Supplies and Services	-27,036	-2,375	-2,224	150
Non Clinical Supplies	-47,404	-3,951	-3,969	-18
Depreciation and Amortisation	-17,659	-1,472	-1,472	0
Net Impairments (DEL)	0	0	0	0
Net Impairments (AME)	0	0	0	0
Restructuring Costs	0	0	0	0
Total Operating Expenses	**-397,178**	**-34,537**	**-34,329**	**208**
Operating Surplus / (Deficit)	**-4,675**	**-2,689**	**-2,776**	**-87**
Non Operating Income and Expenses				
Profit / (Loss) on disposal of assets	0	0	0	0
Interest Income	520	43	145	102
Interest Expenses	-138	-11	-20	-9
PDC Dividends	-5,501	-458	-458	0
Total Non Operating Income and Expenses	**-5,119**	**-427**	**-333**	**94**
Surplus / (Deficit) - as per Accounts	**-9,793**	**-3,115**	**-3,109**	**7**
Adjustments to Financial Performance				
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0	0
Less Impact of I&E (Impairments)/Reversals AME	0	0	0	0
Less Donations & Grants Income	0	0	0	0
Add Depreciation on Donated & Granted Assets	669	56	54	-2
Total Adjustments to Financial Performance	**669**	**56**	**54**	**-2**
Adjusted Surplus / (Deficit) as per NHSI Return	**-9,124**	**-3,059**	**-3,055**	**5**
Deficit Support Funding	**-19,600**	**-1,633**	**-1,633**	**0**
Adjusted Surplus / (Deficit) - without deficit support funding	**-28,724**	**-4,693**	**-4,688**	**5**

Introduction

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

There are **3 indicators that are both failing and have special cause variation of a concerning nature**, these are:

- **58. Capital Programme –** % delivered against plan **(NEW)**

- **59. Better Practice Payment Code –** % cumulative performance **(NEW)**

- **61. CIP (recurrent) –** % delivered against plan

There are **2 indicators that have special cause variation of a concerning nature and do not have a target**, these are:

- **13. Mortality ratio** – HSMR
- **14. Mortality ratio** – SHMI

58. Capital Programme – % delivered against plan (NEW)

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Capital Programme

Capital expenditure at the end of month 1 is £0.1m against a plan of £0.3m.

This is due to timing and is expected to be fully delivered by year end.

The risk associated with delivering the 2025/26 capital plan is being monitored at CPG and reported to FSC.

59. Better Practice Payment Code –% cumulative performance (NEW)

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Better Practice Payment Code (Month)

Mean · · · · LCL · · · · UCL — Plan — In Month Actual

Better Practice Payment Code (Cumulative)

— Plan — Cumulative Actual

Cumulative BPPC performance is 53% which is below the national target of 95%.

The main reason for this is due to cash management measures put in place to mitigate against the Trust's worsening cash position. £2m income from C&M ICB was not received in April 2025 as planned. This related to deficit support funding and the late changes to the contract position for convergence and deficit repayment and has subsequently been received in May 2025. The delay in payment reduced the cash available to meet payment commitments during April 2025.

BPPC is being closely monitored, especially due to cash shortages. This includes daily cash monitoring, ensuring wherever possible we pay SME. BPPC is unlikely to reach the 95% target given the cash position of the Trust.

April 2025 IPR by Exception – Finance

61. CIP – % delivery against plan (recurrent)

CIP recurrent- In Year (% Delivered against plan)
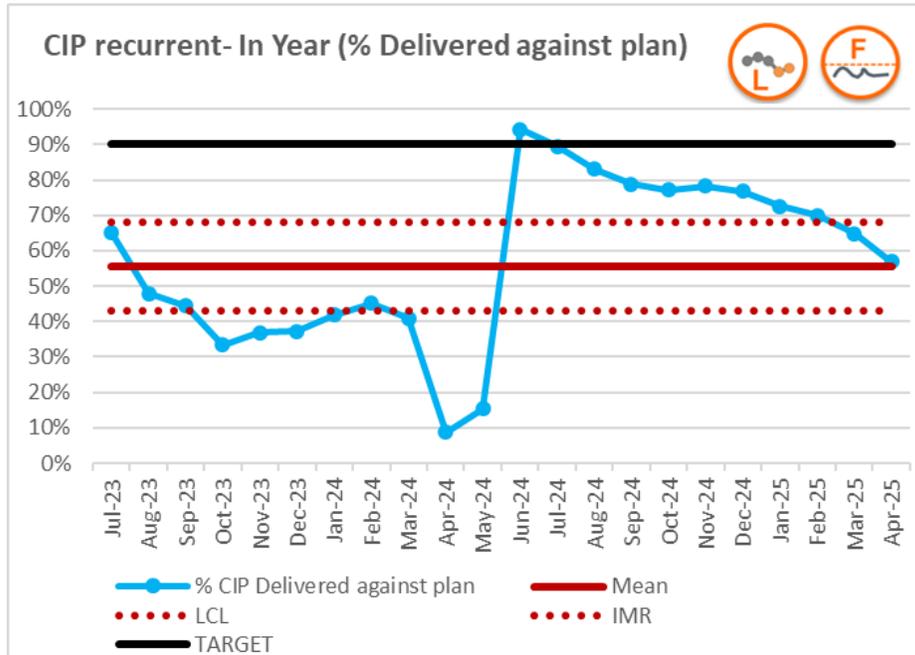
£0.5m CIP has been delivered recurrently against the target of £0.8m.

The Trust aims to deliver CIP recurrently wherever possible and challenges if CIP is not recurrent. Where recurrent CIP has not been realised, efforts have been made to deliver the CIP on a non-recurrent basis rather than not achieving at all.

For 2025/26 a delivery unit has been established to support delivery of the CIP programme. This will include ensuring CIPs are recurrent and quality impact assessed.

![NHS]

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

13,14. Mortality ratio – HSMR and SHMI
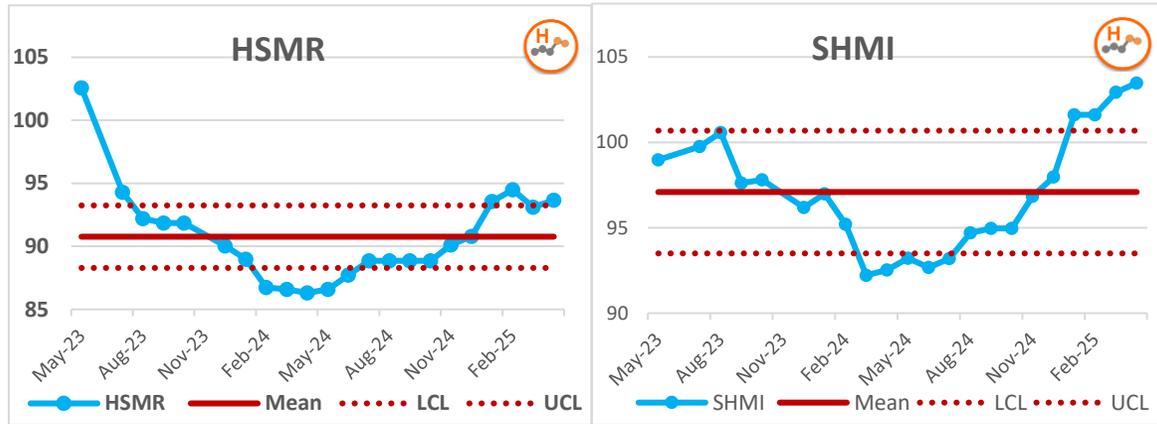
HSMR and SHMI mortality ratios are not outliers and remain within the expected range – with a green rating on HED data.

There has been a rise in SHMI and HSMR due to coding changes in SDEC activity (low risk patients' exclusion from 'admitted patients' dataset due to a progressive move to type 5 UEC activity coding) from October 2023.
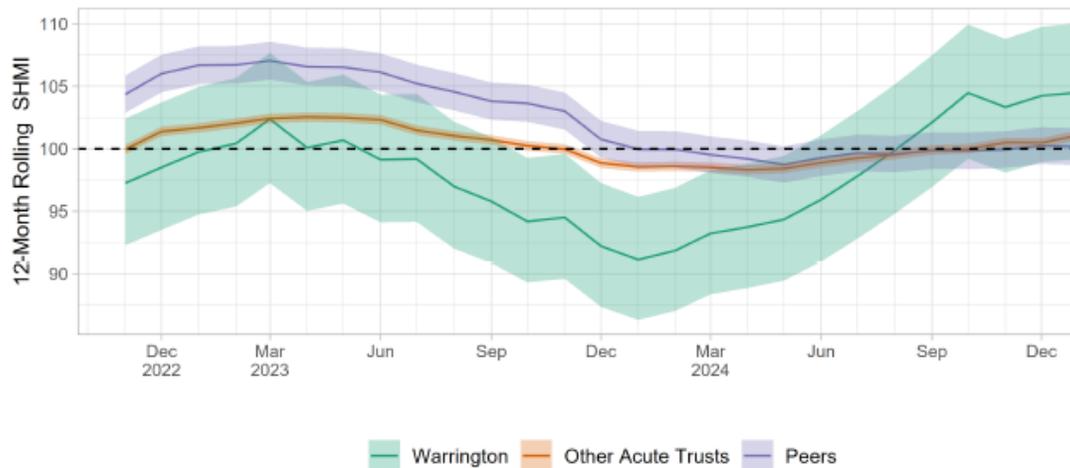
HSMR and SHMI are reported by HED on a 12 month rolling basis, which explains the stabilisation (at a higher level) which has been seen from October 2024 as SDEC activity has been fully excluded from the dataset.

The use of Type 5 reporting will be reviewed by the Trust Executive Team.

The following 5 indicators were previously both failing and had special cause variation of a concerning nature; **these now no longer fall into one, or both, of these categories**:

- Mixed Sex Accommodation Breaches (ITU)
- Sepsis - % screening for all emergency patients
- A&E Waiting times - % patients waiting under 4 hours from arrival to admission, transfer or discharge
- A&E Waiting times - % patients waiting under 4 hours from arrival to admission, transfer or discharge (including WUTC)
- Supporting Attendance

Recommendation

The Trust Board is asked to note the actions being taken in relation to these 5 IPR indicators.

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/06/37a (i)	Meeting	Trust Board	Date Of Meeting	4 June 2025

Date of Meeting	8 April 2025
Name of Meeting & Chair	Quality Assurance Committee, chaired by Cliff Richards
Was the meeting quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up/ Review date
QAC/25/04/004	**Deep Dive – Urology Cancer**	The Committee received a presentation - Deep Dive in relation to Urology Cancer The presentation included • Overview of Incidents/themes and actions relating to Urology cancer • Review of current risk register Points to note include • 6 PSIIs in period June 23 – November 24 linked to urology • 5 complaints in period November 24 – February 2025. • All incidents had a learning review with associated actions • Reduction in overdue flexible cystoscopies and biopsies • Additional risk to be added to risk register	**Limited** **Strong governance and senior oversight.** **needs to reduce number of complaints/ incidents linked to urology cancer and ensure sustainability of performance.**	**Substantial:** **Monthly chairs reporting with Executive oversight through Patient Safety and Clinical Effectiveness Sub Committee. (PSCESC)** **Escalated to through reporting to Quality Assurance Committee (QAC) as necessary.**	**Monthly reporting via Patient Safety and Clinical Effectiveness** **Workplan/ gap analysis to be agreed with Executive oversight**
QAC/25/04/007	**Patient Safety and clinical Effectiveness Sub Committee Report.**	An update from Patient Safety and Clinical Effectiveness Sub-Committee (PSCESC) was provided to the committee.	**Moderate** **Assurance received – regarding fragile**	**Substantial** **Monthly oversight at QAC**	**QAC May 2025**

		Key areas to note • Urology – improving waiting list position • ENT position improved due to insourcing • Clinical harm reviews- 1 low harm noted • Trail of AI to track P patients in Urology • Virtual Fracture Clinic - risk identified in tracking patients – SOP/actions being agreed. • Prompt surgery for fractured neck of femur patients remains an ongoing challenge • Possible delay to blood fridge implementation due to environmental work and testing delays – plans in place. Trust wide blood tracking project remains on track. • Gynaecology non urgent letters backlog.	**services – further improvements required.**	**Executive oversight monthly of all fragile services via PSCESC**	
QAC/25/04/008	**MIAA Theatre Safety Audit**	The committee received • Follow up from MIAA audit that noted limited assurance • Noted actions completed however limited assurance was felt from the committee as the outputs from the completed actions were not clear. • Further actions to be taken regarding ongoing assurance • Review of risk register required • Observational audits required – commence date to be agreed	**Limited** **Actions complete however outputs not able to be articulated. Escalations to be made in month to Chief Nurse and Medical Director ahead of next QAC.**	**Substantive** **Monthly Oversight by Executives Directors and Non-Executives at QAC.**	**QAC monthly**
QAC/25/04/010	**Acute Kidney injury update**	The committee received update on AKI Team noting positive improvements as a result of service • Mortality 22% reduced • Readmission rate at 13 % compared to national 26%	**Moderate** **Improvements noted slight increase in**	**Substantial Monthly oversight in IPR at QAC and Bimonthly by**	**QAC monthly**

			deterioration post diagnosis – actions underway to improve	Board of Directors	
QAC/25/04/011	**Cardiopulmonary Resuscitation (CPR) Biannual report**	The committee noted a recent audit provided high assurance relating to uDNACPR and improved compliance in all areas of the audit.	**Moderate** **Improvements noted however further improvements required on consultant verification in 48hours**	**Substantial** **Biannually to QAC** **Quarterly to Patient safety and Clinical Effectiveness Committee**	
QAC/25/04/015	**QIA report process**	Proposal for single QIA process presented to the committee for approval – it was agreed the QIA tool was essential to maintain the safety of the organisation. This will be under review against other QIA process across WHH and Bridgewater.	**Moderate Need to roll out Trust wide, commence Clinical Quality Advisory Meeting to approve QIAs form Q1.**	**Substantial Executive led fortnightly Clinical Quality Advisory Meeting to approve QIAs form Q1.**	**Biweekly Executive led meeting**

The Committee also received the following items.

QAC/25/04/006 Quality IPR Metrics
QAC/25/04/012 Clinical Audit Report
QAC/25/04/014 ED improvement programme
QAC/25/04/016 Better Care update
QAC/25/04/018 Ward Accreditation Biannual Report
QAC/25/04/019 Claims Biannual Report
QAC/25/04/020 Maternity Update
QAC/25/04/021 Chairs report Research Oversight Sub Committee
QAC/25/04/022 High Level Enquiries External inspections

Assurance Key:

Delivery Assurance: Assurance in achieving outcomes.

Governance Assurance: Assurance in the internal controls in place

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Trust Board: Committee Assurance Report

Agenda Reference	BM/25/06/37 a ii	Meeting	Trust Board	Date Of Meeting	4 June 2025

Date of Meeting	13 May 2025
Name of Meeting & Chair	Quality Assurance Committee, chaired by Cliff Richards
Was the meeting quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up/ Review date
QAC/25/05/030	**Patient Story**	The Committee heard a patient story from a lady who had suffered baby loss during her attendance and actions taken to improve pathway and communication for patients with a similar experience.	**Moderate** **The committee were assured some learning had taken place however requested more assurance re pain management and environmental factors**	**Substantial: Review via Patient Experience and Inclusion Sub Committee**	**Review via Patient Experience and Inclusion Sub Committee June 2025** **Follow up meeting with the Chief Nurse/ Gynaecology Matron**
QAC/25/05/031	**Deep Dive – Cancer Services**	The Committee received a presentation - Deep Dive in relation to Urology Cancer The presentation included • Overview of performance • Overview of pathways and responsibility owners	**Limited** **Need further assurance regarding escalation and tracking processes that**	**Substantial:** **Monthly chairs reporting with Executive oversight through Patient Safety**	**Monthly** **Reporting via Patient Safety and Clinical Effectiveness Next -June 2025**

			Assurance	Assurance	
		• Overview of tracking and escalation process • Themed review of incidents Points to note include • Perform well against 31-day standard • Escalation policy updated and agreed at CBU Governance Quarter 1 • Weekly Priority Target List (PTL) Meeting in place • Partial assurance provided regarding improvements and escalation processes • Cancer dashboard awaiting development	**they have been fully amended and continue to reduce incidents of harm.**	**and Clinical Effectiveness Sub Committee. (PSCESC)** **Escalated to through reporting to Quality Assurance Committee (QAC) as necessary.**	**Workplan assurance being sought by Medical Director**
QAC/25/05/032	**Hot Topic – Chronic Pain Team**	The Committee received a Hot Topic presentation including • Overview of external review commissioned following a series of GP concerns Points to note include • No immediate intervention required for safety • Noted service needs updating with modernised practice that include non-pharmacological methods and MDT approaches • Inconsistencies in documentation noted • Limited clinical engagement noted throughout review	**Limited** **Evidence of MDT working required** **Service specification needs review** **SOPs and standardised letter to be reviewed and developed**	**Limited** **CBU Governance requires strengthening** **Escalate as a Fragile Service – Monthly reporting to Patient Safety and Clinical Effectiveness Sub Committee.**	**Fragile Service Report to PSCESC next June 2025**
QAC/25/05/034	**Patient Safety and clinical Effectiveness Sub Committee Report.**	An update from Patient Safety and Clinical Effectiveness Sub-Committee (PSCESC) was provided to the committee.	**Moderate** **Assurance received – regarding**	**Substantial** **Monthly oversight at QAC**	**QAC June 2025**

		Key areas to note • Cardiology – concerns re diagnostic delays – improvement plans requested • Stroke and Gynaecology presented 2nd 6-month update following step down from fragile services. Good progress has been maintained with significant pathway improvements noted. • Urology – improved waiting list position. However, service remains fragile relating to staffing. • ENT waiting list position improved due to insourcing • Virtual Fracture Clinic – Assurance not received. – Medical Director writing to the Speciality Governance Lead	**Fragile Services – further improvements required.**	**Executive oversight monthly of all fragile services via PSCESC**	
QAC/25/05/036	**MIAA Theatre Safety Audit**	The Committee received • 2nd Follow up from MIAA audit that had noted limited assurance • Further actions to be taken regarding ongoing assurance • Review of risk register required • Observational audits required – commence date to be agreed • Joined regional group re procedural safety • Observational audits being undertaken by senior and executive leads	**Limited** **Actions complete however limited assurance regarding clinical engagement.**	**Substantive** **Monthly Oversight by Executives Directors and Non-Executives at QAC.**	**QAC Monthly June 2025**
QAC/25/05/040	**Draft Quality Account**	The committee received the draft quality account for approval noting next steps • Audit Committee June 2025 • Stakeholder engagement with Health watch/ partners May/June 2025. • ICB presentation 21 May 2025 • Publish on Website by 30 June 2025	**Substantive Remains on track to meet required milestones for publication on 30 June 2025**	**Substantial Monthly oversight in IPR at QAC and Bimonthly by Board of Directors**	**QAC and Audit Committee June 2025**

The Committee also received the following items.
Patient Story
QAC/25/05/033 Board Assurance Framework
QAC/25//05/036 Complaints Annual Report
QAC/25/05/037 Infection Prevention and Control Q4 update
QAC/25/05/038 Sepsis Q4 update
QAC/25/05/039 ED improvement Update
QAC/25/05/041 Maternity update
QAC/25/05/042 Better Care Update
QAC/25/05/043 CIP/ GIRFT Quality Impact Assessment Biannual report.
QAC/25/05/044 Information Governance and Records Subcommittee Quarterly update
QAC/2505/046 High Level Enquiries Update

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Trust Board: Committee Assurance Report

Agenda Reference	BM/25/06/37c	Meeting	Trust Board	Date of Meeting	4 June 2025

Date of Meeting	Wednesday 16 April 2025
Name of Meeting and Chair	Strategic People Committee in Common, Chaired by Julie Jarman
Was the Meeting Quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

Agenda Ref	Agenda Item	Issue and Lead Officer	Delivery Assurance	Governance Assurance	Follow Up/ Review Date
SPCIC/25/04/005	**Hot Topic – Workforce Plan**	**Michelle Cloney, Chief People Officer** The Committee received an update for delivery of the workforce plan for 2025/26. The Committee discussed elements associated with Care Group requirements and actions taken at an organisational level to meet the requirements of the plan, including interdependencies such as sickness and turnover. The Committee noted that a Delivery Unit is being established which will oversee the delivery of CIP and plans locally. Supporting this will be a rigorous process for quality impact assessments, ensuring links are made between leavers, vacancies and CIP.	The Committee received **moderate assurance** on the delivery of the Workforce Plan.	The Committee received **substantial assurance** on the governance of the Workforce Plan.	Q1 – 25/26
SPCIC/25/04/008	**Better Care Together Integration Update (Workforce and Corporate Services)**	**Lucy Gardner, Chief Strategy and Partnerships Officer, Michelle Cloney, Chief People Officer, Adam Harrison-Moran, Head of Strategic Workforce Development & Culture** The Committee received an update on the workforce and corporate service integration for the Better Care Together programme. The Committee noted the	The Committee received **substantial assurance** on the delivery of the Better Care Together	The Committee received **substantial assurance** on the governance of the Better Care Together	May 2025

		positive steps taken focused on staff engagement and the Clinical Summits for service improvement. Additionally the Committee noted the risks outlined in the approach for delivery and potential resource challenges for the programme. It was recognised that monthly updates to the Committee on progress will continue.	integration programme.	integration programme.	
SPCIC/25/04/009	**Workforce Integrated Performance Report – Indicators 2025/26**	**Jennie Dwerryhouse, Deputy Chief People Officer** The Committee received an update on the suggested People KPIs for 2025/26 which have been proposed as part of the integration between Warrington and Halton Teaching Hospitals and Bridgewater Community Healthcare. The Committee discussed the KPIs and approved the recommendations. Additionally the Committee noted the positive use of statistical process control (SPC) reporting and how this would be used for future reporting.	The Committee received **substantial assurance** on delivery of the workforce integrated performance report.	The Committee received **substantial assurance** on the governance of the workforce integrated performance report.	May 2025
SPCIC/25/04/011 (i)	**Staff Survey: Deep Dive by Themes and Protected Characteristics**	**Adam Harrison-Moran, Head of Strategic Workforce Development & Culture** The Committee received an update on the 2024 NHS Staff Survey results, specifically focusing on the results by protected characteristics, sexual safety and Freedom to Speak Up. The Committee acknowledged how the Trust has maintained its position from the 2023 survey with some improvements noted across protected groups. The Committee discussed the disparity by protected characteristics and the increase in incidents of bullying, harassment, violence and aggression. Particularly, the Committee acknowledged an increase in racism and a deep dive into actions	The Committee received **substantial assurance** on delivery of the NHS Staff Survey results for 2024.	The Committee received **substantial assurance** on the governance of the NHS Staff Survey results for 2024.	Q2 – 2025/26

		being taken to address this was requested at a future date.			

Other reports received by the Committee:
- SPCIC/25/04/004 – Staff Story: International Recruitment Experience
- SPCIC/25/04/006 – Chief People Officer Report
- SPCIC/25/04/007 – Workforce Brief on National, Regional, ICB or Local Workforce Issues
- SPCIC/25/04/010 – WHH People Strategy Update Bi-Annual Report
- SPCIC/25/04/012 – WHH Safer Staffing Report
- SPCIC/25/04/013 (i) – National Education and Training Survey (NETS) Report

Chairs Logs received by the Committee:
- SPCIC/25/04/014 – Workforce Inclusion and Culture Sub-Committee
- SPCIC/25/04/016 – Workforce Review Group

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Trust Board: Committee Assurance Report

Agenda Reference	BM/25/06/37c	Meeting	Trust Board	Date of Meeting	4 June 2025

Date of Meeting	Wednesday 21 May 2025
Name of Meeting and Chair	Strategic People Committee in Common, Chaired by Abdul Siddique
Was the Meeting Quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

Agenda Ref	Agenda Item	Issue and Lead Officer	Delivery Assurance	Governance Assurance	Follow Up/ Review Date
SPCIC/25/05/025	**Hot Topic – System Assurance & Vacancy Controls**	**Michelle Cloney, Chief People Officer** The Committee received an update in relation to system assurance and vacancy control. The Committee noted the specific ICB workforce controls which have been outlined and the actions which have been taken and continue to be taken to respond to the requests. The Committee noted the assurance that quality and equality impact is aligned to any processes linked to vacancy control to ensure that patient safety is paramount to any decisions made as well as the collaboration across both Trusts to do things once where possible. Additionally, the Committee noted the criteria of organisational critical roles have been defined by both Trusts and therefore the oversight that the Delivery Unit (Workforce) Group now has.	The Committee received **substantial assurance** on delivery of the system assurance requirements and vacancy control requirements.	The Committee received **substantial assurance** on the governance of the system assurance requirements and vacancy control requirements.	Not required
SPCIC/25/05/030 (ii)	**Workforce Integrated**	**Jennie Dwerryhouse, Deputy Chief People Officer**	The Committee received **substantial**	The Committee received **substantial**	July 2025

	Performance Report	The Committee received an update on the IPR as per the agreed KPIs with Bridgewater Community Healthcare in April 2025. The Committee specifically focused discussions on bank reliance and sickness absence with discussions associated with note of the work completed to convert agency to bank over the past 24 months.	**assurance** on delivery of the workforce integrated performance report.	**assurance** on the governance of the workforce integrated performance report.	
SPCIC/25/05/032	**Freedom to Speak Up**	**Alison Jordan, Freedom to Speak Up Guardian** The Committee received a joint report from the Freedom to Speak Up Guardians for Warrington and Halton Teaching Hospitals and Bridgewater Community Healthcare. The Committee noted the report contents and actions which are being taken to identify and address barriers to speaking up, working with Staff Networks and staff voice groups. The Committee positively noted the alignment of both Guardians, with further opportunities to work collaboratively and share learning highlighted for the future.	The Committee received **substantial assurance** on delivery of Freedom to Speak Up.	The Committee received **substantial assurance** on the governance of Freedom to Speak Up.	6 Monthly
SPCIC/25/05/035	**Safe Staffing Assurance Report**	**Tracy Fennell, Deputy Chief Nurse and Director of Clinical Governance** The Committee received the monthly Safe Staffing Assurance Report. The Committee discussed the contents of the report with specific note on quality and safety of services against fill rates. The Committee were provided assurance on how quality and safety is measured and monitored in line with safe staffing.	The Committee received **substantial assurance** on delivery of safe staffing.	The Committee received **substantial assurance** on the governance of safe staffing.	Monthly
SPCIC/25/05/038	**Guardian of Safe Working**	**Dr Rachel Wallis, Guardian of Safe Working** The Committee received an update from the Guardian of Safe Working for Q3 escalations in line	The Committee received **substantial**	The Committee received **substantial**	Q2 – 2025/26

	for Junior Doctors	with the guidelines. The Committee were advised that the report included an overview of rota gaps, as well as noting that the overall number of exception reports had decreased slightly in line with previous year trends. Additionally, the Committee noted changes to the framework for exception reporting and the role of the Guardian. The Committee noted the impact of this and the work being undertaken to implement this in the Trust.	**assurance** on delivery of the Guardian of Safe Working.	**assurance** on the governance of the Guardian of Safe Working.	
SPCIC/25/05/039 (ii)	**Gender Pay Gap**	**Adam Harrison-Moran, Head of Strategic Workforce Development & Culture** The Committee received the Gender Pay Gap report for 2024/25 with data effective 31 March 2025. The Committee noted the progress delivered in the previous 12 months and actions being taken to address the disparity in pay gap. The Committee formally approved the report for publication on behalf of the Trust Board, noting this would be provided to Trust Board as a supplementary paper in June 2025.	The Committee received **substantial assurance** on delivery of the Gender Pay Gap report.	The Committee received **substantial assurance** on the governance of the Gender Pay Gap report.	Q3 – 2025/26

Other reports received by the Committee:
- SPCIC/25/05/026 (ii) – Board Assurance Framework
- SPCIC/25/05/027 – Chief People Officer Report
- SPCIC/25/05/028 – Workforce Brief on National, Regional, ICB or Local Workforce Issues
- SPCIC/25/05/034 (ii) – Workforce Policies and Procedures Overview Report
- SPCIC-25/05/037 – Volunteers Annual Report

Chairs Logs received by the Committee:
- SPCIC/25/05/040 – Operational People Committee
- SPCIC/25/05/041 – Workforce Review Group

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Trust Board: Committee Assurance Report

Agenda Reference	BM/25/06/37c (i)	Meeting	Trust Board	Date Of Meeting	4 June 2025

Date of Meeting	28 April 2025
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by John Somers
Was the meeting quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up / Review date
FSC/25/04/004	**Hot Topic – CIP • Inc System CIP • Impact of cap on productivity CIP**	The Committee received the presentation noting:- • 5% CIP (£21.5m) plus System CIP (£12m) included in 2025/26 plan • Credibility will depend on delivery of the 5% target • Tangible plans are not in place yet for System CIP • RAG rating of CIP has been updated by the regional team and a new weekly return now required with greater focus on QIA • 'Hopper' needs to be bigger so that there are plans for more than the target to ensure delivery • Latest letter from ICS setting out minimum Board requirements (vacancy freeze for non-clinical posts, highest level vacancy control panel, freeze on all discretionary non-pay and senior / Executive approval for bank / agency usage)	The Committee received **limited** assurance given the targets not being met	The Committee **noted** and discussed the report receiving **moderate** assurance given progress	
FSC/25/04/005	**Deep Dive – Delivery Unit • Governance • Capacity**	The Committee received the presentation noting:- • Focus on what will be different and how people are held to account • Delivery Unit due to start from 6 May all meetings to be chaired by CEO until Executive lead in place • Escalation meeting to be held monthly and to be chaired by the CEO	The Committee received **limited** assurance given that the delivery unit is not yet in place and delivering	The Committee **noted** and discussed the report receiving **moderate** assurance given plans in place	

		• Monthly update to FSC to provide assurance			
FSC/25/04/007	**Corporate Performance Report**	The Committee received the report noting:- • ED performance, 4 and 12 hours remain a concern • DM01 performance achieved the national standard for the second consecutive month (96.65%)	The Committee received **moderate** assurance given some metrics are not achieving	The Committee **noted** the report receiving **substantial** assurance around level of detail reported	**FSC May 2025**
FSC/25/04/008	**Monthly CIP Update**	The Committee received the report noting: • Month 12 CIP position is off plan by £0.9m exceeding forecast delivery by £1.5m	The Committee received **moderate** assurance based on delivery of CIP plan	The Committee **noted** and discussed the report receiving **moderate** assurance	**FSC May 2025**
FSC/25/04/009	**Monthly Productivity Improvement Update**	The Committee received the report noting:- • **Theatres** – highest area of concern, capped theatre utilisation has stalled over the last few months as well as a deterioration on late starts. FDP expected to drive improvement, needs time to embed. • **Outpatients improvement –**confident in delivery next year, through improved recording / rectification of system issues. • **UEC –** progress made in alternatives to ED (FAU and SDEC), the increase in over 65 admissions is a challenge, along with NCTR. Corridor care remains an issue although improving.	The Committee received **moderate** assurance given the progress that has been made	The Committee received **substantial** assurance given the plans in place	**FSC May 2025**
FSC/25/04/010	**Recovery Update M12**	The Committee received the report noting:- • £3m spend in 2024/25, 11,857 appointments, 2,759 clock stops and RTT improvement from 56.78% to 58.41%	The Committee received **moderate** assurance on the delivery of the improvement savings	The Committee **noted** and discussed the report receiving **substantial** assurance of the plans in place	**FSC May 2025**
FSC/25/04/012	**Pay Assurance**	The Committee received the report noting:- • Nursing bank rates to reduce again from 1 May • NW group to be set up and will also be looking at bank and agency rates	The Committee received **moderate** assurance in	The Committee **noted** the paper receiving **substantial**	**FSC May 2025**

			anticipation of the rate reduction	assurance around level of detail reported	
FSC/25/04/014	CDC Phase 4	The Committee received the report noting:- • £2.5m capital funding has been allocated, subject to business case approval • Additional income will be generated in 2026/27 which will feature as part of the business case	The Committee received **moderate** assurance in anticipation of the business case to follow	The Committee received **moderate** assurance in anticipation of the business case to follow	
FSC/25/04/015	Cash Support	The Committee received the report noting:- • £12.145m borrowed in 2024/25 • Cash will be required in 2025/26, however it won't be required in Q1 • ICS looking at ways that cash can be moved around the System • Criteria set to access national funds, however these have a financial consequence which is higher than PDC dividend payments (3.5%)	The Committee received **moderate** assurance on the monitoring of cash requirements	The Committee **noted** the report receiving **moderate** assurance around level of detail reported	**FSC May 2025**
FSC/25/04/016	EPR Procurement Update	The Committee received the report noting:- • Ongoing discussions regarding brokering the capital to work within the March 2026 deadline • FD funding criteria now dependent on providing a single instance, which is not clinically / operationally safe, conversations ongoing • Support for the Procurement Partnership Agreement • Support one off amendment to SFIs, to 80% quality & 20% financial	The Committee received **limited** assurance based on risks around funding	The Committee received **moderate** assurance based on the approach taken to date	
FSC/25/04/017	Monthly Finance position – month 12	The Committee received the report noting:- • Subject to audit, at year end the Trust is reporting a £16.8m deficit (adverse variance of £5.5m due under delivery of CIP, cost pressures not offset and PwC costs)	The Committee received **moderate** assurance	The Committee **noted** the paper receiving **substantial** assurance	**FSC May 2025**

FSC/25/04/019	Capital Position Month 12	The Committee received the report noting:- • Overall underspend of £22k against the overall plan • Movement in capital contingency and ringfencing of £464k in the 2025/26 capital plan was approved	The Committee received **moderate** assurance due to spend being behind plan.	The Committee **noted** the position receiving **substantial** assurance, **approved** the contingency changes and ringfencing of £464k in 2025/26 plan	FSC May 2025

Items for noting

FSC/25/04/006 Operational Plan and Budgets – Final submitted – reported and discussed at Extraordinary Board
FSC/25/04/011 Cost Pressures
FSC/25/04/012 Pay Assurance
FSC/25/04/013 Integration Update
FSC/25/04/018 Revenue Request – TIF Theatres – supported to go to Trust Board for approval following final Executive sign off on 29 April
FSC/25/04/019 Schemes over £500k
FSC/25/04/020 Digital Strategy Group Update
FSC/25/04/021 Update Event Planning Meeting
FSC/25/04/022 Committee Effectiveness Review – Outputs

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Trust Board: Committee Assurance Report

Agenda Reference	BM/25/06/37c (i)	Meeting	Trust Board	Date Of Meeting	5 June 2025

Date of Meeting	02 June 2025
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by John Somers
Was the meeting quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up / Review date
FSC/25/05/029	**Hot Topic – System Assurance • Grip and Control Letter • Monitoring of system wide work • System Improvement • Level Three CIP**	The Committee received the presentation noting:- • ICS is officially in turnaround and PWC are undertaking a governance review of each organisation. • Joint WHH and BW meeting took place 30 May 2025 • Assurance provided based on what had been presented by WHH • High level 4 year sustainability to include integration & model health • Level 3 CIP £12m – profiled in month 12 in line with BW and MWL • Medical staffing are on Rotamap, nursing and AHP are on Allocate. C&M are looking at identifying a preferred provider. • Looking at managing attendances across C&M • Execs have identified non clinical critical roles to ensure that the Trust can still deliver services to our patients. • Delivery units set up – Workforce, Non Pay, Productivity • FCOG held for the system – 10 themes with CIP plans aligned.	The Committee received **moderate** assurance given the actions that have commenced	The Committee **noted** and discussed the report receiving **substantial** assurance around level of detail reported	
FSC/25/05/030	**Deep Dive – Theatre Productivity / Length of Stay**	The Committee received the presentation noting:- • Cataracts pilot planned for July 2025 • Urology utilisation is expected to increase from June 2025 • FDP is live improving monitoring and oversight on utilisation and productivity	The Committee received **limited** assurance given that productivity is still lower than planned	The Committee **noted** and discussed the report receiving **moderate**	FSC August 2025

		• Improving length of stay for elective patients by improving day cases especially in Hysterectomy, hernias, and lap choles and TURBTs. • Further data has been requested to enable trend review • Endoscopy is a key area that is not delivering to plan • Will form part of the Delivery Unit – Productivity		assurance given plans in place	**Q1 update**
FSC/25/05/0 33	**Monthly CIP Update**	The Committee received the report noting: • Month 1 CIP position is in line with the plan - £0.8m achieved of which £0.4m is recurrent • CIP plans of £21.5m have been identified against Levels 1 & 2 CIP • £12.4m of the CIP plans are high risk • There is also £12m Level 3 CIP which will be monitored and delivered at a system level. • Progress is monitored via the weekly Delivery Unit meetings with oversight monthly at the Executive Management Team meeting.	The Committee received **limited** assurance based on delivery of CIP plan in particular the level of high risk	The Committee **noted** and discussed the report receiving **limited** assurance given recurrent plans in place is not delivering to expectations	**FSC June 2025**
FSC/25/05/0 34	**Monthly Productivity Improvemen t Update**	The Committee received the report noting:- • Outpatients improvement **–** confident in delivery next year, through improved recording / rectification of system issues. • UEC **–** ICS is suggesting improvements in NCTR which will be worked on. Oversight meeting will take place with the whole system including local authority.	The Committee received **moderate** assurance given the progress that has been made	The Committee received **substantial** assurance given the plans in place	**FSC June 2025**
FSC/25/05/0 37	**Medical Workforce Review Group – Q4 Update**	The Committee received the report noting:- • Medical workforce bank and agency spend was over budget by £0.8m, some offset from WLI, outstanding revenue requests and vacancies • Bank rates are one of the lowest in C&M • Job planning consistency meeting will occur quarterly commencing from June 2025 onwards.	The Committee received **moderate** assurance given the progress that has been made	The Committee **noted** and discussed the report receiving **moderate** assurance	**FSC June 2025**
FSC/25/05/0 38	**Estates Strategy Process Report**	The Committee received the report noting:- • Total trust-wide high-risk backlog reduced from £2.1m to £1.8m. • However, total trust-wide backlog has increased from £39.8m to £46.3m due to the age of estate and systems. • Delivered £1.5m backlog maintenance program in 2024/25.	The Committee received **moderate** assurance given the progress that has been made	The Committee **noted** and discussed the report receiving **moderate**	**FSC June 2025**

		• Bid made to NHS England to address critical infrastructure risk (CIR) totalling £2.0m. Funding allocation TBC. • Bid made to NHS England to address issues identified in the national estates maternity survey totalling £1.1m. Funding allocation TBC • Surveys completed for building management system (BMS) and solar PV improvements. Bids made to NHS England. Placed on reserve list. • Target investment fund (TIF) awaiting the outcome of the additional bid of £1.9m. •		assurance given plans in place	
FSC/25/05/0 40	Sustainabilit y Strategic Priorities Update	The Committee received the report noting:- • Trust is on target to meet or has met 9 priorities, 5 are behind expectations with mitigations and programmes in place to bring back in line with expectations and 2 are behind expectations with limited or no mitigation • Amended strategic priorities for 2025/26 were supported	The Committee received **moderate** assurance due to spend being behind expectations.	The Committee **noted** the position receiving **substantial** assurance, **supported** for Trust Board approval.	**Trust Board June 2025**
FSC/25/05/0 43	Cash Position Update	The Committee received the report noting:- • Total cash support received up to March 2025 is £19.4m. • £18.3m deficit support will be received in 2025/26 • Trust will need cash support from August 2025 onwards. • Actions has been taken to maintain cash position leading to negative impact on BPPC and creditor days • Cash management measures continues to be in place	The Committee received **moderate** assurance due to the Trust financial position and inevitable requirement of cash support.	The Committee **noted** the paper receiving **substantial** assurance	**FSC June 2025**
FSC/25/05/0 45	Monthly Finance position – month 12	The Committee received the report noting:- • Deficit plan before deficit support funding of £28.7m • £18.3m deficit support funding will be received in 2025/26, therefore reducing the deficit after deficit support funding to £10.4m • Month 1 deficit position is on plan at £4.7m (before deficit support) • CIP delivered in month 1 although £0.4 is non recurrent • Activity plan in month 1 was not achieved	The Committee received **limited** assurance	The Committee **noted** the paper receiving **substantial** assurance	**FSC June 2025**

FSC/25/05/0 46	Revenue Requests – Elective Recovery	The Committee received the report noting:- • Request to draw down £1.2m for elective recovery which will support delivery up to the end of Q2. • £0.5m already drawn down in Q1. • Position will be reviewed for Q3, dependant upon outpatient productivity improvements	The Committee received **moderate** assurance	The Committee **noted** the paper receiving **substantial** assurance and **supported** to go to Trust Board for approval	**Trust Board June 2025**
FSC/25/05/0 47	Capital Position Month 12	The Committee received the report noting:- • M1 underspend of £0.27m against the plan. However, it is expected to catch up over the next 2 months. • Movement in capital contingency was approved	The Committee received **moderate** assurance due to spend being behind plan.	The Committee **noted** the position receiving **substantial** assurance, **approved** the contingency changes	**FSC June 2025**

Items for noting

FSC/25/05/031 Board Assurance Report and Risk Register
FSC/25/05/032 Corporate Performance Report
FSC/25/05/035 Recovery Update M1
FSC/25/05/036 Pay Assurance
FSC/25/05/039 Integration Update
FSC/25/05/041 CDC Phase 4
FSC/25/05/042 Benefits Realisation Q4 Update
FSC/25/05/044 Indicative Financial Cost of Harm
FSC/25/05/047 Schemes over £500k
FSC/25/05/048 Digital Strategy Group Update

Assurance Key:

Delivery Assurance: *Assurance in achieving outcomes*
Governance Assurance: *Assurance in the internal controls in place*

Level of Assurance	Description
High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed
Substantial	There is a good system of internal control designed to meet the system objectives, and that the controls are generally being applied consistently
Moderate	There is an adequate system of internal control; however, in some areas weaknesses in design and/ or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk
Limited	There is a compromised system of internal control as weaknesses in the design and/ or inconsistent application of controls puts the achievement of the system objectives at risk

No	There is an inadequate system of internal control as weaknesses in control, and/ or consistent non-compliance with controls should/ has resulted in failure to achieve the system objectives

Note: *Please fill the Recommendation / Assurance/mandate to receiving body column with the correct colour and state the Committees' level of assurance i.e. No Assurance, Limited Assurance, Moderate Assurance, Substantial Assurance or High Assurance*

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/06/37 (e)	Meeting	Trust Board	Date Of Meeting	7 June 2025

Date of Meeting	24 April 2025
Name of Meeting & Chair	Audit Committee, Chaired by Mike O'Connor
Was the meeting quorate?	Yes

The Committee wishes to bring the following matters to the attention of the Board:

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up/ Review date
AC/25/04/005	**Committee Assurance Updates**	The committee received a verbal update from each of the Chairs of the Board's subcommittees. Of particular note was: • Commenced with a Committee in Common approach with Bridgewater for the Trust's Strategic People Committee • Limited Assurance received for MIAA Theatre Procedural Safety Audit. Detailed action plan presented to Quality Assurance Committee with monthly reporting to QAC in place Extensions were granted; however, the sickness absence action was to be closed and reported to the Committee via email. Job planning would be brought back to the yearend audit committee.	**High –** the committee received evidence that committees were functioning to a high standard	*High -* the committee agreed effective governance systems and processes were in place for board sub-committees	**QAC Monthly**
AC/25/04/007	**Head of Internal Audit Opinion**	The committee received assurance that the overall opinion for the period 1st April 2024 to 31st March 2025 provided **Substantial** Assurance, showing there was a good system of internal control designed to meet the organisation's objectives, and that controls were generally being applied consistently.	**Substantial** – it was evidenced that the Trust were delivering to a substantial standard	**Substantial** – it was evidenced that the Trust had substantial Governance	n/a

		The opinion was provided in the context that the Trust like other organisations across the NHS are facing a number of challenging issues and wider organisational factors particularly with regards to the ongoing elective recovery response, workforce challenges, financial challenges and increasing collaboration across organisations and systems.		**systems and processes in place**	
AC/25/04/015	**Going Concern Annual Report**	The Committee received and approved the preparation of the accounts on the Going Concern basis statement for inclusion in the annual report 2024/25	**Substantial** – it was evidenced that the Trust were delivering to a substantial standard	**Substantial** – it was evidenced that the Trust had substantial Governance systems and processes in place	**n/a**
AC/25/04/019	**Declarations of Interest Annual Report**	The Committee received a report outlining the Trust's adherence to its Conflicts of Interest Policy. In 2024/25, the Trust achieved a year-end compliance rate of 98%, a significant improvement from 90% in 2023/24	**High –** the committee received evidence that committees were functioning to a high standard	*High -* the committee agreed effective governance systems and processes were in place for board sub-committees	**Audit Committee April 2026 & MIAA Internal Audit Report**

Other agenda items:
AC/25/04/004 – Changes or updates to the BAF
AC/25/04/006 – Internal Audit Report on Follow Up Actions
AC/25/04/008 - Internal Audit Progress Report
AC/25/04/009 - Internal Audit Charter Annual Report
AC/25/04/010 – Internal Audit Plan
AC/24/04/011 - External Audit Plan & Fees
AC/25/04/012 - Anti-Fraud Annual Report
AC/25/04/013 - Review Losses & Special Payments
AC/25/04/014 - Review of Quotation & Tender Waivers
AC/25/04/016 - DRAFT Unaudited Accounts & Financial Statements
AC/25/04/017 - DRAFT Annual Governance Statement
AC/25/04/018 - DRAFT Annual Report

AC/25/04/020 – Proposed Changes to the Scheme of Reservation & Delegation and Standing Financial Instructions

Assurance Key:
Delivery Assurance: *Assurance in achieving outcomes*

Governance Assurance: *Assurance in the internal controls in place*

Level of Assurance	Description
High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed
Substantial	There is a good system of internal control designed to meet the system objectives, and that the controls are generally being applied consistently
Moderate	There is an adequate system of internal control; however, in some areas weaknesses in design and/ or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk
Limited	There is a compromised system of internal control as weaknesses in the design and/ or inconsistent application of controls puts the achievement of the system objectives at risk
No	There is an inadequate system of internal control as weaknesses in control, and/ or consistent non-compliance with controls should/ has resulted in failure to achieve the system objectives

Note: Please fill the Recommendation / Assurance/mandate to receiving body column with the correct colour and state the Committees' level of assurance i.e. No Assurance, Limited Assurance, Moderate Assurance, Substantial Assurance or High Assurance

REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/25/06/38	
SUBJECT:	**Fragile Clinical Services**	
DATE OF MEETING:	4 June 2025	
AUTHOR(S):	Paul Fitzsimmons, Executive Medical Director	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate*)	**#2001** If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff , reduced patient experience and reputational damage	

LINK TO PUBLIC SECTOR EQUALITY DUTIES	*Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:*		
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper aims to provide assurance with regards to the Trust's oversight of Fragile Clinical Services. A high-level update is provided on the services currently designated as fragile:		

	Chronic Pain Service Urology Orthopaedics – Fractured Neck of Femur ENT Cardiorespiratory/Cardiology Services Services de-escalated from Fragile Services oversight since last report: None Services entering Fragile Services oversight since last report: Cancer Services		
PURPOSE: *(please select as appropriate)*	Approval	**To note** ✓	Decision
RECOMMENDATION:	Trust board is asked to: • Note the current list of Fragile Services, associated clinical risk and high-level progress updates • Note the escalation of Cancer services into fragile services oversight • Note the de-escalation of ENT from fragile services oversight • Receive further Fragile Service Oversight reports		
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: *(if relevant)*	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Fragile Services Oversight	AGENDA REF:	BM/25/06/38

1. BACKGROUND/CONTEXT

Following recognition of a need for a systematic oversight mechanism for Fragile Services a formal process for oversight of Fragile Services has been incorporated into the PSCESC Agenda reporting to QAC and on to Trust Board since July 2023.

For the purposes of the Fragile Services Oversight program the Trust defines a Fragile Service as: 'A service which is at risk of deterioration with a resulting significant risk to the quality of patient care, with particular reference to patient safety and risk of harm'.

This report aims to provide a high-level overview of services currently identified as being Fragile.

2. FRAGILE SERVICES DE-ESCALATED FROM OVERSIGHT SINCE LAST BOARD

ENT

Following successful recruitment of Consultant Staff, gains from clinic template standardisation and stabilisation of the middle grade rota, improvements have been seen in waiting lists and staffing sustainability. PSCESC has recommended that ENT is de-escalated from Fragile Service Oversight.

Cheshire and Merseyside level work to develop an options appraisal for strategic reconfiguration to deliver sustainable ENT services continues to progress

3. SERVICES ENTERING FRAGILE SERVICES OVERSIGHT SINCE LAST BOARD

Cancer Services

To be escalated to Fragile Services Oversight following presentation as a Deep Dive to QAC in May 2025 – Cancer system issues identified through incidents with harm discussed at SOM, Urology Cancer Deep Dive and Planned Care cancer review.

Priority workstreams identified and underway to standardise and improve key cancer processes:
- Cancer patient tracking escalation
- Consultant upgrade process
- Investigation and results tracking and management
- Post treatment surveillance tracking and standards (speciality level)
- MDT standardisation

Chronic Pain Service

Summary

Escalated to Fragile Services Oversight following presentation as a Deep Dive to QAC. Escalation indicated following external service review commissioned by the Medical Director – concerns regarding compliance with NICE Guidance, injection rates and Opiate prescribing standards

Initial service improvement meeting held with consultant team, MD and AMD

Completed Actions
- Pharmacy review of all opioid recommendations
- No new patients have been commenced on facet joint or trigger point injections

Initial actions (weeks 0-8)
- Service Gap analysis against NICE guidelines
- Develop and implement SOP for Opiate and Gabapentoid initiation
- Standardised GP and patient letter format
- Review of injection activity and caseloads
- Develop clear directory of non-medical options for referral
- Meet with Primary Care to agree pain SOPs before implementation

Medium term actions (weeks 8-12)
- Develop plan for supporting patients on long term injection programmes to transition to less invasive care
- High level succession planning for clinical leadership and staffing service
- Commence scoping for long term actions

Long term actions (12+ weeks)
- Prioritise service (subject to Board support) for integration and transformation with Bridgewater moving from a secondary care medical based illness management service to a community-based MDT re-enablement health improvement service.

Urology

Summary

Improving waiting list position, recent improvement in P2 waiting list, service remains fragile from staffing and capacity / demand profile perspectives

Recent cluster of Urology Cancer incidents with harm – Deep Dive cluster review of cases and action plan presented at QAC April 2025

- Demand and capacity mismatch – driven predominantly by workforce issues and increased demand
- Significant volume of high-risk patients on waiting lists confirmed by AI list validation

- P2 – waiting list remains static
- P3 & P4 waiting lists show an overall positive reducing trend – P3 reducing again after recent growth
- Transperineal prostate biopsy position shows sustained improvement, with (sustained reduction in undated waiting list patients from >120 to <10)
- Surveillance cystoscopy position very significantly improved from peak, with waiting list now fewer than 25 patients
- Tier 2 doctor staffing issues remain a significant challenge

- Completed Actions
    - Increased endoscopy cystoscopy capacity by 40/week
    - WLI and outsourced sessions approved and actioned
    - OP Clinic template standardisation completed
    - Additional middle grades recruited
    - Locum consultants commenced in post
    - Successful transfer of cystoscopy into UIU - UIU have increased cystoscopy case numbers per list.

- Current mitigations
    - Stent register process in place – further failsafe refinements made, with process audited for assurance
    - Hot stone list implemented at Warrington site with hot slots on elective lists when weekly hot stone list unavailable
    - PCNL Stone patients transferred to Chester as required
    - Specialist nurse delivered cystoscopy training underway with practitioners approaching completion of training

- Ongoing improvement plan actions:
    - Urology Cancer Deep Dive output – MDT and surveillance improvement work required
    - Urology Specialty/Tier 2 Doctors require additional support to move to independent practice – plan in place

Orthopaedics – Fractured Neck of Femur

Summary

Prompt surgery remains an unresolved quality and performance issue. Emergent risk around Orthogeriatric review and medical support now resolved

- Demand and capacity mismatch – driven predominantly by increased demand and insufficient theatre capacity for Trauma workload
- Significant improvement across majority of performance indicators – performance at or close to national average in these domains
- Prompt surgery is the remaining significant challenge
- Current mitigations:
  o CBU oversight of trauma delays with additional lists/conversion of elective lists as required to prevent excessive waits
  o Additional orthogeriatric consultant sessions funded & orthogeriatric fellow post appointed to
  o Additional ad hoc fractured neck of femur lists utilising bank locum consultant
  o Clear escalation protocol for Orthogeriatric issues developed with juniors and implemented

- Ongoing improvement plan actions:
  o Focused improvement plan to deliver 'prompt surgery' – revenue request in development to support extended trauma capacity
  o Further embed SOP to ensure that prolonged delays to theatre are escalated with escalation triggered by wait time as well as numbers waiting

Cardiology and Cardiorespiratory Services

Summary

Demand and capacity mismatch driven by Cardiorespiratory vacancies and misalignment of demand and capacity in Cardiology job plans Following job planning and a review of consultant resource Cardiology is close to leaving fragile service oversight

- Cardiology pressures driven by consultant vacancies, consultant illness and a misalignment of activity in job plans resulting in excess capacity being directed towards cath-lab and elective work with a deficit in outpatient and inpatient capacity (Model Hospital data).
- Cardiorespiratory waits driven by demand / capacity gap and workforce issues
- Emergent risk identified in a group of outpatients who are in 'Investigation Pending' access pathways with evidence of delay
- No patient harm identified to date

- Completed Actions
    - Task and finish group established
    - Fixed term consultant appointed to vacant post
    - Job planning process completed – supported by MD
    - Band 7 physiologist post recruited to
    - WatchPat device introduction has reduced formal sleep study demand and workload

- Current mitigations
    - Cardiology vacancy recruited to
    - Successful recruitment into the Assistant Technical Officer posts resulting in a reduction in spirometry wait

- Ongoing improvement plan actions:

    - Complete validation and clinical review of 'Awaiting Results' access plan backlog
    - Develop and Ratify SOP for 'Awaiting Results' access plan management – June 2025
    - Complete scoping exercise for ambulatory disposable patches
    - Complete Revenue Request to reduce WLI spend through consultant appointment (facilitated with Pa's released through job planning)
    - Monitor Spirometry Waiting Times following recruitment of ATOs
    - Pursue training support from Cheshire & Merseyside Physiologist Network for training support in Cardiorespiratory
    - Complete Cardiorespiratory Workforce Skill mix review

5. RECOMMENDATIONS

Trust Board is asked to:

- Note the current list of Fragile Services, associated clinical risk and high-level progress updates
- Note the escalation of Cancer services into fragile services oversight
- Note the de-escalation of ENT from fragile services oversight
- Receive further Fragile Service Oversight reports

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/06/39**	
SUBJECT:	**Communications and Engagement Update (bi monthly) March to April 2025**	
DATE OF MEETING:	4 June 2025	
AUTHOR(S):	Alison Aspinall, Head of Communications and Engagement	
EXECUTIVE DIRECTOR SPONSOR:	Kate Henry, Director of Communications & Engagement	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All	

LINK TO PUBLIC SECTOR EQUALITY DUTIES	*Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate*:			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
		✓		
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	*N/A*
		✓		
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
		✓		
	Further Information:			

EXECUTIVE SUMMARY (*KEY ISSUES*):	This report updates on communications and engagement activity during March to April 2025. Please note this report is now covering a two month period (rather than quarterly) to ensure alignment of communications and engagement activity reporting with the Board meeting cycle. It incorporates reporting on the Working with People and Communities Strategy and elements of the previous Communications and Engagement Dashboard into one report. The report consists of:

	• Overview of communications and engagement activity from March and April 2025 • Updates on Experts by Experience activity and involvement • Key communications campaigns and highlights from the period • Working with People and Communities Strategy March to April 2025 update Details of the current plan of upcoming engagement events which the Trust is hosting or planning to attend during 2025

PURPOSE: *(please select as appropriate)*	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this update on Communications and Engagement activity during the quarter.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome	To note	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None		

Our role within WHH

The Communications and Engagement Team remit covers:

- Communications and Engagement Strategy development
- Communications planning and evaluation to support strategic projects
- Internal communications including content production for The Week and Team Brief
- External communications including media relations and stakeholder updates
- Digital communications including content development for the Trust's corporate social media channels and updates to the website
- Identity, branding and design
- Engagement in our communities
- Experts by Experience programme
- Processing and review of clinical patient information

During the period (March and April 2025) the Communications and Engagement Team…

- processed and allocated **27** communications 'job requests' for design, film, photography and communications campaign support
- issued **3** Trust media releases (plus **2** WHH Charity media releases)
- published **13** stories across our main Trust website, charity website and breast screening services website
- prepared / issued **3** media statements
- handled **7** enquiries from local, regional and national print and broadcast media

March / April activity and achievements overview

- Supported communication planning and feedback collection to celebrate the one-year anniversary of the Patient Engagement Portal (PEP)

- Continued with planning and (internal and external) promotion of WHH's annual Thank You Awards 2024-25 including announcing the shortlisted teams and individuals in each category

- Continued to deliver communications and engagement support for the Better Care Together integration programme workstreams and three staff engagement sessions

- Promoted National Administrative Professionals Day (23 April) to recognise the contributions of colleagues

- Developed templates and processes for content submissions for the Living Well Warrington website launch (26 March) and supported communications to staff

- Undertook engagement on proposed changes to nuclear medicine provision at Warrington Hospital (31 March to 28 April)

- Continued to work on the development of a new WHH Charity website

- Continued to work on the accessibility of the Trust website in response to Government Digital Service audit

Details of other communications and engagement activity is included in the highlights section of this update.

Media

Media releases issued during March and April 2025, including:

Gynaecology Super Clinics praised for work to reduce waiting lists at Warrington and Halton Teaching Hospitals

Read the release

Willow Tree Hub appeal launched to support bereaved families at Warrington and Halton Teaching Hospitals

Read the release

Living Well Hub in Warrington marks its first anniversary

Read the release

All media releases / news items can be viewed on our website.

Production of Patient Information (PINFO)

From March to April the Communications and Engagement Team:

- Supported clinical teams in putting **4** new leaflets through the PINFO process

- Reviewed and edited **14** existing leaflets to ensure content is clinically up-to-date and reflects WHH style guidelines

- Identified **79** expired leaflets (plus 173 leaflets archived as they are no longer in use and have exceeded their expiry date)

- Archived **4** leaflets

- Looking to increase the frequency of reminder emails to authors and CBUs

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

Eating well with a soft, moist diet
Information for patients and relatives

This leaflet should not be used if a speech and language therapist has provided specific diet texture advice.

What are soft, moist foods?

- foods which are naturally soft, for example, a banana or yogurt
- normal foods that have been cooked or prepared in such a way that they have a soft texture, for example, mashed potato, scrambled egg or rice pudding

A variety of foods can be softened by adding sauces, milk or gravy. Soft foods should break down into small pieces that can be chewed easily. You may need to soften some foods using a fork or food masher.

On the following pages, there are suggestions of foods from each food group which are suitable to eat when following a soft, moist diet.

Engagement, involvement and insight

From March to April 2025 we recruited 21 Experts by Experience (EbyEs)

We received requests for engagement support for the following projects:

- Experiences and impacts of hospital deconditioning

- Map testing tasks / location finding (Warrington)

- Outpatients blood test clinic info displays

- Health literacy training participation

- Patient forum - chronic respiratory conditions

- Runcorn Health and Education Hub furniture / seating

- Ward A8 redevelopment

Experts by Experience (EbyE) projects

Project name	Overview	No of EbyEs req	Outcomes
Map testing and location finding	Request for EbyE feedback on current site maps via location finding tasks at Warrington Hospital	5	• 5 EbyEs recruited • Feedback highlighted the need for accessible text, improved signage and updated map locations • Map updated and to be shared with Wayfinding and First Impressions Group
Blood test clinic displays	Request for EbyE feedback on wall display designs within Outpatients blood testing clinics	11	• 11 EbyE survey responses • Overall designs perceived as clear and accurate • Feedback shared with project leads • Ratified design placed in waiting areas
Health literacy training	Request for EbyE involvement and participation in health literacy training sessions to help improve health information communication	10	• 10 EbyEs recruited to undertake training on sessions on 7 and 13 May • Next steps to be agreed with Director for Population Health and Health Inequalities

Experts by Experience (EbyE) projects

Project name	Overview	No of EbyEs req	Outcomes
Chronic respiratory conditions patient forum	Request for EbyE participation in a new patient forum for those affected by chronic respiratory conditions	7	• 7 EbyEs recruited (plus 2 patients recruited via Warrington Disability Partnership) • Information shared with project leads, survey to be shared re: meeting formats / content
Runcorn Health and Education Hub seating	Request for EbyEs to inform seating types (with accessibility considerations) in shared spaces	7	• 6 EbyEs recruited to take part in engagement session on 29 April • 1 EbyE with visual impairments supported via one-to-one session
WHH and BCH integration recordings	Request for EbyE interviews to share thoughts on integration (for Start of Year Conference)	3	• 3 EbyEs recruited • 1 recording completed, 2 recordings pending
Involvement in A8 redevelopment	Request for feedback on proposed upgrades and changes to Ward A8	7	• 7 EbyEs recruited • Session to discuss design proposals on 6 May

Experts by Experience (EbyE) projects

Project name	Overview	No of EbyEs req	Outcomes
Hospital deconditioning recordings / animations	Request for EbyE participation in sharing personal experiences of hospital deconditioning	2	• 2 EbyEs recruited • Info shared with project leads • Personal views and experiences to be developed into filming / animations
Patient Engagement Portal (PEP) feedback	Request for EbyEs to share experiences and feecback to inform one year anniversary of PEP	3	• 3 EbyEs recruited • Feedback and photos shared with project lead to inform celebratory communications

Local / national campaigns shared with EbyEs: 3
- Children's oral health survey (Healthwatch Warrington)
- About me awareness card (Healthwatch Warrington)
- Halton - Personalised Care Plan leaflet (NHS Cheshire and Merseyside)

Key campaigns / highlights from March to April 2025

Better Care Together – integration update

- Published the proposed name for our partnership with Bridgewater following engagement with staff and stakeholders
- Promoted and developed content for a regular programme of staff engagement sessions with 220 colleagues from WHH and Bridgewater joining the session on 7 April
- Shared more details on the benefits of integration including the AI Dermatology service

- Updated Better Care Together microsite with workstream news and FAQs – the site received 2712 site visits from 1 March to 30 April. Most viewed page (excluding home page) was Frequently Asked Questions
- Patient stories produced for inclusion in the Strategic Case for Change document
- Continued to deliver joint good morning messages three times per week and a monthly Team Brief for WHH and Bridgewater colleagues
- Communications and Engagement Delivery Group continues to meet monthly.

MaDE for Easter campaign

Comms support provided to the Multi Agency Discharge Event (MaDE) held in the week leading up to and including the Easter bank holiday weekend (14 to 23 April).

Communications included:

- Good morning messages on 9 April and on 30 April

- Content in The Week on 4 April, 11 April and 17 April

- Included in the Team Brief for BCH and WHH staff in March and April

- Promoted on the intranet via a home page banner with MaDE for Easter branding and an events listing

Maternity Team / Walking Mums event promotion and support

On Wednesday 23 April our Maternity Team, in collaboration with Walking Mums, held a free information event for expectant parents at Warrington soft play centre, The Jungle.

The event welcomed more than 35 parents-to-be along with their birthing partners and offered a fantastic space to connect and showcase the support on offer from across our Maternity Team and local support services.

The event showcased a range of opportunities including maternal vaccines, antenatal classes and education, perinatal physio and pelvic health, infant feeding, smoking cessation support, birth option information, Supportive Sloths sling and cloth nappy library, Dad Matters (support for new fathers), Warrington and Halton Maternity and Neonatal Voices Partnership, 0-19 Children's Service and Improving Me (C&M women's health and maternity programme).

Those who attended shared very positive feedback about the event:

"Really insightful and lovely to attend. My partner felt comfortable too which was fantastic"
"I learnt a lot and since my first pregnancy was in a different area, it was very useful to know what's available."

Thank You Awards

- During March and April final preparations for the annual Trust Thank You Awards began

- The popular free ticket draw was launched to staff, with 117 colleagues entering the draw to win a ticket to the awards ceremony

- Good luck videos for finalists were collated along with design work for event materials, including the awards programme and The Big Raffle for WHH Charity

- Final reminders to claim free tickets, book a place and plans for the evening were shared with staff along with reminders of shortlisted finalists

Thank You Awards 2024-25

Good morning message

Wednesday 12 March 2025

WHH Thank You Awards – win one of 10 free tickets

With just over nine weeks to go until this year's WHH Thank You Awards, planning is well under way to make it a showstopping nig...

Back by popular demand, and as part of our commitment to making this year's event as open and inclusive as possible, we are ...opportunity to take part in a draw to receive one of 10 free tickets to the awards.

To be in with a chance of winning a free ticket, all you need to do is submit an entry for yourself or nominate a colleague or voluntee... 21 March.

All nominations are welcome and, importantly, you do not have to give a reason for the nomination.

Pillar 1: Co-production in Service Change/ Development
Recruit, train, deploy, maintain, recognise and reward patients and public who are 'Experts by Experience' to specific estate and service change programmes

1. Grow Experts by Experience (EbyE) capacity to embed Co-production in service design within WHH	• 68 Experts by Experience recruited during 24/25 (21 from March to April). • 195 Experts by Experience total (cumulatively to date). • Continuing to work with WHH colleagues to identify opportunities to involve EbyEs from the outset of projects (#StartwithPeople).	• Ongoing
2. Support EbyE recruitment and retention	• 21 EbyE Projects delivered in 24/25 (plus 3 extended projects – PEP, site map updates and Runcorn Health and Education Hub). • 55 EbyEs participating in March and April projects.	• Ongoing
3. Enhance our programme for involvement	• Annual involvement timetable for awareness days and events informs engagement plan – dependent on team availability (see slide 21). • Involvement with Estates and Strategy teams to ensure substantial strategic, capital or service developments have EbyE involvement / representation e.g. Ward A8, Runcorn Health and Education Hub.	• Ongoing
4. Undertake consultation and engagement to enable effective support for services	• Inclusion of EbyE engagement from beginning of significant projects • Ongoing EbyE participation to be included in future Q1 projects including Better Care Together engagement and workstreams for clinical and operational services integration.	• Ongoing
5. Ensure representation to support Place-Based integrated care delivery	• Use our resources to support wider place-based initiatives and to access insight from our communities and advocacy / equality groups. • Better Care Together continues to be supported in partnership with Bridgewater colleagues.	• Ongoing

Pillar 2: Accessible Information Standard (AIS)
Launch WHH AIS policy to support those with sensory impairments, learning disabilities and non-English speakers to access our services and participate equally in their care

1. Patient Letters	• Working with Patient Experience and Inclusion and Digital Services to ensure accessibility functionality in the PEP / EPR is maximised before launching the 5 Rights campaign. All communications are ready to go. • Work continues on tendering for a new Electronic Patient Record (EPR) with functionality to support accessible information and communication needs.	• 2025-26
2. Ensure website compliance with Web Content Accessibility Guidelines (WCAG) standards	• Processed 150 PDFs in response to Government Digital Service audit of our Trust website against The Public Sector Bodies (Websites and Mobile Applications) (No. 2) Accessibility Regulations 2018 to support greater accessibility. Continue to work with Informatics Merseyside on outstanding technical fixes. • The Trust website has continued to improve in the Silktide index for accessibility rankings, improving from the February rating of 'Great' at 88% (60th place in the rankings) to being rated at 90% compliant and in 63rd place in the NHS (April 2025).	• Ongoing
3. Accessible content creation	• Working with the Patient Experience Team and Digital Services ahead of launching the 5 Rights campaign, to promote the AIS to support patient's rights. • The AIS staff animation is now available with the 5 Rights messaging and branding and subtitles.	• Ongoing
5. Patient information	• The Production of Patient Information Policy includes references to making information accessible.	• Ongoing
7. Signage/wayfinding	• Delivered via Wayfinding and First Impressions Task and Finish Group. Updated maps are in development for Warrington and Halton alongside signage improvements.	• Ongoing

Pillar 3: Reducing Health Inequalities
Using WHH engagement and understanding health inequalities to geographical areas of Warrington North, Warrington South, Widnes and Runcorn

1. Strengthen WHH engagement programme	• Work ongoing with collective WHH teams (Patient Experience and Inclusion, Workforce EDI / Culture and Inclusion, Membership and Governance, Children / Young People, Dementia, Staff Health and Wellbeing team, charity, volunteers, chaplaincy, catering/estates, ward/service reps) to set / link events calendars and activities for 2025 / 26. • Planning an updated events plan and schedule in partnership with Bridgewater Community Healthcare for 2025 / 26.	• Ongoing
2. Provide opportunities for governors to engage in their communities	• Promotion and encouragement of governor event engagement opportunities i.e. showcasing their roles, sharing info, speaking with visitors about the constituencies they represent, collecting details of visitors interested in becoming WHH Foundation Trust Members. No public engagement events were undertaken during March and April.	• Ongoing
3. Support Place Based activity and other key local events	• Ongoing content uploads and process / template mapping for Living Well Warrington website and ongoing promotion of Living Well Warrington via WHH social media.	• Ongoing

Pillar 4: Anchor Institution/Building Social Value
Use Trust estate and resources in partnership with others for the benefit of the wider community

1. Establish WHH's position as an anchor institution in our communities	• Use WHH communication channels to increase engagement with the voluntary and third sector and raise awareness of key campaigns, health improvement and economic wellbeing initiatives. • Promotion of WHH volunteering opportunities with the EbyE membership, via networking and through social media.	• Ongoing
2. Promote opportunities for work, training or volunteering	• Promotion of refreshed work experience offer c/o the Apprenticeship and Widening Participation Team – career pathways now offer bespoke programmes e.g. 'aspire to be a doctor', 'aspire to be an AHP'. • Promote WHH as a great place to work, train or volunteer to enhance the aspirations and life chances of local people. • Job of the Week highlighted every Friday via social media. • Level of engagement with social media and websites. • Promoted two recruitment events including healthcare support worker events at Halton (10 March) and Warrington (28 April)	• Ongoing
3. To utilise local suppliers and venues	• Use local suppliers and venues to support engagement and involvement programmes, where possible.	• Ongoing
4. Support the work of the WHH Charity	• Continue work with the charity team to facilitate charity presence at public engagement and involvement events. WHH Charity activity and fundraising shared bi-monthly at the Patient Experience and Inclusion Sub-Committee. • Charity stakeholder newsletters shared monthly.	• Ongoing

Upcoming engagement events

Upcoming engagement events: 2025

Date	Event	Time	Venue	Event purpose
14 June 2025	Warrington Pride	9am to 3pm	Warrington town centre / Golden Square	Annual partnership event celebrating the LGBTQIA+ community in the town.
28 June 2025	Warrington Armed Forces Day	10am to 6pm	Crosfields Rugby Club, 131 Hood Lane North, Great Sankey, Warrington, WA5 1XU	Annual partnership event including Armed Forces Rugby League games, military vehicle displays, stands and activities.
13 July 2025	Disability Awareness Day	10pm to 4pm	Walton Hall and Gardens, Higher Walton, Warrington, WA4 6SN	Annual family fun day and pan-disability event led by Warrington Disability Partnership.
31 Aug 2025	Warrington Mela	TBC	Queen's Gardens, Palmyra Square, Warrington, WA1 1JN	Annual open event supporting cultural diversity and community inclusion.
1 Oct 2025	Annual Members' Meeting	TBC	Post Grad Centre, Warrington	Annual Trust membership event, bringing together foundation trust members, governors and the Trust Board.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/06/40**	
SUBJECT:	Bi-monthly Strategy Highlight Report	
DATE OF MEETING:	4 June 2025	
AUTHOR(S):	Megan Wainwright, Strategy Project and Team Support Officer	
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Chief Strategy & Partnerships Officer	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate*)	**145** If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position. **1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	

LINK TO PUBLIC SECTOR EQUALITY DUTIES	*Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:*			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
			✓	
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	*N/A*
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			

EXECUTIVE SUMMARY (KEY ISSUES):	• WHH and BCH's respective Trust Boards have now approved the intention for WHH to formally acquire BCH and become one single integrated organisation. These approvals trigger the start of a transaction

	process and it is anticipated that the single organisation will take effect from 1st April 2027, pending approvals. Work continues across all ten workstreams and the process of developing the case for change has commenced.
	• Over 95,000 additional diagnostic tests have been undertaken in Community Diagnostic Centre (CDC) spaces since the first phase of the development opened in the Nightingale building in May 2023. The national CDC programme team have approached the Trust about the possibility of expanding the CDC facility at Halton Health Hub.
	• The brand-new Living Well Warrington online platform went live to the public on 26th March. The site has received 35,000 views since launch. With the membership and offers listed growing daily, the platform showcases nearly 600 activities that support living well across Warrington.
	• Work continues to implement the new post menopausal bleeding pathway within the CDC in Halton. This will enable women to access a one stop clinic for diagnosis of gynaecological cancers.
	• The full business case for development of the East Pathology Hub is in development and will be shared with the executive team in June before being presented to the Board in July.

PURPOSE: *(please select as appropriate)*	**Approval**	**To note** ✓	**Decision**

RECOMMENDATION:	The Trust Board is asked to note this report for information.

PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	

FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None

Strategy update
March-April 2025

Section 1 - Key messages	
Slide 2	Summary of key developments this reporting period

Section 2 - Stakeholder engagement	
Slide 3-5	Summary of key stakeholders engaged during the reporting period

Section 3 - Key strategic projects

Page	Project	Strategy Lead	Status
Slide 6-7	WHH/BCH Integration programme	Stephen Bennett	
Slide 8-9	Runcorn town deal	Carl Mackie/Viviane Risk	
Slide 10-11	Community diagnostic centre	Lefteris Zabatis/Stephen Bennett	
Slide 12-13	New hospitals programme and strategic estates	Carl Mackie	
Slide 14-15	Warrington Living Well Virtual Health & Wellbeing Hub	Rachel Moran/Stephen Bennett	
Slide 16	Completed projects	Strategy team	

Section 4 - Other trust strategic updates	
Slide 17-18	Summary of other Trust strategy related updates

Section 5 - Cheshire and Merseyside strategic updates	
Slide 19	Summary of strategic updates from Cheshire and Merseyside

Key messages

- WHH and BCH's respective Trust Boards have now approved the intention for WHH to formally acquire BCH and become one single integrated organisation. These approvals trigger the start of a transaction process and it is anticipated that the single organisation will take effect from 1st April 2027, pending approvals. Work continues across all ten workstreams and the process of developing the case for change has commenced.

- Over 95,000 additional diagnostic tests have been undertaken in Community Diagnostic Centre (CDC) spaces since the first phase of the development opened in the Nightingale building in May 2023. The national CDC programme team have approached the Trust about the possibility of expanding the CDC facility at Halton Health Hub.

- The brand-new Living Well Warrington online platform went live to the public on 26th March. The site has received 35,000 views since launch. With the membership and offers listed growing daily, the platform showcases nearly 600 activities that support living well across Warrington.

- Work continues to implement the new post menopausal bleeding pathway within the CDC in Halton. This will enable women to access a one stop clinic for diagnosis of gynaecological cancers.

- The full business case for development of the East Pathology Hub is in development and will be shared with the executive team in June before being presented to the Board in July.

Stakeholder and engagement overview

Key stakeholder engagement in period	Job title, organisation	Topic/Nature of engagement
Caroline Williams	Director of Adult Social Services, Warrington Borough Council	Living Well programme and Virtual Hub
Su Foster	Estates Delivery Lead, Cheshire and Merseyside	Halton Place Estates, Potential CDC expansion
Naz Ghodrati	CEO, Warrington Voluntary Action	Warrington Virtual Hub, UEC Steering group, Warrington Poverty Conference
Ian Triplow	CDC Programme Director, Cheshire & Merseyside	Community Diagnostic Centre and potential CDC expansion
Damian Nolan	Director Commissioning and Provision, Adult Social Care, Halton Borough Council	Urgent and Emergency Care System Improvement
Sally Yeoman	CEO, Halton And St Helen's Voluntary and Community Action	Wider determinants of health priorities and prevention programme in Halton
Peter Bryant Christine Doyle Zoe Bond	Mergers and acquisitions team, NHS England	Support with / insight into integration options appraisal
Rob Cooper	Managing Director, Mersey and West Lancashire Teaching Hospitals	Pathology Collaboration
Phil Merrifield	CEO, Made Open Software	Future developments of Living Well Warrington digital platform
Rick Howell	Lead Commissioner, Adult Social Care, Warrington Borough Council	Ageing Well programme board
Wesley Rourke	Executive Director, Environment and Regeneration	Runcorn Shopping City, Levelling up, Runcorn Town Deal
Lee Bloomfield	Associate Director of Strategic Operations, Merseycare NHSFT	Living Well Hub - strategic oversight group
David Wilson	One Halton Clinical director	UEC Steering group

Stakeholder and engagement overview

Key stakeholder engagement in period	Job title, organisation	Topic/Nature of engagement
Tony Leo	Place Director, Halton	Place development and integration programme
Carl Marsh	Place Director, Warrington	Place development
Nick Armstrong	Cheshire and Merseyside ICB	Strategic estates planning, Warrington
Tim McPhee	Associate Director Integration, Transformation and Partnerships, Mersey Care	Runcorn Health and education Hub, One Halton delivery plan
Tasha Zacune Dan McCabe	Cheshire East Council and Place partners	Living Well Hub site visit
Kate Clark	Director of Strategy MWL	Regional Pathology hub
Graham Urwin	CEO, NHS Cheshire and Merseyside	Integration
Sarah Bowman-Jones Mathew Jones Asia Bibi Sunil Sharma	Alder Hey Children's Hospital, Paediatric Surgical team	Paediatric hub project team meeting
Mark Hogg	Director of Finance, Mersey and West Lancashire NHS Trust	Pathology Hub

Stakeholder and engagement overview

Key stakeholder engagement in period	Job title, organisation	Topic/Nature of engagement
Steve Park	Director of Growth, Warrington Borough Council	Living Well Hub – MHCLG evaluation, Warrington Town Deal Board
Chris Woodforde	GP- Halton	CYP CDC Respiratory diagnosis pathway
Debbie Watson	Director of Public health, Warrington Borough Council	Living Well Virtual Hub – exec oversight, Ageing Well Programme Board
Michael Bell	Planning Policy and Programmes Manager	Strategic Estates Programme South Warrington urban Expansion
Paul Tyerman Lee Matthews Laurence Pullan Tom Kearney Rachel Cartwright	Warrington Borough Council	Living well virtual Hub
Louise Berry	Partnership Manager, Warrington disability partnership	Living well virtual Hub
Jay Deakin	Talk Hub C.I.C	Living well virtual Hub
Jane Kinnaird	Samaritans Warrington Manager	Living well virtual Hub
Sam Birchall	Warrington Housing	Living well virtual Hub
Alice Fairhurst	Warrington Youth Zone/CAMHS Partnership	Living well virtual Hub
Paul Corless	Transformation and PCN Lead, ICB	Living well virtual Hub
Sarah Hall	MP	New hospitals programme

Integration – part 1

Programme Overview

Bridgewater Community Healthcare NHS Foundation Trust (BCH) and Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) are coming together and working as one to improve healthcare services for our communities. Warrington and Halton need strong and resilient clinical services, and our healthcare system must be sustainable for the future. We know that we can achieve more together for both our patients and staff.

The integration programme- "Better Care Together" has been established with 10 workstreams: Strategic Programme Development, Estates, Workforce, Finance, Corporate Service Integration, Clinical and Operational Services Integration, Digital Services, Communication and Engagement, Clinical Governance and Quality, and Corporate Governance. Each workstream is developing a detailed delivery plan and working with partners to deliver objectives.

What does this mean for WHH?

The preferred option of a formal acquisition of BCH by WHH has now been approved by both Trust Boards and the organisations are now working towards coming together to form a single legal entity wef 1st April 2027. Work is well underway across all ten workstreams to develop the clinical, operational and corporate models, structures and processes that will deliver the best possible care for the populations of Warrington and Halton, both in hospital and out in the community.

Progress:

- Exploring option to accelerate the transaction process – Case for Change in draft

- 3 Clinical summits have been held, and the outcomes have been summarised

- WHH & Bridgewater staff provided feedback/ideas regarding integration and specifically on services which should be provided closer to and in people's homes at joint Start of the Year Conference

- Strategic People Committee-in-Common commenced in April

- Dermatology AI Skin Analytics Hub went live in April

- Re-analysed base data to quantify growth in corporate WTE between 18/19 and 24/25 following amended national guidance.

Integration – part 2

Quality	People	Sustainability
Patient Safety ✓	**Looking after our people** ✓	**Working in partnership** ✓
Clinical effectiveness ✓	**Innovating the way we work** ✓	**Working responsibly** ✓
Patient experience ✓	**Growing our workforce for the future** ✓	**Sustainable estate and digitally enabled** ✓
Research, development and innovation	Belonging in WHH	**Financial sustainability** ✓

Milestone	Date
Present proposal for acceleration of programme at Trust Boards and ICB	July 2025
Development of clinical model/clinical strategy	July/August 2025

Better Care Together
Home · Community · Hospital

Integrating community and hospital services provided by Bridgewater Community Healthcare NHS Foundation Trust and Warrington and Halton Teaching Hospitals NHS Foundation Trust

Contact details
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Chief Strategy and Partnerships Officer WHH
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Stephen Bennett
Head of Strategy and Partnerships WHH
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Runcorn town deal-part 1

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

Project Overview

WHH is a key partner within Runcorn Old Town's submission to the Town Deal Investment Fund, with an overall opportunity to bring up to £25m to the town. The health and education hub project is led by WHH and is one of 7 projects within the Town Deal plan. The hub is planned to deliver services focussed on prevention, women and children and long-term conditions from a central location in Runcorn.

The project is being developed in partnership with a range of health and care providers across Runcorn, including Bridgewater and Halton Borough Council. The scheme includes a flexible education element designed in partnership with Riverside College.

What does this mean for WHH?

- Delivery of WHH services, including maternity, respiratory, and phlebotomy, from a convenient and accessible town centre location.

- Opportunity to work with local further education college to provide education and training tailored to jobs in health and care, helping to reduce our vacancies.

- Opportunities to further integrate services with other providers across health, care and wellbeing.

Progress since last report

- Library decanted

- Construction programme underway as 1st April

- First session for wider project stakeholders commenced in April, including over 30 participants representing a range of public, voluntary and other organisations supporting delivery of health, education and wellbeing services across Runcorn

- Development of wider communication and engagement plan, including options for hub names

Runcorn town deal- part 2

Quality	People	Sustainability
Patient Safety	**Looking after our people ✓**	**Working in partnership ✓**
Clinical effectiveness ✓	**Innovating the way we work ✓**	**Working responsibly ✓**
Patient experience ✓	**Growing our workforce for the future ✓**	**Sustainable estate and digitally enabled ✓**
Research, development and innovation	Belonging in WHH	**Financial sustainability ✓**

Milestone	Date
Public engagement and naming survey	May – June 2025
Construction complete	Oct 2025
Services go live	Jan 2026

Contact details
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Carl Mackie
Halton Healthy New Town and Strategy
Manager
carlmackie@nhs.net

Community diagnostic centre-part 1

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

Project Overview

- As part of the national strategic vision to create Community Diagnostics Centres (CDC) across England, the Trust is working alongside the regional team to develop a centre for outpatient diagnostics to serve the populations of Warrington and Halton. This will also be a regional resource.

- The final approved CDC Programme covers three phases:
    - ➤ Phase 1 (now complete) saw the development of a range of diagnostic services within the Nightingale Building at Halton.
    - ➤ Phase 2 (now complete) saw a range of diagnostic services established within the Halton Health Hub at Runcorn Shopping City.
    - ➤ Phase 3 will see the development of a new build extension to the CSTM building on the Halton site to accommodate additional CT and MRI services.

What does this mean for WHH?

- Additional capacity to undertake diagnostic testing for patients of Halton and Warrington, and the wider Cheshire and Merseyside region.

- New estate at Halton General Hospital and at the Halton Health Hub in Runcorn Shopping City, which supports new hospitals plans and the estates strategy.

Progress since last report

- Over 90,000 additional diagnostic tests have been undertaken in the new CDC spaces (Phases 1+2) since Phase 1 went live in May 2023.

- MRI and CT services have now recommenced in the Captain Sir Tom Moore building following early handover of the original rooms.

- Completion of the final phase of the programme is planned for May 2025 with clinical activity scheduled to commence from June 2025.

- New AI-led pathway for dermatology is now live in collaboration with Bridgewater.

- Activity plan for 25/26 is now agreed with national CDC programme team. Over 87,000 tests will be delivered, generating revenue in excess of £5m for the Trust.

- Potential opportunity to expand the CDC development at the Halton Health Hub with further allocation of funding from the national programme. Business case to be developed in May to explore financial implications of any planned new development.

Community diagnostic centre- part 2

Quality	People	Sustainability
Patient Safety ✓	Looking after our people ✓	Working in partnership ✓
Clinical effectiveness ✓	Innovating the way we work ✓	Working responsibly
Patient experience ✓	Growing our workforce for the future ✓	Sustainable estate and digitally enabled ✓
Research, development and innovation ✓	Belonging in WHH ✓	Financial sustainability ✓

Milestone	Date
Installation of new CT and MRI scanners	May 2025
Completion of new build CDC (phase 3)	May 2025
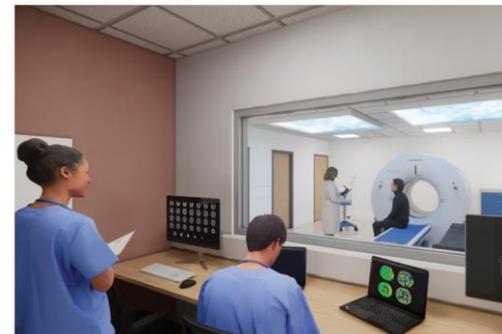
Contact details
Lefteris Zabatis
Senior Strategic Project Manager
lefteris.zabatis@nhs.net

New hospitals and strategic estates planning- part 1

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

Project Overview

- Development of new WHH hospital estate and infrastructure.

- Within Warrington, this is the development of a new hospital, either on the current site or elsewhere in the town.

- Within Halton this is the redevelopment of the Halton Hospital site, including extending Captain Sir Tom Moore to incorporate all existing services and additional services, whilst releasing land to support the Hospital and Wellbeing Campus vision.

What does this mean for WHH?

- Delivery of Trust services from modern, accessible and safe environments.

- Opportunities to develop service provision in appropriate clinical settings and expand opportunities to work with local partners or in external locations.

Progress since last report

- Developed a programme of work to be undertaken across 2025/25 to update the Trust's new hospitals masterplan

- Plans for an urgent treatment centre in development

- Continued development of strategic estates planning work at Halton General Hospital

- Strategic development of future estate programme as part of wider integration in discussion, including potential for shared corporate space to enable the transaction

New hospitals and strategic estates planning- part 2

Quality	People	Sustainability
Patient Safety ✓	**Looking after our people** ✓	**Working in partnership** ✓
Clinical effectiveness ✓	**Innovating the way we work** ✓	**Working responsibly** ✓
Patient experience ✓	**Growing our workforce for the future** ✓	**Sustainable estate and digitally enabled** ✓
Research, development and innovation ✓	Belonging in WHH	**Financial sustainability** ✓

Milestone	Date
Delivery of updated strategic estates masterplan	March 2026

Contact details
Carl Mackie
Halton Health New Town and Strategy Manager
carlmackie@nhs.net

Living Well Virtual Hub- part 1

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

Project Overview

- To lead the development of new Living Well Virtual Hub for Warrington place in partnership with stakeholders across Warrington.

- To replace previous council run "Mylife" service directory with a modern, accessible multi-functional online platform that serves as a one stop shop for many more service providers from across the borough ranging from small grassroots organisations to larger statutory providers.

- The new virtual hub will form part of a growing programme of work at Place to strengthen the offer around prevention, early intervention and empowering self-care through a "community-led" approach.

- The new platform will empower users to navigate their health and wellbeing journey more independently and would become the single digital entry point for any health and wellbeing-related enquiries for the public of Warrington and also for any staff working across the local system.

- Phase 2 will focus on growing the network and providing tools (such as online social prescribing) and actionable insights to professional working within Warrington for better targeting and supporting health needs of local population groups.

What does this mean for WHH?

- Delivery of a new digital product under the Living Well umbrella which supports the shift from analogue to digital, from hospital to community and from sickness to prevention.

- Longer term, the online platform will support improving health outcomes, reducing inequalities and help reduce future demand and pressure on statutory health and care services across the Borough.

Progress since last report

- Launch of Website to public 26th March.

- Continued stakeholder engagement and presentation at various meetings as part of communications plan.

- Completed spend of UKSPF allocated funds.

- 300 new members to platform, 570 live activities, 6,000 active users, 35,000 page views

- Scoping platform sustainability planning started

Living Well Virtual Hub- part 2

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Quality	People	Sustainability
Patient Safety ✓	Looking after our people	**Working in partnership** ✓
Clinical effectiveness ✓	**Innovating the way we work** ✓	**Working responsibly** ✓
Patient experience ✓	Growing our workforce for the future	**Sustainable estate and digitally enabled** ✓
Research, development and innovation ✓	Belonging in WHH	**Financial sustainability** ✓

Milestone	Date
Ongoing network development and onboarding to platform	April-Sept 25
Sustainability and business proposal completion	Sept 25

LIVING WELL IN WARRINGTON

Contact details
Stephen Bennett
Head of Strategy & Partnerships
stephen.bennett13@nhs.net

Rachel Moran
Strategic Project Manager
rachel.moran1@nhs.net

Completed Projects

Halton Health Hub

- Halton Health Hub Phase 1 was completed in November 2022, enabling the delivery of orthoptics, optometry, audiology, and dietetic therapy services from within the Runcorn Shopping City centre in Halton Lea.

- Services in Phase 1 have since been expanded to add MSK therapies, a GP out-of-hours service, public health services, including weight management and smoking cessation, and a Wellbeing Service delivered by Wellbeing Enterprises CIC.

- In November 2023, Phase 2 opened. Phase 2 comprises a Community Diagnostics Centre, offering residents improved access to range of diagnostics and treatments usually only accessible via an acute hospital.

- As October 2024, more than 50,000 patient contacts have occurred at the hub.

Warrington Living Well Hub

- Attendances at the Living Well Hub are now approaching 20,000 since the facility opened in March 2024. 88% of visitors to the Hub live in and around the central wards of the borough which are the most deprived areas of the town.

- The service model continues to evolve with the following new services commencing during the report period:
    - First Response team drop-in
    - Early Years funding support team drop-in advice

- The Living Well programme across the town has been entered into the 2025 HSJ awards as an exemplar programme of work demonstrating a high-quality integrated care approach and provider collaboration.

Other Trust strategic updates

Daycase Unit & Theatre 5 at CSTM, Halton

- Construction works complete

- All areas handed over to operational teams

C&M Endoscopy Hub at Nightingale Building, Halton

- Construction works complete

- All areas handed over to operational teams

Theatre 3 at Nightingale Building, Halton

- T1 & T2 were handed back from contract to Trust on 22nd April 2025, internal Estates works to be completed and IPC sign off required.

- Operational Team plans in place to re-open T1 & T2

- T3 currently in full construction

- WHH Project Team working closely with contractors to manage early warning notices and compensation events

Upgrade to Ward B2 at Nightingale Building, Halton

- Construction works complete

- All areas handed over to operational teams

Other Trust strategic updates

Urgent and Emergency Care System Improvement

- The Urgent and Emergency Care System Improvement Programme continues. All five workstreams are working to agreed delivery plans and making progress which is reported to the ICB regularly. The length of time patients are being nursed on the A&E corridor has reduced from 13 hours in April 2024 to 6 hours in March 2025. Activity in the Same Day Emergency Unit (SDEC) remains consistently above target at 1,192 attendances in April. Bed occupancy rates remain a challenge as do the 4 and 12- hour waiting time targets for the emergency department. Targeted work is ongoing to address these issues and includes the development and expansion of hot clinics. A workshop is being planned with senior managers and ICB colleagues to review progress of the programme which has been operational for 12 months and to agree key areas of focus for the next 12 months.

Digital Projects

PEP Update (Stats from April 2025)

- All appointment, TCI and Radiology letters are now being sent digitally to the NHS App and the Patient Portal.
  - 70% of patient letters have been read digitally reducing the need for printing and postage of letters 12% up on the previous reporting period]
- 62% of our local population are registered with the NHS App (59% Halton, 63% Warrington)
- 129k notification messages have been sent to our patients
  - 75k (58%) were sent via the NHS App
  - 28k were read on the NHS App –reducing SMS messages by 22%
- The WHH physio team have been sending the MSK DART tool (funded by GIRFT) by Broadcast message, approx. 50% of patients have completed the assessment online to triage them and reduce the waiting list for physiotherapy appointments

Cheshire and Merseyside strategic updates

Laboratory Information Management System (LIMS)

- The Full Business Case for a unified LIMS across 5 healthcare organisations was approved by the Trust Board in June 2024. The contract has been awarded to the preferred supplier and implementation is planned to begin in 2027. The local WHH team are collab orating with the regional team to prepare for implementation. Collaboration with the regional pathology collaboration team working on the hub model continues to ensure alignment.

Pathology collaboration

- Work continues to develop the East Pathology Hub and an outline business case was approved by WHH Trust Board in November 2024. Detailed work is ongoing to develop a full business case which will be presented to the Trust Board in July. The full business case will detail the proposal to develop a hub at Whiston hospital and essential services laboratories in Warrington, Halton, Southport, Ormskirk and St Helens. The WHH team are working closely with partners to ensure development of a high- quality service that delivers the needs of our population and staff.

Paediatric surgery

- The pilot of Alder Hey @ Warrington continues with paediatric theatre lists being delivered by Alder Hey surgeons in Warrington. Collaboration with Alder Hey continues with a view to expanding the project to incorporate some activity on the Halton site. A Project Manager in Alder Hey has been appointed to develop the project plan and the Alder Hey team will be visiting the Halton site shortly.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/06/41**
SUBJECT:	**Declarations required by General Condition 6 (G6(3)) and Continuity of Service Condition 7 (CoS7) of the NHS Provider Licence**
DATE OF MEETING:	4 June 2025
AUTHOR(S):	John Culshaw, Company Secretary
EXECUTIVE DIRECTOR SPONSOR:	Nikhil Khashu, Chief Executive

LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓

LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**All**

LINK TO PUBLIC SECTOR EQUALITY DUTIES	*Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:*			
		Yes	**No**	**N/A**
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct			✓
	Further Information:			
		Yes	**No**	**N/A**
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not			✓
	Further Information:			
		Yes	**No**	**N/A**
	3. Foster good relations between people who share a protected characteristic and those who do not			✓
	Further Information:			

EXECUTIVE SUMMARY (KEY ISSUES):	NHS Foundation Trusts are required to self-certify annually whether or not they have complied with the conditions of the NHS provider licence. In addition, Directors of the Board are required to state if they have a reasonable expectation that the Licensee will have required resources available.

PURPOSE: (*please select as appropriate*)	**Approval** ✓	**To note**	**Decision**

RECOMMENDATION:	The Board is asked to note compliance with NHS Conditions G6 and CoS7 and approve the self-certification.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.

	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None	

REPORT TO TRUST BOARD

SUBJECT	Declarations required by General Condition 6 (G6(3)) and Continuity of Service Condition 7 (CoS7) of the NHS Provider Licence	AGENDA REF:	BM/25/06/41

1. BACKGROUND/CONTEXT

NHS Foundation Trusts are required to self-certify annually whether or not they have complied with the conditions of the NHS provider licence.

In addition, Directors of the Board are required to state if they have a reasonable expectation that the Licensee will have required resources available.

The declarations required in relate to the following conditions of the licence are:

1. Condition GS6(3): Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Act and NHS Constitution by 31st May each year and publish this by 30 June each year.

2. Conditions to support continuity of service (CoS7): Allows NHSE to assess whether there is a risk to services and to set out how services will be protected if a provider gets into financial difficulty by 31st May each year.

2. KEY ELEMENTS

Condition GS6(3) Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Act and NHS Constitution
The Trust is required to respond 'Confirmed' or 'Not confirmed' to the following statement. Explanatory information should be provided where required.

Statement:	Response (and supporting information/ assurance)
Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution	**Confirmed** The Head of Internal Audit Opinion, 1st April 2024 to 31st March 2025, provides Substantial Assurance that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. This is a key piece of evidence to support compliance against this condition of the provider licence. The opinion was reached by conducting reviews of key areas of the Trust's activity, for example, the Assurance Framework, Risk Management Controls, Fit & Proper Persons and General Ledger. The review of the Assurance Framework in particular provides assurance that there is sufficient, continuous and reliable assurance, organisational stewardship and effective management of risks to achieve organisational success.

	Further evidence to support this condition includes the Board discussions on the Operational Plan, The Trust's information processes provide the opportunity to review performance data across multiple domains, to improve the availability and accuracy of data and the flow of information and assurance through the governance structure.

Conditions to support continuity of service (CoS7)	
The Trust is required to respond 'Confirmed' or 'Not confirmed' to the following statement. Explanatory information should be provided where required.	
Statement:	**Response (and supporting information/ assurance):** **Confirmed**
After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	The Trust recorded an adjusted deficit of £16.8m which is £5.5m away from the £11.3m deficit plan (adjusted from £27.8m following receipt of £16.5m deficit support funding). This adjusted deficit is the value which NHSE monitors the Trust against and the movement from plan was approved by the ICS. The annual capital programme was £21.7m (including IFRS16 and donated assets) and the actual spend for the year was £21.9m which was an allowable overspend. The cash balance at the end of the year was £16.3m. The cash balance will be utilised to pay both capital (£8.4m) and revenue creditors. There were no failures in financial governance during the year. The Finance and Sustainability Committee reviewed and scrutinised the financial position and performance of the Trust closely throughout the year and escalated any relevant items to the Board in the Chair's exception report. Furthermore, the Board reviewed the position and challenged forecast outturns and mitigations on a regular basis. Capital has been monitored through the year via the Capital Planning Group and Finance and Sustainability Committee, with a particular focus on schemes over £0.5m. Over the past 12 months the Trust has continued to have regular meetings with the ICS where the financial position, forecast and capital have been discussed, reviewed and challenged. Furthermore, in April 2025, the Audit Committee approved the Going Concern Report and recommend that it is appropriate for the accounts to be prepared on the going concern basis

3. APPENDICES

Appendix 1 – G6 & CoS7 Certificate

4. RECOMMENDATIONS

The Board is asked to note compliance with NHS Conditions G6 and CoS7 and approve the self-certification.

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2   General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1   Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.   **Confirmed**   **OK**

3   Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a   After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.   **Confirmed**

OR

3b   After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

3c   In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration
In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust recorded an adjusted deficit of £16.8m which is £5.5m away from the £11.3m deficit plan (adjusted from £27.8m following receipt of £16.5m deficit support funding). This adjusted deficit is the value which NHSE monitors the Trust against and the movement from plan was approved by the ICS.
The annual capital programme was £21.7m (including IFRS16 and donated assets) and the actual spend for the year was £21.9m which was an allowable overspend.
The cash balance at the end of the year was £16.3m. The cash balance will be utilised to pay both capital (£8.4m) and revenue creditors.
There were no failures in financial governance during the year. The Finance and Sustainability Committee reviewed and scrutinised the financial position and performance of the Trust closely throughout the year and escalated any relevant items to the Board in the Chair's exception report. Furthermore, the Board reviewed the position and challenged forecast outturns and mitigations on a regular basis.
Capital has been monitored through the year via the Capital Planning Group and Finance and Sustainability Committee, with a particular focus on schemes over £0.5m.
Over the past 12 months the Trust has continued to have regular meetings with the ICS where the financial position, forecast and capital have been discussed, reviewed and challenged.
Furthermore, in April 2025, the Audit Committee approved the Going Concern Report and recommend that it is appropriate for the accounts to be prepared on the going concern basis

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature   **Signature**

Name Steve McGuirk   **Name** Nikhil Khashu

Capacity Chair   **Capacity** Chief Executive

Date 04.06.2025   **Date** 04.06.2025

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/25/06/42	
SUBJECT:	**Board and Board Development Effectiveness Review Outputs Report**	
DATE OF MEETING:	4 June 2025	
AUTHOR(S):	Emily Kelso, Corporate Governance & Membership Manager, John Culshaw Company Secretary	
EXECUTIVE DIRECTOR SPONSOR:	Nikhil Khashu, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All	

LINK TO PUBLIC SECTOR EQUALITY DUTIES	*Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate*:			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✔
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	*N/A*
				✔
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✔
	Further Information:			

EXECUTIVE SUMMARY *(KEY ISSUES):*	The review of the effectiveness of Board and Board Development meetings throughout 2024/25 was undertaken during May 2025. Both executive and non-executive directors were asked to complete an online questionnaire consisting of 14 multiple choice questions (first question was name only) and one free text question around topics for future board development. • 11 completed surveys were received out of a possible 15. • The scores from the multiple-choice questions were largely positive

	• Board members were asked to suggest topics for future board development for the 2025/26 financial year. The suggested topics are listed within the report. • The board is responsible for taking forward any actions for improvement identified in this report and from Board discussions and to monitor progress against those actions agreed.

PURPOSE: *(please select as appropriate)*	Approval	To note ✓	Decision ✓

RECOMMENDATION:	The Trust Board is asked to: • Note the results of the board and board development effectiveness review • Agree actions for improvement to take forward and monitor in 2025/26.	
PREVIOUSLY CONSIDERED BY:	Committee	Choose an item.
	Agenda Ref.	
	Date of meeting	
	Summary of Outcome	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None	

SUBJECT	Board and Board Development Effectiveness Review Outputs Report	AGENDA REF:	BM/25/06/042

1. BACKGROUND/CONTEXT

The Trust needs to be confident that effective corporate governance arrangements are in place to meet the requirements of the Board, to comply with NHS England's NHS Foundation Trust Code of Governance and to meet the KPIs set out in the NHS England well-led framework **(KLoE 4: Governance).**

This will be achieved through:
- Review of the record of attendance
- self-assessment of the Boards effectiveness
- identification of items for consideration for the following year (i.e., Cycle of Business, presented to and approved by the Trust Board at its meeting, 2 April 2024 (agenda item **BM/25/04/20**)

2. KEY ELEMENTS

Review of Attendance

The complete attendance record, including Extra-Ordinary Private Board meetings, is included as **Appendix 1.** Trust Board members are asked to review, and advise if they feel there are any inaccuracies, as attendance data will be published in the 2024/25 annual report.

Formal apologies have been received on those occasions where Board members have been unable to attend, and in all cases, deputies have attended when Executive Directors have sent apologies, these details are recorded in the minutes for each meeting.

Quorum (given below) has been achieved for all Board meetings throughout 2024/25.

Trust Constitution
> *4.14 No business shall be transacted at a meeting of the Board unless at least half of the Board are present including at least two Executive Directors and two Non-Executive Directors.*

Corporate Governance Observations

Prior to Board meetings, Board members take part in leadership observational visits, the schedule for visits developed by the Trust's Patient Experience Team and cover clinical and non-clinical areas of the Trust. The visits provide an opportunity for Board members to meet staff members and triangulate in "real time" the information presented in Board and Committee meetings. Board members value this time spent with staff and complete an observational report following each visit, which is collated by the Patient Experience Team.

Meetings are always held on the scheduled date and begin promptly. Typically, meetings run to-time, which suggests agendas are well planned and Board meetings are chaired well, with structured discussions on agenda topics.

Circulation of agendas and papers is usually one week prior to meetings. The agenda and papers for Part 1 of Trust Board meetings are made available in the public domain via the Trust website.

The Lead Governor is invited to observe and is included in the paper circulation for both Part 1 and Part 2 of all Trust Board meetings. The Lead Governor is also invited to attend all extra-ordinary Trust Board meetings and following all meetings produces and presents an observation report to the Council of Governors at their next formal meeting.

Board meetings take place across Trust sites, typically alternating between Warrington and Halton Hospitals.

The Survey

Board members were asked to complete an online survey consisting of 14 multiple choice questions and one free text question. There were 11 responses out of a possible 15.

All responses have been treated in confidence i.e., they are not individually attributed.

The scoring system **(Table 1)** applied to the responses/statements is given below:

Strongly Agree	
Agree	
Disagree	
Strongly Disagree	
Unable to Answer	

Table 1: Scoring System

The survey outputs are provided in full as **Appendix 2.**

Survey Outputs
The responses to survey questions were largely positive. It is encouraged that Board members discuss the outputs of the question detailed below.

Question 8: Reports are clear and concise, providing the Board with robust information and effective assurance.

The majority of board members responded with agree, as opposed to strongly agree, and one board member disagreed. which was off trend when benchmarked against other question responses.

Whilst it is recognised board reports have improved over time, given the comments received and the off-trend response to this question, it is recommended that the guidance "A Guide to Effective Report Writing" produced during 2024/25 by the Corporate Governance Team is recirculated to report authors.

Action	Owner
Recirculation of A Guide to Effective Report Writing, via the Corporate Governance Workspace on the Trust SharePoint Gude to all report authors.	Company Secretary

Supplementary Question

Question 14: List any suggested topics for future Board Development

Board members responses have identified 2 topics for future Board Development Days, these are given below:

	Topics	Linked comments
1	Development of the new integrated strategy for North Cheshire and Mersey Healthcare Partnership	Future strategy
2	Potential impact of financial restraints on quality of care	How we move to outstanding - given current pressures are we still pushing our practice on quality sufficiently Discussion on the impact of financial constraints on patient quality and safety which remains our responsibility - and how we are mitigating the risks. Is covered in QAC but would be good for wider Boards to understand this more

The following action will be taken forward:

Action	
A 2025/26 schedule for board development topics to be developed, the schedule will remain fluid so that ad hoc items can be added as and when required. Topics suggested by Board members will be built into the 2025/26 schedule.	**Company Secretary**

3. RECOMMENDATIONS

The Trust Board is asked to:
- Note the results of the board and board development effectiveness review
- Agree actions for improvement to take forward and monitor in 2025/26.

	TRUST BOARD ATTENDANCE LOG 2024-25											
	2024								2025			
Name	03-Apr	Extra April	05-Jun	07-Aug	02-Oct	Extra Nov	04-Dec		05-Feb	Extra March	Extra March	Total
Members & Attendees												
Steve McGuirk, Chair	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	**10 of 10**
Simon Constable, Chief Executive	✓	A	✓	✓								**3 of 4**
Nikhil Khashu, Chief Executive							✓		✓	✓	✓	**4 of 4**
Michael O'Connor, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓		✓	A	✓	**9 of 10**
Cliff Richards, Non-Executive Director	✓	A	✓	✓	✓	✓	A		✓	✓	✓	**8 of 10**
Julie Jarman, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	**10 of 10**
John Somers, Non-Executive Director	✓	✓	✓	✓	A	✓	✓		✓	✓	A	**8 of 10**
Jayne Downey, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓		✓	A	✓	**9 of 10**
Jane Hurst, Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	**10 of 10**
Jan O'Driscoll, Partner Non-Executive Director	A	A	✓	A	A	A	A		A	A	A	**1 of 10**
Ali Kennah, Chief Nurse	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	**10 of 10**
Dan Moore, Chief Operating Officer (acting Chief Exec 1st Sept - 31 Oct)	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	**10 of 10**
Michelle Cloney, Chief People Officer	✓	✓	✓	✓	✓	✓	✓		✓	A	✓	**8 of 10**
Paul Fitzsimmons, Executive Medical Director	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	**10 of 10**
Lucy Gardner, Chief Strategy & Partnerships Officer (01.09.24)	✓	✓	✓	✓	✓	✓	✓		✓	A	✓	**8 of 10**
Kate Henry, Director of Communications & Engagement	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	**10 of 10**
John Culshaw, Company Secretary	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	**10 of 10**
Ailsa Gaskill-Jones, Director of Midwifery	✓		✓	A	✓	✓	✓		✓		A	**6 of 7**

KEY:

A = Apologies

A/D = Apologies/Deputy in Attendance

R = Left Trust

ID	Start time	Completion time	The frequency of the meetings is sufficient to ensure that assurance can be	The length of the meetings is right.	The agenda is appropriate and supports the assurance required	The engagement/ patient stories are working well?	The escalation from the Board Committees is working as it should be	Strategic risks are a priority for the Board and are captured and discussed sufficiently.	Reports are clear and concise, providing the Board with robust information and	There is robust and appropriate challenge by all members of the Board.	Each agenda item is 'closed off' with a clear conclusion and actions.	Board Development sessions help support the strategic objectives and development aims	The frequency of development sessions are sufficient to help support the Board	The subjects covered in the development sessions are appropriate.	List any suggested topics for future Board Development.
1	5/13/25 16:11:15	5/13/25 16:11:55	Strongly Agree	Strongly agree	Strongly Agree	Agree	Strongly agree	Strongly agree	Disagree	Agree	Strongly agree	Agree	Agree	Agree	
2	5/14/25 11:11:36	5/14/25 11:17:34	Strongly Agree	Strongly agree	Strongly Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly Agree	Strongly agree	
3	5/14/25 14:59:01	5/14/25 15:00:00	Strongly Agree	Strongly agree	Strongly Agree	Strongly agree	Strongly agree	Agree	Agree	Agree	Strongly agree	Agree	Agree	Agree	
4	5/14/25 16:05:49	5/14/25 16:06:31	Strongly Agree	Strongly agree	Strongly Agree	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly Agree	Strongly agree	
5	5/14/25 16:34:48	5/14/25 16:37:32	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Future strategy
6	5/15/25 16:50:58	5/15/25 16:52:09	Agree	Agree	Agree	Agree	Strongly agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	
7	5/19/25 7:52:57	5/19/25 7:53:38	Strongly Agree	Strongly agree	Strongly Agree	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	Strongly agree	Strongly Agree	Strongly agree	
8	5/20/25 14:05:17	5/20/25 14:05:51	Strongly Agree	Strongly agree	Strongly Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly Agree	Strongly agree	
9	5/21/25 11:44:46	5/21/25 11:50:48	Strongly Agree	Strongly agree	Strongly Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Strongly Agree	Agree	How we move to outstanding - given current pressures are we still pushing our practice on quality sufficiently Discussion on the impact of financial constraints on patient quality and safety which remains our responsibility - and how we are mitigating the risks. Is covered in QAC but would be good for wider Boards to understand this more
10	5/23/25 16:10:17	5/23/25 16:11:03	Strongly Agree	Strongly agree	Strongly Agree	Strongly agree	Strongly agree	Strongly agree	Strongly agree	Agree	Strongly agree	Strongly agree	Strongly Agree	Strongly agree	
11	5/23/25 20:00:57	5/23/25 20:02:05	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	Agree	

AGENDA REFERENCE:	BM/25/06/043			
SUBJECT:	**Amendments to the Constitution – Removal of Condition 21.6 & appointment of new Partnership Governor**			
DATE OF MEETING:	**4 June 2025**			
AUTHOR(S):	**John Culshaw, Company Secretary**			
EXECUTIVE DIRECTOR SPONSOR:	Nikhil Khashu, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.			✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future			✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.			✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All			

LINK TO PUBLIC SECTOR EQUALITY DUTIES	*Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:*			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
		✓	✓	✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	*N/A*
		✓	✓	✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
		✓	✓	✓
	Further Information:			

EXECUTIVE SUMMARY *(KEY ISSUES):*	The Trust's Constitution states: *45. Amendment of the constitution* *45.1. The Trust may make amendments to its constitution if:* *45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and* *45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.* Following approval by the council of Governors at its meeting 15 May 2025, the paper sets out the recommendation to make the following two key changes to the WHH constitution (as detailed within the paper) 1. It recommends the removal of Condition 21.6, which mandates the appointment of a Non-Executive Director from the University of Chester's Senior Management Team. This

change is driven by the Trust's realigned strategic priorities following the agreement to acquire Bridgewater Community Healthcare NHS Foundation Trust, a focus on flexibility for future board appointments, and challenges faced by previous appointees in meeting statutory obligations due to time constraints.

2. The report proposes appointing Rachael Bagshaw, founder of Walking Mums Cheshire, as a new Partnership Governor. This community group, with significant local engagement, supports mothers through walks and events, addressing mental health and social isolation. The appointment aims to enhance governance by bringing diverse perspectives, facilitating community-focused campaigns, and improving access to the group's membership for Trust initiatives. The Council is recommended to approve both amendments to align with the Trust's strategic objectives and strengthen community engagement

PURPOSE: *(please select as appropriate)*	**Approval** ✓	**To note**	**Decision**
RECOMMENDATION:	The Trust Board is asked to: • Approve the proposal to remove Condition 21.6 form the Trust's Constitution, as outlined in the report • Approve the appointment of Rachael Bagshaw, Founder of 'Walking Mums Cheshire. As outlined in the report		
PREVIOUSLY CONSIDERED BY:	Committee	Council of Governors	
	Agenda Ref.	**COG/25/05/14**	
	Date of meeting	15.05.2025	
	Summary of Outcome	Recommended for approval by Trust Board	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None		

<div align="center">**REPORT TO TRUST BOARD**</div>

SUBJECT	Amendments to the Constitution – Removal of Condition 21.6 & appointment of new Partnership Governor	AGENDA REF:	BM/25/06/043

1. Background/Context

In regard to amendments to the Trust's Constitution, the current WHH Constitution states:

The Trust's Constitution states:

> *45. Amendment of the constitution*
> *45.1. The Trust may make amendments to its constitution if:*
> *45.1.1 more than half of the members of the Board of Directors of the Trust voting approve the amendments; and*
> *45.1.2 more than half of the members of the Council of Governors of the Trust voting approve the amendments.*

This report outlines the process and justification for he recommendations being made to amend the Trust's Constitution; the two proposed changes are:

1. Removal of condition 21.6
2. Appointment of new Partnership Governor.

2. Updates to the WHH Constitution

2.1 Removal of condition 21.6

Background

To support the Trust's wish to have diversity of experience amongst Non-Executive Directors and support the Trust's ambition to achieve 'University Teaching Hospitals' status, in January 2021 the Council of Governors and Trust Board supported the addition of Condition 21.6 to the Trust's Constitution.

Condition 21.6 of the Trust's constitution (version 4.4) stipulates:

"One Non-Executive Director will be appointed from the Senior Management Team of the University of Chester in line with the Trust's strategy. The appointment would form part of a Memorandum of Understanding (MOU) with the University of Chester. In the event the MOU is disestablished, the role of the Non-Executive Director would also be disestablished."

This condition, located within paragraph 21, governs the composition of the Board of Directors. The proposed removal of condition 21.6 aims to remove the requirement for a specific Non-Executive Director from the University of Chester, potentially broadening the pool of candidates for future board appointments.

Rationale for removal

It is proposed to remove Condition 21.6 for the following reasons:

- Following the Board's approval to acquire Bridgewater Community Healthcare NHS Foundation Trust and the NHS's shifting focus towards strengthening local healthcare delivery, optimising resource allocation, and digital transformation; the Trust has realigned its strategic priorities.
- Provides flexibility for potential future appointments, for example the appointment of a Non-Executive Director with a specific skillset or experience.
- Although the appointed individuals from the University of Chester had streamlined responsibilities compared to other Non-Executive Directors, their statutory obligations remained unchanged. Furthermore, those who took on the role struggled to dedicate sufficient time to fulfil the position's demands, resulting in limited participation in the Trust Board.

2.1 Appointment of new Partnership Governor

Background

Partner governors play a valuable role in NHS Foundation Trusts by supporting enhanced governance, accountability, and community engagement. They are typically appointed from key stakeholder organisations, such as local authorities, universities, or community groups, bringing diverse perspectives and expertise to the Trust's Council of Governors.

Partner governors play a role in holding the Trust's Board of Directors accountable by scrutinising performance and ensuring decisions reflect the interests of the wider community. Their external perspective helps maintain transparency and public trust. They also act as a bridge between the Trust and the communities it serves, ensuring local needs and priorities are considered in decision-making. This helps the Trust remain responsive to its population's health and wellbeing requirements.

Currently the Trust's Partnership Governors Consist of representatives from:

- Warrington Borough Council
- Halton Borough Council
- Warrington & Weaver Vale Colleges
- Warrington Sikh Gurdwara

Following discussion at the Governor Engagement Group on 1 May 2025, it is proposed that Rachael Bagshaw, Founder of 'Walking Mums Cheshire' is appointed as an additional Partnership Governor.

Walking Mums Cheshire is a community group founded by Rachael Bagshaw, a mum-of-two from Higher Walton, Warrington. Launched in September 2024 during her maternity leave, the group connects mothers through regular walks, meetups, and events across Warrington

and Cheshire. It has grown rapidly, attracting over 2,400 social media followers and 850 Facebook group members within weeks. The group organises pram-friendly, 3-to-4-mile walks in locations like Walton Gardens, Knutsford, and Bents Garden Centre, fostering friendships, mental health support, and outdoor activity. Walking Mums provides a supportive network for mums, addressing issues like postpartum anxiety and isolation, and has become a vital community hub: https://walkingmums.com/

Rationale for appointment

In addition to providing a valuable and further diverse perspective to the existing Partnership Governors, appointing a representative from Walking Mums Cheshire will support the Trust to access it's the group's membership for such things as surveys and support for important ad hoc campaigns and communications such as RSV Vaccinations.

3. Recommendations

Following approval at the Council of Governors meeting, It is recommended that the Trust Board
- Approve the proposal to remove Condition 21.6 form the Trust's Constitution, as outlined in the report
- Approve the appointment of Rachael Bagshaw, Founder of 'Walking Mums Cheshire. As outlined in the report
-

Following approval from the ruts Board, the proposed changes will take immediate effect.