Warrington and Halton Teaching Hospitals
NHS Foundation Trust

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 1 October 2025, 10.00am – 12:30pm
Lecture Theatre, Education Centre, Halton Hospital

Agenda Item	Time	Agenda Item	Objective/ Desired Outcome	Process	Presenter
BM/25/10/93	**10:00**	Engagement Story Luke's Story - Diabetic Management Admission	***To note***	**Presentation**	Kate Preston, MacIntyre (Provider for learning, support and care of Luke) Clinical Lead: Zetta Edwards, WHH Matron Learning Disabilities and Autism
BM/25/10/94	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***	***Verbal***	Chair
BM/25/10/95	**10:17**	Minutes and Action Log of the previous meeting held on • 6 August 2025	***For approval***	***Minutes***	Chair
BM/25/10/96	**10:20**	Matters Arising	***To note for assurance***	***Verbal***	Chair
BM/25/10/97	**10:25**	Chief Executive's Report	***For assurance***	***Report & Verbal***	Deputy Chief Executive
BM/25/10/98	**10:35**	Chair's Report	***For info/update***	***Verbal***	Chair
BM/25/10/99	**10:40**	Board Assurance Framework	***For approval***	***Report***	Company Secretary
Strategic aims:	  			
BM/25/10/100	**10:45**	Integrated Performance Reports (IPR) and Assurance Committee Reports IPR Dashboard	***For assurance***	***Report***	All Executive Directors
(a)		**Quality Dashboard** **Including** Assurance Reports Quality Assurance Committee 12.08.25, 09.09.25	***For assurance***	***Report***	Chief Nurse Cliff Richards, Committee Chair
(b)		**People Dashboard** **Including** Assurance Reports Strategic People Committee in Common 20.08.25, 17.09.25	***For assurance***	***Report***	Chief People Officer Julie Jarman, Committee Chair

(c) **d)** **e)**		**Sustainability Dashboard - *including Cash Support*** **Including** Assurance Reports Finance and Sustainability Committee/Committee in Common 26.08.25, 22.09.25	***For assurance***	***Report & Presentation***	Chief Finance Officer John Somers, Committee Chair
		Audit Committee Assurance Report 28.08.25	***For assurance***	***Report***	Committee Chair. Mike O'Connor
		Charitable Funds Committee Assurance Report 18.09.25	***For assurance***	***Report***	Committee Chair. Steve McGuirk
Strategic aim:			**Quality**		
BM/25/10/101	**11:10**	Fragile Clinical Services Update	***To note for assurance***	**Report**	Chief Nurse /Executive Medical Director, Chief Operating Officer & Deputy Chief Executive
BM/25/10/102	**11:20**	Compliance Update Q1	***To note for assurance***	**Report**	Chief Nurse
BM/25/10/103	**11:30**	Quality Strategy Update	***To note for assurance***	**Report**	Chief Nurse
BM/25/10/104	**11:35**	Maternity Overview Paper I. ATAIN Q1 2025/26 II. Maternity Incentive Scheme Year 7 position III. September Maternity Quality & Safety update IV. Transitional Care Q1 2025/26	***To note for assurance***	**Report**	Director of Midwifery
Strategic aim			**People**		
BM/25/10/105	**11:45**	Bimonthly Communications and Engagement Report	***To note for assurance***	**Report**	Director of Communications and Engagement
BM/25/10/106	**11:55**	GMC Re-validation Annual Report inc Statement of Compliance	***To note for assurance***	**Report**	Executive Medical Director
BM/25/10/107	**12:00**	i. Workforce Race Equality Standard (WRES) Annual Report 2024/25 ii. Workforce Disability Equality Standard	***To note for assurance***	**Report**	Chief People Officer

		(WDES) Annual Report 2024/25			
Strategic Aim	**Sustainability**				
BM/25/10/108	**12:10**	Bimonthly Strategy Highlight Report	***To note for assurance***	**Report**	Chief Strategy & Partnerships Officer
BM/25/10/109	**12:15**	Organisational Strategy and Values	***To note for assurance***	**Report**	Chief Strategy & Partnerships Officer

Governance					
BM/25/10/110	**12:20**	Committee Chairs Annual Report - Audit Committee	***To note***	**Report**	Mike O'Connor Committee Chair
BM/25/10/111	**12:25**	Cheshire and Merseyside Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common – Terms of Reference	***To approve***	**Report**	Company Secretary

SUPPLEMENTARY PAPERS for noting (see Supplementary Pack)

To Note For Assurance					
BM/25/10/112	Learning From Experience Summary Report Q1	Quality Assurance Committee Date: 12/08/2025 Ref: QAC/25/08/119 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/25/10/113	DIPC Q1 Report	Quality Assurance Committee Date: 12/08/2025 Ref: QAC/25/08/121 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/25/10/114	Learning From Deaths Q1	Quality Assurance Committee Date: 09/09/2025 Ref: QAC/25/09/143 Outcome: Noted	***To note for assurance***	**Report**	Executive Medical Director
BM/25/10/115	Guardian of Safe Working Report Q1	Strategic People Committee in Common Date: 17/09/2025 Ref: SPCIC/25/09/118 Outcome: Noted	***To note for assurance***	**Report**	Chief People Officer
BM/25/10/116	Digital Services High Level Briefing	Finance and Sustainability Committee Date: 26/08/2025 Ref: FSPCiC/25/08/55 Outcome: Noted	***To note for assurance***	**Report**	Executive Medical Director
BM/25/10/117	Senior Information Risk Officer Report	Finance and Sustainability Committee Date: 22/09/2025 Ref: FSPCiC/25/09/83 Outcome: Noted	***To note for assurance only***	***Report***	Executive Medical Director

BM/25/10/118	Charitable Funds Committee Chair's Annual Report / Impact Report		Charitable Funds Committee Date: 18/09/2025 Ref: CFC/25/09/17 Outcome: Noted	***To note for assurance only***	***Report***	Director of Communications and Engagement
Closing						
BM/25/10/119	**12:30**	Review of the Meeting		To discuss	**Verbal**	Chair
BM/25/10/120		Any Other Business		To discuss	**Verbal**	Chair
Date and time of next meeting 3 December 2025, Trust Conference Room, Warrington Hospital						

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

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Luke Robinson

Diabetic Management Admission

Luke Robinson

Luke is a gentleman with Learning disabilities, autism and complex needs and nonverbal

He does not like touch and has very set routines to keep him safe

He lives in a supported living setting with 2:1 staffing due to his need

Luke’s behaviour started to change and health concerns needed to be ruled out

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Diabetic review and management

Luke was on medication for suspected diabetes, could not define if it was type 1 or 2, was been treated for type 2 at the time

A referral came into the hospital diabetic team

Multi Disciplinary Team (MDT) approach was needed

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Admission

ENT review

Interventional Radiology admission

Further management of Diabetes and desensitisation blood work

Warrington and Halton Teaching Hospitals NHS Foundation Trust

What has not worked

Further management of Lukes diabetes

Desensitisation work

Next steps and learnings

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Patient awaiting date for admission

Recognised further education needed for supporting learning disability and autism patients; patient story to be included within learning disability and autism training provisions

Improvement to admission process with an update to hospital passport to support patients further

Collobartion work with the community team and provider with desensitisation work to support ongoing management of Lukes diabetes

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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 6 August 2025 Conference Room Halton Hospital Education Centre/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
Dan Moore (DM)	Chief Operating Officer and Deputy Chief Executive
Ali Kennah (AK)	Chief Nurse
Paul Fitzsimmons (PF)	Executive Medical Director
Jane Hurst (JH)	Chief Finance Officer
Apologies	
Nikhil Khashu (NK)	Chief Executive
In Attendance	
Lucy Gardner (LG)	Chief Strategy and Partnerships Officer
Kate Henry (KH)	Director of Communications & Engagement
Michelle Cloney (MC)	Chief People Officer
Lynne Carter (LC)	Director of Delivery Unit
Zoe Harris (ZH)	Director of Operations and Performance and Deputy Chief Operating Officer
John Culshaw (JC)	Company Secretary
Emma Hackett (EH)	Associate Chief of Nursing – Corporate Nursing **BM/25/08/52**
Emily Kelso	Corporate Governance and Membership Manager **(minutes)**
Observing	
Sue Fitzpatrick	Lead Governor – Public Governor

Agenda Ref	Agenda Item
BM/25/08/52	**Engagement Story – Mia's Story** The Board received an engagement story presented by EH, sharing the experience of Mia, a young footballer who sustained an ACL and meniscus injury in November 2023. Mia and her father, Lucas Kelly, described their care journey at Warrington Hospital via a prerecorded video. Initial care at the minor injuries unit was slow due to timing but compassionate; once seen, Mia received prompt treatment and consistent physiotherapy support. However, early care was fragmented, with repeated assessments due to staff changes. The second MRI was significantly faster, but LK noted that a reassessment six months post-injury could have expedited surgery and reduced recovery time by up to 18 months. Concerns were raised about the lack of clarity in treatment

	options and the emotional impact of delayed decisions, particularly given the importance of football in Mia's life. EH emphasised the need for honest, personalised communication and shared that feedback had been circulated to relevant teams. The Board discussed the ethical and operational implications of private treatment pathways, noting that Mia's private surgery was pursued only after delays in NHS care. SMcG requested a review of how waiting time and private care options are communicated to patients. LG highlighted the importance of repatriating patients post-private treatment. The Board noted the story and agreed it was valuable to revisit these issues at a future meeting. **The Trust Board discussed and noted the Engagement story**
BM/25/08/53	**Welcome, Apologies and Declarations of Interest** SMcG welcomed the Trust Board, attendees and observers to the meeting, and noted apologies as detailed above. It was confirmed that there were no declarations of interest. LC was welcomed to the meeting in her capacity as Director of Delivery Unit, a non-voting advisory and interim role. SMcG informed all present that the meeting would be recorded for the purposes of producing the minutes using AI, in line with the Digital Acceptable Use Policy, and no objections were raised. **The Trust Board noted the apologies and declarations of interest.**
BM/25/08/54	**Minutes and Action Log of the previous meeting held on 4 June 2025** The minutes of the meeting held on 4 June 2025 were agreed as an accurate record subject to two amendments. In relation to ongoing actions, LG confirmed that a board development session on accountable care organisations would be scheduled for November. SMcG confirmed that he had requested to meet with the councils in the near future to gain a better understanding of forthcoming changes. LG further reported that both Warrington and Halton Councils were submitting bids to become pilots for neighbourhood health, and that these bids had been supported by the Trust. It was also noted that the mayor elections had been postponed by a year. **The Trust Board approved the minutes of the meeting held on 5 May 2025 and noted the Action Log**
BM/25/08/55	**Matters Arising** **The Trust Board noted that there were no matters arising.**
BM/25/08/56	**Chief Executive's Report** DM presented the paper in the absence of NK. The paper was taken as read, and the following key points were highlighted: • The national 10-year health plan was released on 3 July 2025, which reaffirmed priorities such as shifting care from hospital to community settings, increasing digital integration, and focusing on prevention over treatment.

	• Penny Dash's NHS Review was published on 7 July, which outlined nine recommendations to improve safety regulations across health and care. Further guidance was expected in the following weeks and months. • The Trust was rated level 4 in the NHS Oversight Framework. Work had been ongoing to understand the drivers behind this rating and to implement actions to improve the Trust's position. • Resident doctors undertook industrial action from 25 to 30 July. The Chief Executive thanked staff for maintaining safe services during this period, which was acknowledged by NHS England and the Secretary of State. No further action was planned. • The Older Person Short Stay Unit opened on 23 June. It aimed to support frailty care by enabling discharge within 72 hours. Early signs were positive, particularly in terms of improving medical staffing in elderly care. • Louise Shepherd, the new North West Regional Director for NHS England, visited the Trust. She toured the Emergency Department and maternity services and officially opened the Urgent Treatment Centre at Warrington Hospital. **The Trust Board noted the Chief Executive's Report**
BM/25/08/57	**Chair's Report** SMcG provided a verbal update since the last Board meeting. He noted the publication of the 10-year plan, observing similarities with previous strategies but emphasising that meaningful change would depend on political processes. He explained the accompanying review as more focused and critical of past regulatory approaches, welcoming its potential to drive improvement alongside the work of Sir Jim Mackey. It was noted that that monthly performance statistics were now being published and would feature in the Integrated Performance Report, marking progress in transparency. AK shared feedback from the Chief Nurse's National Conference, noting the strong nursing voice in the plan and assurance that patients and staff remain central to the agenda. SMcG acknowledged the challenges of recent industrial action, expressing gratitude for the way it had been managed. He also highlighted the significant demands of acquisition work and ongoing financial scrutiny from the ICB and PWC, which risked limiting capacity for service delivery. Finally, he noted changes within local councils and upcoming changes to the CQC regime, including Board observation in December ahead of a likely inspection in 2025/26. **The Trust Board noted the verbal update from the Chair.**
BM/25/08/58	**Board Assurance Framework (BAF)** JC introduced the report which provided the board with an update on each of the Trust's strategic risks. The board approved the re-escalation of the industrial action risk from the corporate register to the Board Assurance Framework (BAF), increasing its rating from 9 to 12. Other risks remained unchanged, details on controls and

	assurances along with assurance gaps were detailed for each individual risk within the report. The EPR programme was discussed in relation to its associated risks. PF explained the Trust was currently in the pre-market engagement phase, with procurement planned. While the timeline remains on track, significant financial risks persist, particularly around budget certainty and funding availability. The Board acknowledged the importance of maintaining fidelity to procurement standards and ensuring robust assurance mechanisms are in place. It was noted that a programme director has been appointed to oversee the EPR rollout, and the Board discussed the need for external assurance to avoid the pitfalls experienced in previous procurement rounds. JD raised a concern about whether the fragile services (Risk 2001) still justified a rating of 20. Noting that while challenges persist, the mechanisms for oversight and escalation—particularly through the Quality Assurance Committee were robust. It was agreed the risk rating would be reviewed further at the August Risk Review Group meeting, considering whether it still represented an existential threat or whether it could be downgraded to reflect improved oversight. The Board expressed concern over the growing financial pressures and external scrutiny. Letters from PwC and the ICB outlined extensive action requirements, and the Board acknowledged that these pressures were beginning to restrict decision-making and investment capacity. SMcG questioned whether the financial risk 134 rating should be increased from 20 to 25, given the existential nature of the challenge. While no formal change was made during the meeting, the Board agreed to revisit this at the next FSC meeting, particularly in light of the outcomes from the PwC engagement. **The Trust Board approved the changes and updates to the Strategic Risk Register and Board Assurance Framework**
BM/25/08/59	**Integrated Performance Report** DM 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. SMcG then identified that the nature of the way the recently published league tables had surfaced the performance of WHH demanded a more detailed consideration by the board on the constitutional targets. The IPR discussion subsequently, then centred on the Trust's performance in urgent care, particularly the 12-hour wait times in the Emergency Department (ED). The Trust had been identified as one of the lowest-performing providers nationally for this metric: • In the June 2025 national data, the Trust ranked 111 out of 111 for 12-hour ED breaches. • For 4-hour performance, the Trust ranked 105 out of 134.

These rankings had triggered increased scrutiny and intervention from national bodies, including direct engagement with NHS England.

The Trust is now part of a Tier 1 improvement programme focused on urgent care recovery.

Several factors were identified as contributing to the poor performance:

- Closure of winter beds in June 2025, which was planned but coincided with other pressures.
- Collapse of intermediate care at home services provided by Warrington Borough Council, which accounted for 70% of the Trust's activity. This led to sustained high bed occupancy and delayed discharges.
- No criteria to reside patients continue to occupy beds, limiting flow and capacity.

The Board acknowledged that while some of these issues were systemic and outside the Trust's direct control, others—particularly around non-admitted pathways, were within its remit and must be addressed urgently.

The Executive Team outlined a series of targeted actions to improve performance:

- Focus on non-admitted patients, who account for 38% of 12-hour breaches. These include patients waiting for next-day services or internal referrals.
- Deflection strategies to reduce unnecessary ED attendances.
- Workforce alignment to ensure timely assessments and interventions.
- Learning from high-performing trusts to adopt best practices.

The Board emphasised the need for a clear, unified approach and empowered the Executive Team to take decisive action. There was consensus that the Trust must move beyond data interpretation and focus on operational delivery.

Board members expressed concern about the reputational impact of being at the bottom of national performance tables. SMcG noted that while some data discrepancies exist (e.g., exclusion of UTC performance), the overall picture was clear and demanded urgent attention.

There was also discussion about the need for improved engagement with local authorities, particularly Warrington Borough Council, to address system-wide challenges. SMcG committed to meeting with council leadership to clarify roles and responsibilities and explore collaborative solutions.

The Board then discussed the broader financial challenges facing the Trust, specifically:

- Letters from PwC and the Integrated Care Board (ICB) outlined extensive action plans and restrictions.
- The Trust must reduce spending by approximately £1 million per month to meet financial targets.
- Cash preservation measures were in place, and the Board approved a request for national cash support.

CR highlight the following key items from **Quality Assurance Committee** assurance reports:

- The committee received a Deep dive and were receiving monthly updates on outpatients spending extended periods in A&E corridor care. There

	were key concerns around whether patients receive appropriate care and the impact of delayed treatment. There had been no confirmed evidence of harm identified so far, though it was difficult to determine long-term outcomes due to small sample sizes. PF explained that mortality reviews had been updated to include a specific question asking whether a long stay in A&E contributed to the patient's outcome. PF also confirmed that this would be raised with coronial inquests so that the issue may be formally considered as part of investigations. • Nationally, there had been pushback on PSIRF. JJ highlighted the following key items from the **Strategic People Committee in Common** assurance reports from a people perspective: • A pilot programme on flexible working and self-rostering had been introduced. However, progress on rolling out the initiative more widely has been constrained by financial pressures and current capacity limitations, meaning expansion could not proceed as quickly as originally planned. JS presented the highlight from **the Finance and Sustainability Committee:** • The last two deep dives had focused on Urgent and Emergency Care (UEC) and performance. • Financially, Month 3 results were broadly on track, but there was a requirement to reduce expenditure by £1 million per month in order to achieve a £12 million stretch target. JS confirmed that a cash request for Q2 had been supported by the Committee and now required board approval. • The new national processes stipulates that payments should not be made until sufficient cash reserves were available. This change would require further dialogue with neighbouring organisations who hold cash balances. SMcG confirmed a formal meeting had been held with PwC, who had been appointed to support the recovery programme. The recovery team includes LC, MC, JH, NK, AK and Eshita Hassan, Deputy Medical Director. Discussions were ongoing as to whether the work should be taken forward by the full group or a smaller core team. **Charitable Funds Committee** No further updates were reported by SMcG. **Audit Committee** MO'C reported that there were no additional items to raise from the meeting. **The Trust Board noted the contents of the report and approved the cash support request for Q2.** **Action: SMcG Undertook to liaise with JS and the CEO on his return from leave to consider whether any additional assurance or support arrangements would assist to address the constitutional targets challenge.**
QUALITY	
BM/25/08/60	**Fragile Clinical Services Update** PF introduced the report, providing a status update on the Trust's oversight of services currently designated as fragile: Chronic Pain Service, Urology, Cancer

	Services, Orthopaedics – Fractured Neck of Femur (FNOF), Cardiorespiratory/Cardiology Services: Key highlights from the report included: • **Fractured Neck of Femur (FNOF)**: Mortality rates, previously within the expected range, had now exceeded it. The underlying performance deficit was linked to delays in time to theatre, an increase in pressure ulcers among this patient group and also been recorded. A mortality pre-alert was received, and the required improvement in theatre access had not yet been achieved. Daily reporting to the care group was now in place, alongside weekly executive updates. Formal correspondence had been issued to the care group outlining individual accountability. The Board was assured that a clear escalation roadmap was in place, and QAC was sighted on the required interventions CR noted that a deep dive into the issue had not convinced QAC of the adequacy of the current plan, which appeared to rely on opening a new unit without a viable alternative. PF confirmed that the team lacked the resources to open a new unit and that the priority was on improving access to theatre. The team now understood the need to grip theatre processes more effectively. The plan presented to QAC had since been revised and escalated SMcG acknowledged the seriousness of the matter and requested a separate meeting involving PF, AK, CR, and JD to discuss the issue in more detail. **The Trust Board: noted the current list of Fragile Services, associated clinical risk and high-level progress updates**
BM/25/08/61	**Mortuary Licensed Activity Bi-Annual Report (Including Fuller update)** The Board received the bi-annual update on mortuary licensed activity, which confirmed that the Trust is now compliant with all 17 recommendations from phase 1 the national enquiry. A point raised at QAC regarding Action 14 was addressed, confirming the designated individual, the Trust's Senior Histopathologist, was actively involved in supporting the completion of the report. While AK presents the paper to Board as the named Executive Lead for mortuary matters, it was confirmed that Dr Chengly's name would be included in future versions which would be presented biannually. The Trust also received an unannounced inspection earlier in the year, which resulted in two partial non-compliances. These had since been resolved and closed. **The Trust Board is asked noted the current compliance of the Fuller Recommendations**
BM/25/08/62	**Risk Management Strategy – Annual Report** AK presented the revised Risk Management Strategy, reaffirming the Trust's commitment to minimising risk to all stakeholders through a comprehensive system of internal control. The strategy outlined an integrated approach to risk management across the organisation, encompassing all risk types. Presented to QAC associated papers with the policy quite straight details on oversight, had risk summit recently will go live. The following key points were highlighted from the discussion: • Associated papers were presented to QAC, with clear details on oversight.

	• A Risk Summit was recently held; implementation of outcomes was expected to go live shortly. • JC noted timing issues with papers for the Strategic People Committee in Common confirming the ToR would be updated. • The FSCiC papers were current and accurate. • SMcG queried the positioning of terror and fire risks. AK clarified that fire risks were managed via the Estates Risk Register, while broader handling sits within the Corporate Risk Register. **The Trust Board noted the contents of the paper.**
BM/25/08/63	**Compliance Update Q4** AK provided an update on Q4 compliance, noting engagements noting the July engagement had been particularly important for Q1 planning. Measures had been implemented to backfill the Head of Compliance post to ensure continuity of work. It was noted that board observations often coincide with well-led CQC inspections, and the organisation was gearing up accordingly. Key areas of focus include: • Mandatory training compliance • Exception reporting • Core governance and assurance processes Ongoing compliance work was highlighted, along with operational tasks requiring attention. The operational team had reviewed the status of ongoing inquiries, confirming that all that could be closed had been completed, ensuring compliance obligations were met and Q1 priorities could proceed smoothly. The table within the report was referenced providing visibility into the status of each inquiry and associated actions. **The Trust Board noted the content of the report.**
BM/25/08/64	**Maternity Review of Year Progress Report** AGJ introduced the presentation which provided the Trust board with an overview of progress during the previous year around Maternity Services. The following key highlights were taken from the presentation: • Sustained staffing improvements were achieved, with some staff returning after leaving; three international recruits thrived following initial support and completion of the *Your Future, Your Way* programme. • Full compliance was achieved with the Maternity Incentive Scheme and *Saving Babies' Lives* bundle; strong governance was maintained through guideline review groups and triangulated learning from patient safety events. • Staff engagement was strong; an example was provided of the "Ideas Sessions" leading to actionable improvements, which were communicated weekly via "You Said, We Did" updates to staff. • Personalised care planning and debriefs were embedded, with family feedback shared through "Thank You Thursday" to celebrate positive experiences. • Staff were recognised for compassionate care, including support during Ramadan and bereavement cases; Team River was awarded Team of the Year. • Stillbirth rates remained below the national average; triage performance was consistently strong and SPC targets were met or exceeded.

	• The Trust was identified as a high-performing organisation for equity and expanded baby loss remembrance events to include inclusive community venues. • A Good CQC rating was maintained; the Trust was one of the top-performing maternity units in the Northwest, with strong LMS assurance feedback. • Quality improvement projects continued, including work on postpartum haemorrhage (PPH), with plans to resume once regional guidelines were finalised. JD explained value of maternity safety walkarounds, noting staff engagement and consistently positive feedback from women and families. SMcG shared a personal reflection on the transformation of maternity services over the past decade, commending AG-J for her leadership and commitment. **The Trust Board noted the content of the presentation, and the progress made across maternity services and, as this was AG-J's last meeting, wished to collectively commend her for her commitment and leadership over the last few years.**
BM/25/08/65	**Maternity Overview Paper** AGJ introduced the paper explaining the Maternity Dashboard, which consolidates key performance indicators and strategic updates, was currently being handed over to her successor. It would be formally presented at a future meeting once the transition was complete. AGJ highlighted that while improvements had been seen in areas such as induction of labour, progress on postpartum haemorrhage (PPH) had been limited. A quality improvement project was paused pending the finalisation of a regional guideline on medication use. Although the guideline was originally expected in February, delays have prevented further action. Dr Bethan is scheduled to attend QAC next week to provide an update and help reconcile the guideline with local plans. The Board expressed strong support for AGJs leadership and presentation style, noting that her clarity and focus have helped shift attention to the most pressing issues. **The Trust Board noted the content of the report,**
BM/25/08/66	**SHMI – Update** PF introduced the report, which had been requested at the June Board meeting, to provide assurance regarding the Trust's SHMI. Although the index had shown an upward trend, it had now stabilised and continues to remain within the expected range. It was confirmed that the Trust's SHMI remains within expected limits and was not an outlier. An increase in SHMI observed in the 12 months to April 2024 was discussed, with the Board noting that this rise was attributable to a change in Type 5 Emergency Department activity coding rather than an increased risk of death. Following this coding change, SHMI had stabilised at a new baseline within expected limits.

	PF explained the higher-than-expected SHMI for Acute Cerebrovascular Disease, confirming that this was driven by stroke case-mix SHMI for Fluid and Electrolyte Disorders was also noted to be higher than expected. The Board was informed that a detailed case-by-case review is ongoing, with findings to be reported through the Quality Assurance Committee once complete. Non-SHMI mortality indicators were considered, with the National Hip Fracture Database identifying hip fracture mortality as a concern. The Board noted that a detailed analysis and action plan will be presented to the July 2025 QAC as part of a Deep Dive review. The Board acknowledged that the recent increase in SHMI was primarily due to coding changes and that the indicator had now stabilised within expected limits. The Board received assurance that mortality data is actively monitored and that appropriate investigative and corrective actions are undertaken when outlying trends are identified. **The Trust Board noted the contents of the report.**
PEOPLE	
BM/25/08/67	**Communication and Engagement Dashboard Q4** KH introduced the report and confirmed that the Communications and Engagement update would be provided on a bimonthly basis going forward, rather than quarterly, to better align with the Board's cycle of business. The key highlights from the report discussed were as follows: • The Thank You Awards had been successfully held, and planning was underway for the following year's awards. • Communications around Martha's Rule and other high-profile charity campaigns had been noted as impactful and ongoing • Work had continued to update and improve patient information leaflets, with a focus on accessibility and relevance • WHH and BCH teams had continued to meet weekly and monthly. A joint intranet was in development, requiring significant planning to be in place by April. The public and patient voice had been actively fed into the integration programme • 15 new experts had been recruited to the Experts by Experience programme, bringing the total to over 200. Six new requests for involvement had been received during the period • A new governor from Walking Mums Cheshire had joined the Council of Governors, representing one of many community groups the Trust aimed to engage with more proactively **The Trust Board noted the report**
SUSTAINABILITY	
BM/25/08/68	**Emergency Preparedness Annual Report** ZH introduced the report explaining, that the Trust's self-assessment for 2024/25 remained overall non-compliant, with 68% of core standards met (42 out of 62). This marked a significant improvement from the previous year's 5% compliance, reflecting progress in key areas.

	Work was ongoing to close remaining gaps, particularly in HAZMAT response, CBRN planning, and major incident scenario testing. Internal practice sessions had been initiated and were being aligned with wider system exercises. SMcG queried preparations for the upcoming Creamfields event, noting the benefits of last year's on-site medical support and suggested future planning could be combined with live event exercises to enhance realism and engagement. ED and ITU have been involved in this year's planning, and site visits were underway. It was confirmed that the medical charity previously managed on-site provision and that the Trust receives a small charitable contribution annually. The Board discussed the importance of linking emergency preparedness with the Trust's risk management strategy and agreed to continue strengthening this connection. **The Trust Board noted the significant work and achievements undertaken during 2024-25 and the planned work programme for 2025-26**

BM/25/08/69	**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 following key points were highlighted from the report:
	• The report confirms that the Trust is broadly on track with its strategic aims, but six KPIs remain red-rated.
	• These six areas include:
	  • Hospital delays and discharge pathways.
	  • MUST screening compliance below 95%.
	  • Two indicators related to sickness absence.
	  • Value for money concerns.
	  • Delivery of the Climate Action Plan.
	• The Board acknowledged that while some targets are unmet, these areas are actively being addressed.
	
	A request was made for the executive summary to clearly list the six red-rated areas for future reporting.
	
	The Trust Board noted the report.

BM/25/08/70	**Strategy Biannual Delivery Report**
	
	LG introduce the biannual report which reviewed delivery against strategic objectives for the second half of FY 2024/25. It tracked progress, identified areas of concern, and supports assurance for the Board and external regulators. Key points highlighted from the report and discussion were as follows:
	• UTC (Urgent Treatment Centre) and CDC (Community Diagnostic Centre) would be discussed further in Part 2 of the meeting.
	• Update shared on local authority leadership:
	  o Halton Borough Council's interim Chief Executive was currently serving as Corporate Director.
	  o Warrington Borough Council's interim Chief Executive was Steve Park, formerly Director of Growth, noted for his supportive engagement with the Trust

	• A reform councillor was elected in Warrington, marking the first such appointment. • A health group has recently been formed to explore devolution plans across Cheshire. Debbie Watson, Director of Public Health Warrington Council had offered to present on devolution progress. The Board expressed interest in including this in a future development day. **The Trust Board noted the content of the report.**
GOVERNANCE	
BM/25/08/71	**Code of Governance Compliance** JC presented the annual compliance statement against the NHS Code of Governance for NHS Provider Trusts. It was explained Trusts are expected to either comply with each provision or explain any departures under the "Comply or Explain" principle. Non-compliance does not constitute a breach of Condition FT4 of the NHS Provider Licence. It was confirmed that the Trust was fully compliant with all provisions of the Code except two, for which formal explanations have been provided and included in the Trusts 2024/25 annual report: • **C.4.3** – Explanation provided • **D.2.1** – Explanation provided. **The Trust Board noted the contents of the report**
BM/25/08/72	**Fit and Proper Persons Test - Annual Report on Board Members** JC presented the annual FPPT report, confirming that the Trust has updated its Fit and Proper Persons Policy to align with the new NHS England FPPT Framework, which came into effect on 30 September 2023. The following key points were taken from the report and the board discussions: • The Trust had submitted all required FPPT evidence to the Regional Director of NHS England by the deadline of 30 June 2025, confirming that all directors remain fit and proper for their roles • The Board was assured that the Trust was fully compliant with the framework and that robust governance mechanisms are in place to maintain ongoing compliance and acknowledged the administrative complexity of the FPPT process but agreed on its necessity for safeguarding leadership integrity. **The Trust Board noted the contents of the report**
BM/25/08/73	**Committee Chairs Annual Reports** **I) Quality Assurance Committee** **II) Strategic People Committee in Commo** **III) Finance and Sustainability Committee** **The Trust Board noted the reports.**
BM/25/08/74	**Finance, Sustainability and Performance Committee in Common Terms of Reference and Cycle of Business** JC introduced the report explaining that the committee had been established to enhance collaboration, strategic alignment, and efficient decision-making across BCH and WHH Trusts, supporting integration ensuring compliance with NHS regulations and local priorities.

	SMcG noted that the establishment of the Quality Assurance Committee in Common was currently pending final approval and was anticipated to be formally constituted in the near future. **The trust Board Approve the Terms of Reference for the Finance, Sustainability & Productivity Committee in Common (Version 1).**
BM/25/08/75	**Cheshire and Merseyside Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common** JC introduced the item, noting that Cheshire and Merseyside providers have formalised collaborative working through the CMPC, evolving from CMAST and MHLDC. The report provided updated governance documents, endorsed by the CMPC Leadership Board and developed with legal input for Trust Board adoption, reflecting expanded scope and clearer decision-making arrangements across acute, specialist and community services. The board discussed the issues around delegation ambiguity, specifically the lack of clarity on what powers are delegated to the CMPC and which remained with individual Trusts. A mapping exercise was needed to define boundaries and responsibilities. SMcG highlighted that the shift from CMAST to CMPC introduced governance challenges, particularly around financial decision-making and accountability. **The Trust Board agreed to endorse and agree the CMPC Joint Working Agreement and Committee in Common as proposed and to bring detail to a future development day to fully understand the implications of delegation and CMPC authority.**
Supplementary Papers – To note for Assurance	
BM/25/08/76	**Complaints Annual Report**
BM/25/08/77	**Learning From Deaths Q4**
BM/25/08/78	**Medicines Management**
BM/25/08/79	**Controlled Drugs Annual Report**
BM/25/08/80	**Infection Prevention and Control BAF Bi-annual report**
BM/25/08/81	**Learning From Experience Summary Report Q4**
BM/25/08/82	**Director of Infection Prevention and Control Annual Report**
BM/25/08/83	**Health and Safety Annual Report#**
BM/25/08/84	**Safeguarding Report**
BM/25/08/85	**Safe Nurse Staffing** AK highlighted the Safe Nurse Staffing update, was based on data from the end of last year and previously reviewed by QAC in February. Further work had been undertaken to reduce bank usage and rates, though the Trust currently reports a staffing deficit of 37.98 WTE. A follow-up data collection was completed in July, with a full report due in December.
BM/25/08/86	**Violence Reduction Strategy**
BM/25/08/87	**Health and Wellbeing Report**
BM/25/08/88	**Guardian of Safe Working Annual Report**
BM/25/08/89	**Digital Strategy Group Update**
BM/25/08/90	**Trust Senior Management Organograms**
Closing	
BM/25/08/91	**Review of the Meeting**

	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/25/08/92	**Any Other Business** No further business was raised. **Meeting ended at 12:58pm**
Date and time of next meeting – 10am, Wednesday 1 October 2025 – Lecture Theatre, Education Centre, Halton Hospital	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

TRUST BOARD

AGENDA REFERENCE	BM/25/10/95i	SUBJECT:	ACTION LOG	DATE OF MEETING	6 August 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
BM/25/06/34	04.06.25	**Chief Executive's Report**	Neighbourhoods and accountable care organisations. Topic should be scheduled for a future board development session to clarify the local interpretation and implementation of neighbourhood care models.	Execs	TBC	TBC	Ongoing	
BM/25/08/70	06.08.25	**Strategy Biannual Delivery Report**	The executive summary to clearly list the six red-rated areas for future reporting.	LG	Feb 2026		Due in February 2026	

3. ACTIONS COMPLETED AND CLOSED SINCE LAST MEETING

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

RAG Key

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/10/97**			
SUBJECT:	**Chief Executive's Report**			
DATE OF MEETING:	1 October 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/25/10/97

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 6 August 2025, some of which are not covered elsewhere on the agenda for this meeting.

2. KEY ELEMENTS

2.1 National News

NHS Oversight Framework Dashboard and League Tables

NHS England has published the first interactive performance dashboard and league tables under the new NHS Oversight Framework NHS England » Segmentation and league tables, which assesses all trusts across key areas such as access, quality, safety, workforce, and finance. Trusts are ranked into segments based on their performance, segment 1 represents the organisations with the narrowest range of challenges while segment 4 contains those with the broadest. Any trust in financial deficit cannot be ranked higher than segment 3, regardless of their wider performance.

High performing trusts in segment 1 may receive greater autonomy and freedom. More challenged trusts, particularly those in segment 4, will be offered support or receive further interventions. For providers facing the most significant performance or governance challenges, NHS England may decide that intensive, tailored support is required and place them in segment 5.

Currently, Warrington and Halton Teaching Hospitals (WHH) is in segment 4 (ranked 118/134 acute and specialist trusts), with colleagues at Bridgewater Community Healthcare (BCH) in segment 3 (ranked 39/61 non-acute trusts). These results reflect both areas of excellence and those requiring improvement, particularly in emergency department waiting times, financial recovery, and elective care.

We are actively addressing these challenges through targeted improvement programmes, cost-saving initiatives, and operational changes. Notably, both trusts perform well in urgent community response, cancer treatment times, staff engagement, and financial plan delivery.

The dashboard will be updated quarterly, providing ongoing transparency and opportunities to track our progress. We remain committed to improvement and to delivering the best possible care for our patients.

2025 NHS Staff Survey

As we approach our transition to a single organisation in April 2026, this year's NHS Staff Survey is especially significant. The survey, launched on 9 September, will be administered independently by IQVIA to ensure confidentiality and anonymity. All staff are encouraged to participate, with dedicated time provided during the working day to complete the survey.

The survey remains separate for WHH and BCH this year and takes less than 20 minutes to complete. High response rates are vital, as feedback directly informs our improvement actions, and we are asking once again for your support in helping us achieve our highest ever response rates and surpass last year's results.

Over the coming weeks, we will share examples of positive changes made as a result of previous staff feedback. Your continued engagement is essential as we work together to make our organisation the best possible place to work and receive care.

2024 Inpatient Survey Results

The Care Quality Commission (CQC) has published the results of the 2024 adult inpatient survey, reflecting feedback from over 62,000 patients across 131 acute and specialist trusts. Our response rate increased to 41% (from 37.13%), with 478 patients participating and the results are published on the CQC's website.

Benchmarking shows our results are broadly in line with peer trusts. We continue to be rated highly for staff kindness, compassion, and respect, with patients expressing confidence in our clinical teams and feeling involved in their care. Notably, our Patient Experience and Inclusion Team has been recognised for work supporting the Deaf community.

The survey highlights ongoing improvements in communication, accessibility, and cultural and religious sensitivity. However, challenges remain, particularly around waiting times for admission, elective care, and discharge support. These areas are being actively addressed in collaboration with community partners.

Overall, the results provide valuable insight into patient experience and reinforce our commitment to continuous improvement as we move towards becoming a single, integrated trust.

Building on our progress in the second half of 2025/26

In a letter from Sir James Mackey, Chief Executive NHS England, NHS England has acknowledged the significant progress made so far this year, moving from a predicted £6 billion deficit to a balanced system position, while continuing to improve waiting times for elective, cancer, and emergency care. The focus for the remainder of 2025/26 is on maintaining financial discipline, accelerating delivery against key performance targets, and preparing for winter pressures.

Key priorities include:

- Ensuring robust financial management and decisive action where plans are off track.
- Returning elective and urgent care performance to plan, with a particular focus on reducing long waits and improving emergency department flow.
- Strengthening access to primary care, community pharmacy, and urgent dental care.
- Completing winter preparedness, including vaccination uptake, discharge planning, and leadership visibility.

- Participating in mid-year reviews to ensure credible plans are in place for operational and financial standards.
- Continuing to support staff wellbeing and leadership, especially during periods of high demand.
- Beginning preparations for 2026/27, with an emphasis on local service transformation, digital innovation, and workforce planning aligned to the 10 Year Health Plan.

The letter concludes with thanks for the collective efforts to date and a call to maintain momentum and collaboration as the NHS navigates ongoing challenges and builds for the future

2.2 Regional Update

Cheshire & Merseyside Provider Collaborative (CMPC) Leadership Arrangements

Following Ann Marr's decision to step down as convenor of the Provider Collaborative, there is now a vacancy on the ICB Board and a need to confirm new leadership for the CMPC. In line with the joint working agreement and terms of reference, (detailed later in the Board Meeting agenda) it has been proposed that Janelle Holmes should act as interim convenor, with formal endorsement for the period October 2025 to April 2028.

ICB Senior Leadership Team Updates

The ICB Senior Leadership Team has undergone several changes due to departures, the upcoming Model ICB reorganisation, and a renewed focus on 2025/26 priorities.

Andrea McGee has joined as Interim Executive Director of Finance and Contracting, while Mark Bakewell has moved on secondment to NHS Lancashire and South Cumbria ICB. Internal recruitment is underway for an Interim Deputy Director of Finance.

Former Place Director for Knowsley, Alison Lee, has joined the Corporate Directors leadership team as Interim Transformation Director for a period of up to six months to 31 March 2026. Alison has taken on portfolio responsibility for All Age Continuing Care and Neighbourhood Health.

Carl Marsh will join the Corporate Directors leadership team as Interim Transformation Director - for a period of up to six months to 31 March 2026 - with portfolio responsibility for Independent Sector Commissioning and Frailty.

Several interim Place Director appointments have been made across the region, including Knowsley (Jenny Wood), Warrington (Amanda Ridge), Cheshire East (Richard Burgess), Sefton (Tracy Jeffes), and continued interim arrangements for Liverpool (Anthony Leo).

Laura Marsh (Cheshire West) and Simon Banks (Wirral) have taken on additional system-wide responsibilities, including work on learning disabilities, neighbourhood health, and mental health recovery.

The leadership team structure and updates are available on the ICB's public website and will be kept current as changes take effect ICB Leadership Team

2.3 Cheshire & Merseyside Provider Collaborative (CMPC) Leadership Board Meeting Updates

August 2025:

The CMPC Leadership Board met on Friday 1st August and discussed a number of system wide issues currently in focus. Trust Chairs were provided with an open invitation given some of the system stretch areas under discussion.

A large part of the meeting was used to explore commercial approaches and opportunities within the system drawing upon experience and lessons from within C&M, the region and progress to date through the CMPC Efficiency at Scale programme. Discussions were led by Bill Gregory, NHSE and James Thomson, UHLG Chief Commercial Officer and sought to provide a framework for response to the system's efficiency requirements but also the recent policy push from NHSE. Following discussions Trust representatives were asked to confirm their organisation's intention to participate in the next phase of the commercial opportunities programme covering the prioritised system opportunities - Pharmacy, Procurement, Estates & Facilities, and Digital - requirements for additional resource in areas including legal, tax, procurement, and PMO, will be subject to a further proposal for specific resourcing as the work develops.

Next the Leadership Board received an update on the work of the Community Services Programme which has been reviewed and reframed since becoming a CMPC programme. Its focus remains on schemes which reduce hospital admissions or enhance rates of discharge including virtual wards and urgent community response schemes. The programme's in year focus is on reducing variation and maximising consistency across C&M. Consideration was also given the an ICB request for review of virtual ward services with a view to a circa 25% funding reduction £3m of £13m. while it is clear that a commissioning decision is required by the ICB views were put forward and explored on the least disruptive options that could be explored as a result of any such reduced funding envelope.

Finally, the Board were provided with a briefing on the work being progressed at the request of the ICB and the region to collate and prioritise schemes for Regional Transformation Bids. While no decisions had yet been made discussions were taking place on deliverability and in year benefit realisation covering NHS priorities: Analogue to Digital; Hospital to Community; Neighbourhood Healthy and other.

Update papers were also provided on the following areas:

- Update in implementation of Federated Data Platform (FDP) – this included a deployment update, consideration of enhanced governance and to build toward a system decision on use of a single PTL
- System financial report
- System performance update

September 2025:

The CMPC Leadership Board met on Friday 5th September and discussed a number of system wide issues.

The Board noted Ann Marr's resignation from the ICB Board and her contribution to provider collaboration within C&M and took the opportunity to consider the next steps for provider collaboration within C&M while CMPC leadership choices were considered by Trusts during the early part of September. These discussions took two parts a Provider Collaborative reset and the development of a provider strategy – an NHS provider Trust blueprint.

On the opportunity for a CMPC reset discussions focussed upon:

- Leadership and alignment with our Trust execs
- Alignment with the ICB and establishment of a recovery cell with the ICB
- Reset of our priorities focussing on:
    - Planned care including elective and diagnostics
    - Community services standardisation and patient flow
    - Clinical pathways and fragile services
    - Efficiency at scale including corporate services opportunities

In respect of the draft and in development NHS provider Trust blueprint opportunities discussed included:

- Fragility of clinical services – exploring creation of service chains for specialist services
- Number and scale of NHS Trust providers – development of provider groups and sub regional partnerships
- Variation in service integration across the ICS – alignment of community services with Places
- Multiple corporate and clinical support services – consolidation

Finally, the Board were provided with a brief over of the 65 week wait position and the need for individual Trust clarity in relation to these positions and expected reductions.

Update papers were also provided on the following areas:

- System financial report
- System performance update

2.4 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 5 – August 2025. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside the relevant Committee Assurance Reports.

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:

August & September 2025

- Continued to celebrate South Asian Heritage Month
- Easts & South East Asian Heritage
- Urology Awareness Month
- Pulmonary Fibrosis Awareness
- World Suicide Day
- World Patient Safety Day
- National Inclusion Week
- International Week of the Deaf
- Organ Donation Week
- World Pharmacists Dat

- ICON Week (**I** – Infant crying is normal, **C** – Comforting methods can help, **O** – Its OK to walk away, **N** – Never, ever, shake a baby)

2.14 Signed under Seal

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

3 MEETINGS ATTENDED

The following is a summary of key external stakeholder meetings I have attended in August and September 2025 since the last Trust Board meeting:

- ICB & Provider Chief Executive Group
- Cheshire & Merseyside Provider Collaborative (CMPC) Leadership meeting
- Sonya Currey, CEO St Rocco's Hospice
- Simon Worthington, PWC
- Joint CEO / NHSE meeting
- Charlotte Nicholls, MP
- Sarah Hall, MP
- Cathy Elliott, Cheshire & Merseyside ICB Chief Executive
- Central & West Warrington CEOs and Strategy Directors Meeting

4 RECOMMENDATIONS

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

5 APPENDICES

Appendix 1: CEO Dashboard – Month 5 (August 2025)

Appendix 1 - CEO Dashboard Month 5 – August 2025

NHS Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality

Operational Performance

Indicator	Target/Limit	Actual	SPC
Diagnostic waiting times - 6 Weeks	above 95%	95.94%	
RTT 18 Weeks	above 92%	57.00%	F
RTT - patients waiting 52+ Weeks	0	1497	F
RTT - patients waiting 65+ Weeks	0	130	F
Elective Outpatient activity	104%	93%	
A&E % patients seen within 4 hours	Below 78.00%	62.87%	F
A&E % waiting longer than 12 hours	Below 2.00%	23.03%	F
Cancer 28 Day Faster Diagnostic Standard	above 75%	74.10%	F
Cancer 62 Day Wait	above 85%	77.90%	F
Ambulance Vehicle Handovers within 45 mins	100%	91.41%	F
Cancelled Operations – not rearranged within 28 days	0	3	
Capped Theatre Utilisation	above 85%	78.57%	F

Quality of Care

Indicator	Target/Limit	Actual	SPC
Incidents open over 40 days	0	29	F
Sepsis Screening Emergency	above 90%	62.00%	F
Sepsis Screening Inpatients	above 90%	79.00%	F
Sepsis Antibiotics Emergency	above 90%	52.00%	F
Sepsis Antibiotics Inpatient	above 90%	83.00%	F
Inpatient Falls	30 (10% reduction from 2024/25)	36	?
VTE	above 95%	94.38%	F
Pressure Ulcers (Category 2 and above)	11 (20% reduction from 2024/25)	14	?
Medication Reconciliation (within 24 hrs)	above 80%	33.16%	F
Complaints over 6 months	0	1	F
Healthcare Infections - MRSA	0	0 YTD	?
Healthcare Infections - MSSA	below 8 YTD	18 YTD	No SPC
Healthcare Infections – CDI (cumulative)	below 15 YTD	38 YTD	?
Healthcare Infections - E. coli (cumulative)	below 20 YTD	34 YTD	?
Healthcare Infections – Klebsiella (cumulative)	below 7 YTD	10 YTD	?
Healthcare Infections - P. aeruginosa (cumulative)	below 2 YTD	7 YTD	?
Maternity Postpartum Haemorrhage >1500ml	below 3.7%	5.80%	F
MUST nutritional assessment completion	above 85%	76.26%	F

Sustainability

Finance

Indicator	Target/Limit	Actual	SPC
Income & Expenditure (£m)	-£3.37	-£3.37	No SPC
Capital Spend (£m)	£9.42	£1.63	F
Cash Balance (£m)	£4.19	£11.24	No SPC
Better Practice Payment Code (£m)	above 95%	43%	F
Agency Reduction (£m)	£1.21 (30% reduction from 2024/25 plan)	£1.01	?
Bank Reduction (£m)	£11.38 (10% reduction from 2024/25 plan)	£13.00	F
CIP In Year Delivered in relation to plan	90% of plan	100%	P
CIP In Year Delivered in relation to plan (Recurrent)	90% of plan	39%	F

People

Workforce

Indicator	Target/Limit	Actual	SPC
Supporting Attendance	Below 5%	5.77%	F
Turnover	Below 13%	11.68%	P
Core/Mandatory Training	above 85%	90.72%	P
PDR Compliance	above 85%	79.99%	F

Strategy

- **WHH and BCH continue to work towards becoming a single organisation.** Trust Boards approved a proposal to accelerate the transaction to become a single organisation from April 2026.
- **Over 100,000 additional diagnostic tests have been undertaken in Community Diagnostic Centre (CDC) spaces since it opened in May 2023.** The third phase of the CDC programme completed in May 2025 and both the new CT and MRI scanners are now fully operational. There is a potential opportunity to develop a fourth phase of the CDC with further funding from the national programme pending approval of a business case. If successful, this would enable ophthalmology assessment services to be provided at Runcorn Shopping City.
- **The Living Well Warrington online platform went live to the public on 26th March.** The site has received over 92,000 views with the membership growing daily. The platform showcases over 680 activities that support living well across Warrington.
- **The Warrington Together Living Well Programme, which includes the Living Well Hub, Talking Points and Living Well Warrington online platform has been shortlisted for a HSJ Award in the Integrated Care Initiative of the Year category.** Results will be announced on 20th November 25.
- **The full business case for development of the East Pathology Hub has been approved by the Trust Board.**

(F) Low assurance – variation indicates consistently (F)ailing short of the target over 7+ months

(P) High assurance – consistently (P)assing target over 7+ months

(?) Inconsistently passing/failing target

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/10/99**
SUBJECT:	**Board Assurance Framework**
DATE OF MEETING:	1 October 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:***

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):*	**Board Assurance Framework** This report provides an update on the Trust's 11 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:** • There have been no new strategic risks added to the BAF. • The risk description of **risk 2001** around fragile services has been amended, as approved by the Quality Assurance Committee (QAC) at its September meeting.

	• There have been no updates to current risk ratings • No target risk ratings or risk appetites to current risk have changed Key updates to existing risk; controls, assurances and gaps are detailed within section 2.7 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 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/25/10/99

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 triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	16 (L4xC4) ⟷	Cautious	FSC

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) ⟷	Seek	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) ⟷	Minimal	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
1757	EMD	If industrial action takes place, then there is a risk of significant workforce gaps across critical services, which may disrupt operational service delivery and compromise the Trust's ability to maintain safe, effective, and timely patient care.	12 (L3xC4) ⟷	Cautious	QAC
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.

Starting from August 2025, each risk has been categorised under one or more of the five CQC domains: Safe, Effective, Caring, Responsive to People's Needs, and Well-Led. This approach was discussed during the August Risk Review Group meeting and reflects best practice aligned with the CQC inspection methodology and the Single Assessment Framework. The relevant domains for each risk are listed in **Appendix 1**.

2. UPDATES SINCE THE LAST MEETING

2 Since the last meeting

2.1 New risks

Since the last meeting no new risks have been added to the

2.3 Amendment to risk ratings

There have been no amendments to current risk ratings.

2.4 Amendments to descriptions

Following discussion at the previous Board meeting and at the September Quality Assurance Committee (QAC), the description of **Risk 2001** was amended to clarify the scope of the fragile services risk. The revised description acknowledges that the risk remains present both where services continue to be fragile and where the Trust is unable to mitigate the associated

challenges. While some services may improve and exit fragile services oversight, others may deteriorate and require inclusion. Given this dynamic and the number of services currently under fragile oversight, the existing risk rating of 20 remains appropriate.

From: *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.*

To: If services remain fragile or 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.

2.5 De-escalation of risks

No risks have been closed or deescalated.

2.6 Risk appetite

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

2.7 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
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.	**Control** • Overnight capacity on ward B4 at Halton planned to open October 25 will take pressure from the Warrington site and support elective recovery **Assurances** • CDC phase 2 including CT & MRI opened in June 2025 CDC phase is underway	**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	**Control** • High level 4-year plan shared with PWC, Chair and CEO. The 4-year plan was reviewed. Further developed at the Exec Away Day September 2025 • Cash Support received for 2024/25 was £12.145m and £4.5m YTD 2025/26 • 2024/25 Phase 2 PWC final report signed off, recommendations actioned and monitored each has an Exec lead and PID. **Assurances** • Changes to WTE have been reviewed by the Finance & Sustainability Committee during the year and the Trust has seen a significant reduction in agency and bank staff. The 2025/26 challenge is to reduce agency by 30% and bank by 10%. Agency is achieving this	**20**	None ⟷

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		target. Bank is slightly over due to IA costs and speciality. • At month 5 2025/26 CIP is on plan achieving 6.7m YTD. **Control and Assurance Gaps** • Risk delivery of the system wide (Level 3) CIP £13M Risk of not receiving deficit support funding. The Trust received Q1 but Q2 has been withheld until C&M ICS has more robust delivery plans in place. Q3 is also expected to be withheld.		
2001	**Updated Risk Description** If services remain fragile or 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**	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	**Gaps In Assurance** • Requirement to re-launch PME September 2025	**16**	**None** ⟷
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.	**Assurances** • Increase in registered nursing establishment in the Emergency Department, November 2024 reducing band 5 vacancy rate to 15 WTE In July 2025 WTE from 46.84 WTE in May 2024. 25 nurses are in pipeline to commence in the next 3 months. • Nursing: Registered Nurse turnover has decreased from 17.34% in January 2023 to 10.02% in July 2025 • Overall CHPPD sustained between 7.3-7.5 in Q4. Noted at 7.6 in July 2025 • Cost avoidance of £2,363,508 m (end April 2025) from agency managed service (AMS) contract started August 2022 and this was ceased in May 2025 due to stopping agency use in all areas apart from AED and Nurse Pool (School holidays only). **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;	**12**	none ⟷

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		accelerated transfers and boarding out of hours – there were 144 escalated beds during April 2025 this increased to 176 in July 2025 • 392 Red Flags reported in July 2025 - Red Flags were linked to escalation areas and enhanced 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	**Sickness Absence** The rolling 12-month sickness absence rate is 6% as at July 2025 and is showing a slight increase from June 2025 (5.98%). Trust target from April 2025 is 5% as approved by the Strategic People Committee following a benchmaking exercise across the C&M region and consideration of health inequalities in the community we recruit staff from. **Controls** • Supporting Attendance Policy and processes in progress August 2025 taking into account benchmarking the policy and best practice. • There is a regional and executive-level call to action initiated in May. The 'Improving Attendance Together' initiative is a strategic response to reduce sickness absence by 1%. Led by the People Directorate, it addresses persistent high absence impacting teams, care, and budgets. It is a strategic priority for the Board and part of the People Plan. Due to high and persistent sickness absence across the Trust and the pressure absence places on teams, patient care, and financial resources. • The WHH Improving Attendance Plan aims to foster a supportive and healthy work environment that encourages staff to maintain their well-being and attendance. This initiative is designed to address the challenges of absenteeism and promote a culture where employees feel valued and motivated to be present at work. Objectives of the programme are as follows: • **Enhance Employee Well-being:** To embed a systematic and compassionate approach to health and wellbeing. • **Reduce Absenteeism:** To demonstrate clear grip and control over staff absence trends and interventions and ensure compliance with regulatory, financial and operational obligations • **Promote a Positive Work Culture:** To enable Board-level scrutiny and accountability on staff experience and productivity where employees feel appreciated and motivated to attend work regularly. • **Improving attendance action plan summary:** o Promoting Health and Wellbeing: Mental health responders, wellbeing champions, physiotherapy, OH services. o Absence Management: Data deep dives, reduction targets, review of dashboards, intervention packages.	**12**	none ⟷

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		o Training: Stress risk assessments, OH referrals, leadership modules. o Support Mechanisms: Culture of belonging phased return, redeployment. o Policy Review: Compassionate language, updated triggers, alternative leave options. • WHH Chief People Officer has agreed to be SRO for a regional C&M led reducing sickness absence policy and WHH Chief Finance Officer has agreed to provide the financial overview and scrutiny of the regional project. Actions to date: o A project plan with key milestones is under development o A data gathering exercise is underway focusing on absence data, reasons, policy and interventions **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 2.89 % in June 2025. However, July has seen this figure increase to 3.23% conseqently there has been a MDT review in collaboration with HR and OH to review all long term sickness absence cases over 100 days to ensure there absence is being managed in accrodance with Trust policy and that a plan is in place to welcome the individual back to work or exit the organisation. • HR and OH identifying areas with high sickness absence, and target interventions, such as specialist OH support for leaders. **Turnover and Attraction** • Turnover in July 2025 remains below the target of 13% at 11.46%, a 1% decrease from the figure reported in February 2025. Turnover of permanent staff in July 2025 was 10.79%. • Retirements, relocation work/life balance remain the main reason for leaving. • The Trust's July 2025 vacancy rate is 8.09% from 7.42% in June 2025, Trust target is below 9%. **Assurances** • The responses to Exit Interviews are positive, only 12.87% as at July 2025 of questions answered are negative, with looking forward to going to work receiving the highest proportion of negative responses. • Staff completing apprenticeships is above the 2.3% target. **Temporary Staffing and Agency spend**		

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		Bank and Agency reliance in July 2025 has decreased to 13.16% . The Trust target is 9%. Bank reliance has reduced to to 9.% from 13% in July 2024 and agency reliance continues to reduce to 0.9%. **Controls** • NHSP bank rates have reduced to the bottom of the banding pay scale and all other AFC bank rates will be mirroring this apporach from Oct-25. • Medical bank rate card was implemented in Oct-24 and alongside a rate escaltion SOP. Top earning workers, are reported to the care groups monthly, so enable mitigation plans to be developed.		
1757	If industrial action takes place, then there is a risk of significant workforce gaps across critical services, which may disrupt operational service delivery and compromise the Trust's ability to maintain safe, effective, and timely patient care.	**Assurances** • Learning identified from the July 2025 experience will be embedded into any future instances of action, a debrief was carried out to capture the learning • Ballot for Consultant and SAS Doctors opened on 21st July 2025 and closed on 1st September 2025. The groups voted in favour of industrial action and have called for negotiations with the government. There has been no further information released regarding intentions to strike. • Ballot for FY1 doctors opened 8th September and will close 6th October. Outcomes of this ballot will be monitored.	**12**	**none**

3. RECOMMENDATIONS

The Board is asked to:

- Discuss and note the updates to the Strategic Risk Register and Board Assurance Framework

Appendix 1

Board Assurance Framework – October 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	CQC Domain(s)	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)	Effective Responsive	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)	Safe Responsive	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)	Well-Led	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)	Safe Responsive	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)	Well-Led	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)	Safe Effective	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)	Well-Led Responsive	Seek	Finance & Sustainability Committee

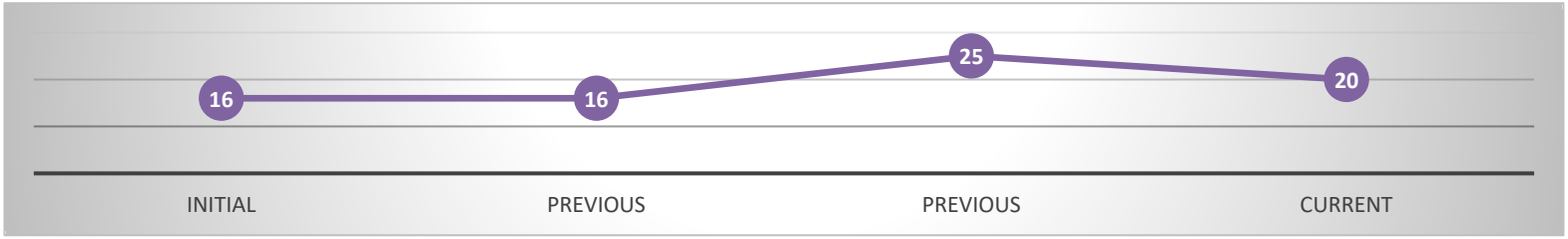
Board Assurance Framework – October 2025

		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)	Safe Caring	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)	Safe Caring	Open	Strategic People Committee
1757	EMD	If industrial action takes place, then there is a risk of significant workforce gaps across critical services, which may disrupt operational service delivery and compromise the Trust's ability to maintain safe, effective, and timely patient care.	1	12 (L4xC3)	8 (L4 xC2)	Safe Responsive	Cautious	Quality Assurance 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)	Well-Led	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

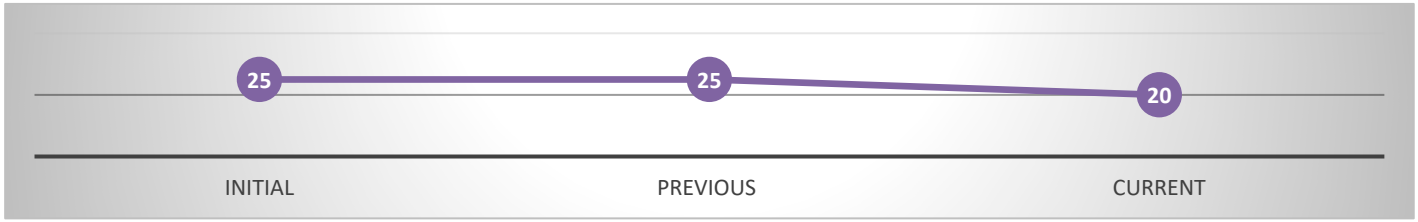
Risk ID	224	**Executive Lead**	Chief Operating Officer	**Rating**	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description	If there are capacity constraints in the Emergency Department, 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.			**Initial**	16(L4xC4)
				Current	20(L5xC4)
				Target	8 (L2 xC4)
CQC Domain	**Effective and Responsive**				
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** • 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 • QI led project to support improving Ambulance handover times **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	(ongoing)	
Ongoing Monitoring of the Emergency Access Standard	ED Insight report daily SITREP report	Ongoing monitoring of risk via daily report SITREP,	Bowman, Karen	(ongoing)	

	National report and benchmarking outcome UEC north dashboard Robust ongoing monitoring	Daily Capacity and Demand report from 4* daily bed meetings. 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	ongoing	

Board Assurance Framework

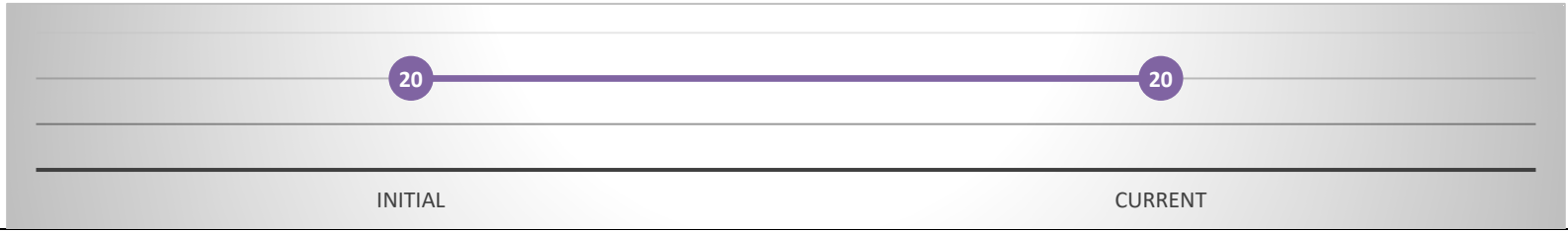
<table>
<tr><td>Risk ID</td><td>1215</td><td>Executive Lead</td><td>Chief Operating Officer</td><td colspan="2" rowspan="2">Rating</td></tr>
<tr><td>Strategic Objective</td><td colspan="3">Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.</td></tr>
<tr><td>Risk Description</td><td colspan="3">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.</td><td>Initial</td><td>25 (L5xC5)</td></tr>
<tr><td></td><td colspan="3"></td><td>Current</td><td>20 (L4xC5)</td></tr>
<tr><td></td><td colspan="3"></td><td>Target</td><td>6 (L3xC2)</td></tr>
<tr><td>CQC Domain(s)</td><td colspan="5">Safe and Responsive</td></tr>
<tr><td>Risk Appetite</td><td colspan="5">Open: Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.</td></tr>
<tr><td>Risk Movement</td><td colspan="5"> 
</td></tr>
<tr><td>Assurance Details</td><td colspan="5"><u>Controls</u>.
• 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 and development of Transfer of care hub team is gaining maturity
• 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 sit. This has given the Trust an additional endoscopy room which is operational now and an additional Theatre at Nightingale which is due completion in September 25
• 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
• Overnight capacity on ward B4 at Halton planned to open October 25 will take pressure from the Warrington site and support elective recovery

<u>Assurances</u>
• All elective patients have been clinically reviewed and categorised in line with national guidance.</td></tr>
</table>

	• 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 GPs 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 2 including CT & MRI opened in June 2025 CDC phase is underway • 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	Ongoing	

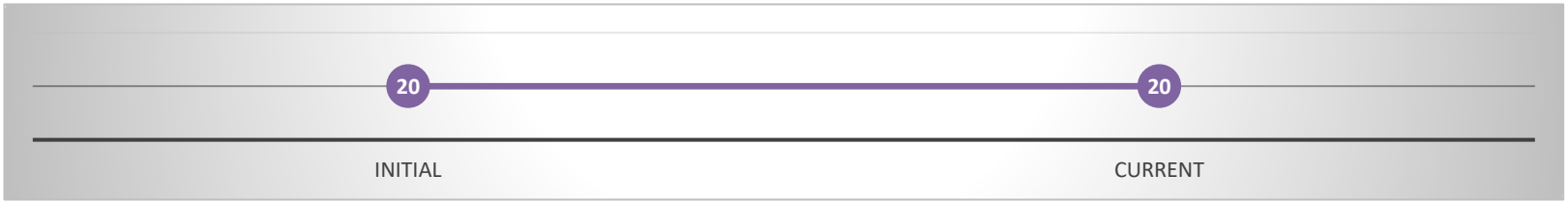
Board Assurance Framework

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)
CQC Domain(s)	**Well-Led**				
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** •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 • Procurement/tender waiver training in place • 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 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, High level 4-year plan shared with PWC, Chair and CEO. The 4-year plan was reviewed. Further developed at the Exec Away Day September 2025 • Capital Plan for 2025/26 approved at 2 April 2025 Trust Board meeting. • Operational Plan approved by Trust Board 28.04.2025 • Introduced system of escalation where there are risks to CIP delivery • Process embedded 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 spends 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 non-catalogue spend and implemented cease option to purchase some items • Cash Support received for 2024/25 was £12.145m and £4.5m YTD 2025/26 • 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 • Monthly 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. • 2024/25 Phase 2 PWC final report signed off, recommendations actioned and monitored each has an Exec lead and PID.				

	• 2024/25 received high assurance for general 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 and to bottom of scale 01.05.25 • Daily cash flow + 12 month forecast in place to manage cash • 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 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 and bank staff. The 2025/26 challenge is to reduce agency by 30% and bank by 10%. Agency is achieving this target. Bank is slightly over due to IA costs and speciality. • 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. • 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. • 2024/25 CIP £18.5m achieved of which £12.5m was the recurrent higher CIP achieved. At month 5 2025/26 CIP is on plan achieving 6.7m YTD • Operational Plan submitted in line with timetable. • Monthly 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 and 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/ CIP • There 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 which 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) CIP £13M • Risk of not receiving deficit support funding. The Trust received Q1 but Q2 has been withheld until C&M ICS has more robust delivery plans in place. Q3 is also expected to be withheld.

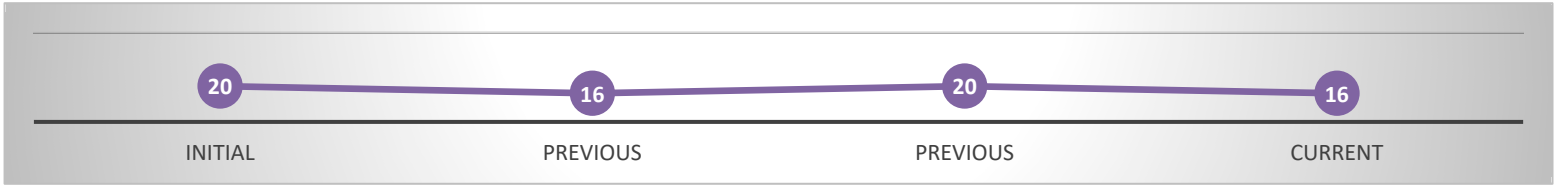
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

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 services remain fragile or 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					
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 • 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

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.				
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)
CQC Domain(s)	**Well-Led**				
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					
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) • All servers and desktops are currently under Microsoft support. **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 • Despite discussions and efforts last year, progress on a regional Cheshire and Merseyside cyber initiative has stalled leaving gaps in Trusts' compliance, assurance, processes, and purchasing of cyber technologies. • A number of Windows 10 devices are not Windows 11 compliant and would need renewal, posing a significant cost impact due to their unique nature.

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	Migrate all 2003 and 2008 servers to 2016.	NICE guidance fully migrated by IT Services and the Communications Team. Both servers now shutdown.	Deacon, Stephen	30/06/25	31/07/25

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. We either need to migrate or decommission the unsupported Windows Server 2003 and Windows Server 2008 to Windows 2016 (Latest server operating system).					
Multifactor authorisation (MFA/PAM) review of Trust critical systems	NHS England reports that using Multi-Factor Authentication (MFA) can prevent or stop 80% of cyber attacks within 20 minutes. Reviewing critical Trust systems and implementing a PAM solution for WHH administrators and third-party vendors is recommended by NHS England's Data Security and Protection Toolkit (DSPT)	Objective: By 31 December 2025, integrate designated WHH system/network administrators and approved 3rd party vendors into the Privileged Access Management (PAM) system, ensuring all access to critical systems is protected with Multi-Factor Authentication (MFA). Specific Tasks & Owners: 1. Bid for ICB Funding – Digital Compliance, IT Services & Bridgewater Secure required capital for PAM procurement. Status: COMPLETE 2. Evaluate PAM Solutions – Digital Compliance, IT Services & Bridgewater Assess and select a suitable PAM product. Status: COMPLETE 3. Purchase PAM System – Procurement, Digital Compliance, IT Services & Bridgewater Acquire licenses and support. Status: COMPLETE 4. Install PAM System – IT Services Deploy system infrastructure and baseline configuration. Status: COMPLETE	Deacon, Stephen	31/12/2025	

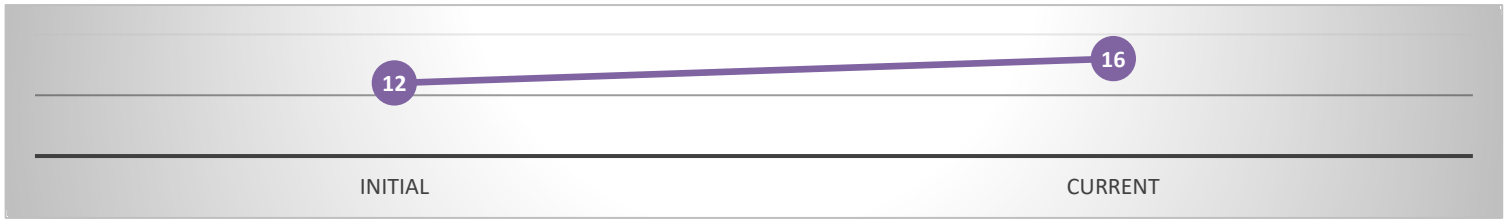
		5. Configure Vendor Access (Phase 1) – Digital Compliance, IT Services Set up PAM access with MFA for 3rd party vendors. Status: IN PROGRESS 6. Configure WHH Admin Access (Phase 2) – Digital Compliance, IT Services Enforce PAM and MFA for all internal privileged users. Status: NOT STARTED Measurable Outcome: 100% of targeted WHH admins and approved vendors securely access critical systems via PAM with MFA by the target date Progress Tracking: 3rd Party Vendors added: - Autsco – CDC Nurse Call - DB Dental Equipment – Dental scanners - OBSBMS – Estates BMS systems - Solventum - Medicode WHH system and network administrators added: - To be completed after the vendors access			
Migrate Windows 10 to Windows 11	Upgrade Windows 10 to Windows 11 before October 2025, as security update support will end.	Objective: Complete the organisation-wide upgrade from Windows 10 to Windows 11 by 30 October 2025, ensuring compatibility with all critical systems and devices. Specific Tasks & Owners: 1. Internal Testing in IT Services – IT Services Validate Windows 11 functionality in a controlled environment. Status: COMPLETE 2. Testing with Critical Systems – IT Services & Clinical/Business Application Owners	Waterfield, Tracie	31/10/2025	

		Ensure compatibility with key operational systems. Status: COMPLETE 3. Rollout on New Devices – IT Services Deploy Windows 11 on newly procured hardware. Status: IN PROGRESS 4. Rollout on Rebuilt Devices – IT Services Upgrade devices through a reimaging process. Status: IN PROGRESS Measurable Outcome: Upgrade completion rate reaches 100% by the 30 October 2025. Progress Tracking: Current progress is 93.73% complete.			
Migrate/decommission Windows Server 2016	Upgrade or decommission Windows Server 2016 before October 2026, as security update support will end.	Objective: Migrate all Windows Server 2016 systems to supported platforms, accounting for varying complexity levels, additional time requirements, and potential migration costs for complex servers. Specific Tasks & Owners: 1. Develop a plan – Server Team Create a detailed rollout strategy Status: COMPLETE 2. Bid Capital monies 25/26 – IT Services Secure required capital for vendor support Status: COMPLETE 3. Execute migration/decommission of low-complexity servers – Server Team Upgrade servers via an in-place upgrade or deploy new servers, then decommission the old servers.	Waterfield, Tracie	29/01/2027	

		Status: IN PROGRESS 3. Plan and schedule complex server migrations – Server Team Upgrade servers via an in-place upgrade or deploy new servers, then decommission the old ones using vendor support when required. Status: NOT STARTED Measurable Outcome: Upgrade completion rate reaches 100% by the 30 October 2026. Progress Tracking: Current progress is 38% complete.			
Removal of generic Window accounts	While generic accounts can simplify workflows for clinical staff, they pose security risks. Eliminating these accounts is essential, as their lack of individual ownership makes tracking activity difficult and increases the risk of data breaches or unauthorised access.	Objective: While generic accounts can simplify workflows for clinical staff, they pose security risks. Eliminating these accounts is essential, as their lack of individual ownership makes tracking activity difficult and increases the risk of data breaches or unauthorised access. Specific Tasks & Owners: 1. Clinical Safety Risk Assessment – CNIO, Digital Compliance, IT Services & Head of Information Review the existing and planned processes to assess potential risks, estimate user logon time with the new process, and determine the scope of the task. Status: NOT STARTED 2. Plan for removal of generic accounts – IT Services Develop a plan for the removal of generic accounts. Status: NOT STARTED 3. Approval of plan via Change Advisory Group (CAG) – IT Services & Change Control Approval required for the plan to removal of generic accounts by CAG.	Waterfield, Tracie	31/12/25	

		Status: NOT STARTED 4. Implement the plan - IT Services Implement the plan for the removal of generic accounts. Status: NOT STARTED Measurable Outcome: All safe-to-remove generic accounts have been removed and users using their own accounts. Progress Tracking: Not Started.			
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 BadgerNet v70 upgrade is scheduled for release on 15th July 2025. The Maternity department will submit a change control request to the Change Approval Group to seek approval of the software upgrade.	Deacon, Stephen	24/07/25	24/06/25
Extend Microsoft Windows 10 support for a limited number of devices	Some Windows 10 devices are not compatible with Windows 11 and need renewal, which would require Trust capital bids for 2026/27 due to the high cost. From October 2025, these devices will pose a cybersecurity risk as any vulnerabilities identified will remain unaddressed. Although Microsoft provides extended support for Windows 10, it entails additional costs.	Objective: IT Services are preparing a NHS England capital bid to extend Microsoft Windows 10 support for these devices while submitting Trust capital bids for 2026/27 to replace them. Key Steps/Actions: - Planned bid with IT Services and confirmed with Bridgewater on potential joint contracts (COMPLETE) - Bid submitted to ICB (See documents) (COMPLETE) - Wait on ICB for decision (IN PROGRESS) Progress Tracking: Waiting on ICB decision	Whitfield, Simon	30/09/25	

Board Assurance Framework

<table>
<tr><td>Risk ID</td><td>1372</td><td>Executive Lead</td><td>Executive Medical Director</td><td colspan="2" rowspan="2">Rating</td></tr>
<tr><td>Strategic Objective</td><td colspan="3">Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.</td></tr>
<tr><td>Risk Description</td><td colspan="3">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</td><td>Initial
Current
Target</td><td>12 (L3 xC4)
16 (L4xC4)
8 (L2 xC4)</td></tr>
<tr><td>CQC Domain(s)</td><td colspan="5">Safe and Effective</td></tr>
<tr><td>Risk Appetite</td><td colspan="5">Cautious – Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential.</td></tr>
<tr><td>Risk Movement</td><td colspan="5"> 
</td></tr>
<tr><td>Assurance Details</td><td colspan="5">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
• PME launched July 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 appointed
• 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</td></tr>
<tr><td>Assurance Gaps</td><td colspan="5">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
• Brokering of FD funds for use in future years not fully agreed
• Requirement to re-launch PME September 2025

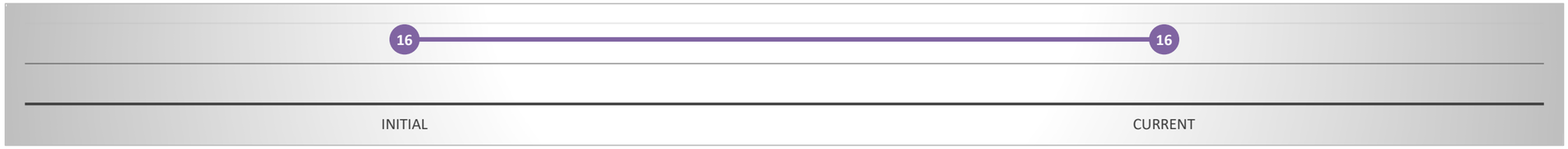
Gaps In Controls</td></tr>
</table>

Board Assurance Framework

	• 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 • Further assurance required regarding state of readiness for implementation

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
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	30/9/25	

Board Assurance Framework

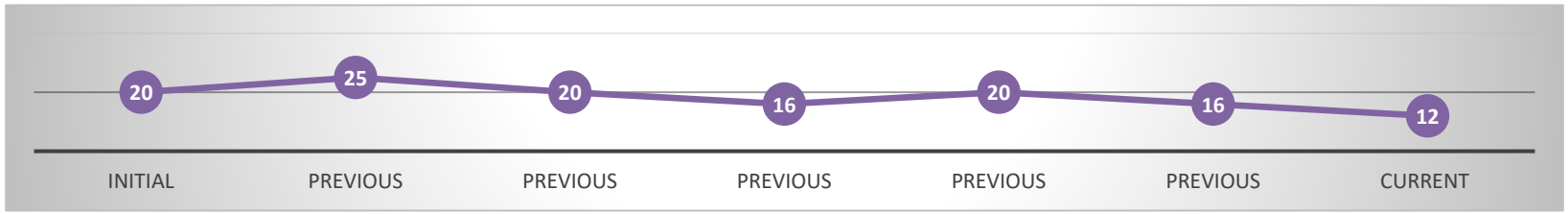
Risk ID:	2273	**Executive Lead:**	Chief Strategy and Partnerships Officer	**Rating**	
Strategic Objective	**Strategic Objective 3:** We will...Work in partnership with others to achieve social and economic wellbeing in our communities				
Risk Description:	If the Trust cannot deliver its strategic vision, 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)
CQC Domain(s)	**Well-Led and Responsive**				
Risk Appetite	**Seek** - Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).				
Risk Movement					
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) opened in 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				

Board Assurance Framework

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 Project manager post to support phased redevelopment plan approved at executive EC panel and will be advertised in September 25	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

<table>
<tr><td>Risk ID</td><td>115</td><td>Executive Lead</td><td>Chief Nurse</td><td colspan="2" rowspan="2">Rating</td></tr>
<tr><td>Strategic Objective</td><td colspan="3">Strategic Objective 1: We will… Always put our patients first delivering safe and effective care and an excellent patient experience.</td></tr>
<tr><td>Risk Description:</td><td colspan="3">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.</td><td>Initial
Current
Target</td><td>20 (L5xC4)
12 (L3xC4)
8 (L2xC4)</td></tr>
<tr><td>CQC Domain(s)</td><td colspan="5">Safe and Caring</td></tr>
<tr><td>Risk Appetite</td><td colspan="5">Minimal – Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.</td></tr>
<tr><td>Risk Movement</td><td colspan="5"> 
</td></tr>
<tr><td>Assurance Details:</td><td colspan="5">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.
• 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
• 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 15 WTE In July 2025 WTE from 46.84 WTE in May 2024. 25 nurses are in pipeline to commence in the next 3 months.
• Latest ED recruitment generated 170 applicants
• Nursing: Registered Nurse turnover has decreased from 17.34% in January 2023 to 10.02% in July 2025
• Overall CHPPD sustained between 7.3-7.5 in Q4. Noted at 7.6 in July 2025</td></tr>
</table>

	• Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 14.47% in July 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 £2,363,508 m (end April 2025) from agency managed service (AMS) contract started August 2022 and this was ceased in May 2025 due to stopping agency use in all areas apart from AED and Nurse Pool (School holidays only). • 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. • 16 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 – there were 144 escalated beds during April 2025 this increased to 176 in July 2025 • Increased requests to provide enhanced care. • Necessity to consistently 'board on wards' with 1 extra patient and to ensure safety is maintained – with a 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. Discharge lounge moved to A10 in April to provide more flexibility for discharge • Partially funded revenue requests • Time to post when recruiting new staff. • 392 Red Flags reported in July 2025 - Red Flags were linked to escalation areas and enhanced care • In Quarter 1 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

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)
CQC Domain(s)	Caring and Safe				
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Control & Assurance Details	**Sickness Absence** The rolling 12-month sickness absence rate is 6% as at July 2025 and is showing a slight increase from June 2025 (5.98%). Trust target from April 2025 is 5% as approved by the Strategic People Committee following a 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 and processes in progress August 2025 taking into account benchmarking the policy and best practice. • 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. Review of absence data by OH to ensure all relevant cases have been referred to OH. • There is a regional and executive-level call to action initiated in May. The 'Improving Attendance Together' initiative is a strategic response to reduce sickness absence by 1%. Led by the People Directorate, it addresses persistent high absence impacting teams, care, and budgets. It is a strategic priority for the Board and part of the People Plan. Due to high and persistent sickness absence across the Trust and the pressure absence places on teams, patient care, and financial resources. • The WHH Improving Attendance Plan aims to foster a supportive and healthy work environment that encourages staff to maintain their well-being and attendance. This initiative is designed to address the challenges of absenteeism and promote a culture where employees feel valued and motivated to be present at work. Objectives of the programme are as follows: • **Enhance Employee Well-being:** To embed a systematic and compassionate approach to health and wellbeing.				

Board Assurance Framework

	• **Reduce Absenteeism:** To demonstrate clear grip and control over staff absence trends and interventions and ensure compliance with regulatory, financial and operational obligations • **Promote a Positive Work Culture:** To enable Board-level scrutiny and accountability on staff experience and productivity where employees feel appreciated and motivated to attend work regularly. • Improving attendance action plan summary: • Promoting Health and Wellbeing: Mental health responders, wellbeing champions, physiotherapy, OH services. • Absence Management: Data deep dives, reduction targets, review of dashboards, intervention packages. • Training: Stress risk assessments, OH referrals, leadership modules. • Support Mechanisms: Culture of belonging phased return, redeployment. • Policy Review: Compassionate language, updated triggers, alternative leave options. • WHH Chief People Officer has agreed to be SRO for a regional C&M led reducing sickness absence policy and WHH Chief Finance Officer has agreed to provide the financial overview and scrutiny of the regional project. Actions to date: • A project plan with key milestones is under development • A data gathering exercise is underway focusing on absence data, reasons, policy and interventions **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 2.89 % in June 2025. However, July has seen this figure increase to 3.23% conseqently there has been a MDT review in collaboration with HR and OH to review all long term sickness absence cases over 100 days to ensure there absence is being managed in accrodance with Trust policy and that a plan is in place to welcome the individual back to work or exit the organisation. • 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. • HR and OH identifying areas with high sickness absence, and target interventions, such as specialist OH support for leaders. • Welcome Back Conversations annual compliance was 74.07% in July 2025, below the target of 85%. Review underway, historically low compliance attributed to delays in recording data and reporting periods. **Turnover and Attraction** • Turnover in July 2025 remains below the target of 13% at 11.46%, a 1% decrease from the figure reported in February 2025. Turnover of permanent staff in July 2025 was 10.79%. • Retirements, relocation work/life balance remain the main reason for leaving. • The Trust's July 2025 vacancy rate is 8.09% from 7.42% in June 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 workwith funding secured to continue with this programme. • 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 campagin which incldues two wards going live with preference rostering from Jan 2025.

Board Assurance Framework

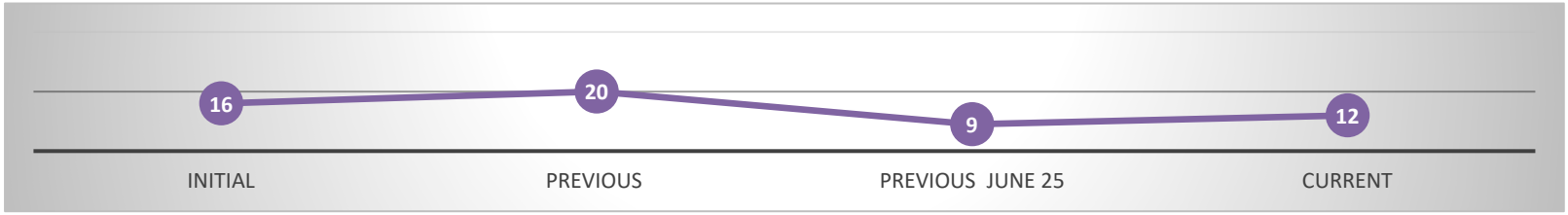
	• Implementation of VCP panels throughout the organisation ensuring vigorous scruitiny of vacancies across the Trust. Promoting internal recruitment and secondment opportunities and also collaborative ring fenced opportunites for Bridgewarer staff and vice versa.
	• To support with attraction, the Trust 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 12.87% as at July 2025 of questions answered are negative, with looking forward to going to work receiving the highest proportion of negative responses.
	• Staff completing apprenticeships is above the 2.3% target.
	
	Temporary Staffing and Agency spend
	Bank and Agency reliance in July 2025 has decreased to 13.16% . The Trust target is 9%. Bank reliance has reduced to to 9.% from 13% in July 2024 and agency reliance continues to reduce to 0.9%.
	
	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 VCP process for non-clinical vacancies, overtime and medical agency.
	• NHSP bank rates have reduced to the bottom of the banding pay scale and all other AFC bank rates will be mirroring this apporach from Oct-25.
	• Medical bank rate card was implemented in Oct-24 and alongside a rate escaltion SOP.
	• Top earning workers, are reported to the care groups monthly, so enable mitigation plans to be developed.
	
	Assurances
	• Compliance against our processes and rate cards is monitored through the Finance and Sustainability Committee
	• To support agency controls, a refined VCP 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 no significant change. This is reflective of sickness absence regionally. • Bank and agency reliance continues to be above target and is demonstrating no significant change. • 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	Laura Hilton & Carl Roberts	31.08.25	31.08.25

		proactive health interventions for staff • Develop a plan for implementation of proactive health support for staff			
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 appraisal review of the current exit interview process.	• Develop SOP for Stay Conversations • Develop Options Appraisal for exit interview process to inform future approach. Depending on the option agreed will determine future actions to address exit interview compliance.	Laura Hilton	30.09.25	

Board Assurance Framework

Risk ID	1757	**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 industrial action takes place, then there is a risk of significant workforce gaps across critical services, which may disrupt operational service delivery and compromise the Trust's ability to maintain safe, effective, and timely patient care.			**Initial**	16 (L4 xC4)
				Current	12 (L3 xC4)↑
				Target	8 (L4 xC2)
Risk Appetite	**Cautious –** Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Risk Movement					
Control & Assurance Details:	**Controls** • Trust policies updated in relation to industrial action • Trust approach to industrial action established following learning from experiences in 2022-2024 • Advance rostering to identify gaps and plan for temporary staffing as far in advance as possible. • Planning templates shared with all clinical services with risks flagged through the Industrial Action Planning Group in advance of the periods of action • Escalation processes and support materials incorporated into industrial action communications • IA tactical meeting schedule established for the days of strike action, including where system IA being taken and not specific to WHH. • Participation in ICB IA Clinical Cell calls where applicable. • Use of Industrial Action Bank Shift Rate Card to incentivise and secure adequate medical staffing during periods of medical IA. • IA Task and Finish group completed organisational preparedness for industrial action policies and procedures ratified and FAQ documents created and published and updated regularly. • Executive Medical Director led check and challenge meetings for periods of industrial action to prepare and mitigate risk. Final sign off of rotas and plans by the Executive Medical Director / Deputy • Attendance at national and regional briefing sessions and working groups to ensure up to date and sharing of best practice. • Following national guidance available for instances of IA • Regular briefing sessions held virtually for senior leaders and staff • Supporting materials available on the Trust intranet including FAQs and the response plan **Assurance** • Amendments to policy agreed at JNCC to ensure policies fit for purpose during strike action. • No derogations been required thus far - awaiting further instruction from ICS / NHS England • Robust reporting mechanisms in place for quantifying the workforce, activity and financial impacts of industrial action • Long term NHS Workforce plan published 30/06/23 to address gaps in workforce. • Ballot open for Resident Doctors with 55% in favour of Industrial Action, 6 month period for action to be carried out (until January 2026) • First phase of industrial action taking place 25th - 30th July 2025, with a planning and oversight structure in place led by the Executive Medical Director / Deputy Medical Director • Learning identified from 2022-2024 industrial action has been embedded into Trust policy and planning for industrial action • Learning identified from the July 2025 experience will be embedded into any future instances of action, a debrief was carried out to capture the learning				

Board Assurance Framework

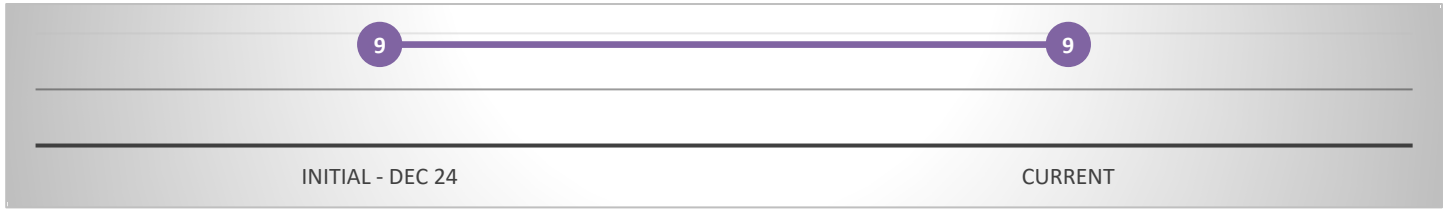
Assurance Gaps:	• Trust EPRR lead linking in with ICB to provide any information requests • Potential financial and recovery implications associated with periods of industrial action. • Cancellation of elective and outpatient appointments to support medical cover over the period of Resident Doctor industrial action. This will impact on performance. • Ballot for Consultant and SAS Doctors opened on 21st July 2025 and closed on 1st September 2025. The groups voted in favour of industrial action and have called for negotiations with the government. There has been no further information released regarding intentions to strike. • Ballot for FY1 doctors opened 8th September and will close 6th October. Outcomes of this ballot will be monitored. • Other Trade Union groups have opened consultation with members regarding the 2025/2026 pay award • 67% of GMB Union workers have voted to reject the pay award in an initial consultative vote, this mainly impacted upon the Ambulance service in 2022-2023. Future industrial action is anticipated from this group, a formal ballot is expected • The ballot for Unite the Union closed 21st July 2025, the results are not yet published • The Royal College of Nursing carried out consultation and is likely to reject the pay deal for 2025/26. A formal ballot is likely in the Autumn • Financial implications of cancelled activity, mitigation plans and safe staffing plans • Impact on restoration and recovery • Reputational damage

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Monitor whether the trust is experiencing or aware of any forthcoming: • Industrial action or strike activity. • Ballots in progress or planned Other related actions which may impact service delivery	Continue to monitor the intelligence surrounding any industrial action that may impact services across the trust and within the ICS	Coordinate the Trust response to any planned industrial action	Paul Fitzsimmons, Executive Medical Director Supported by Rachel Clint, Head of EPRR	31/12/2025	
Use Trust standard operating policy to respond to any planned instance of industrial action	Embed learning from previous instances of industrial action to support planning for future events	Capture learning through the debrief process	Paul Fitzsimmons, Executive Medical Director Supported by Rachel Clint, Head of EPRR	31/12/2025	
Collaborate with Union Representatives and the people Directorate to plan for any workforce related challenges	Ensure there is collaborative planning as part of the Trust response to Industrial Action	Trade Union Representatives engaged as part of the planning process.	Paul Fitzsimmons, Executive Medical Director Supported by Rachel Clint, Head of EPRR	31/12/2025	

Board Assurance Framework

Take direction from ICB / NHS England	Where there is system, regional or national guidelines available, ensure these are acted upon. This includes the derogation of services and agreement on payment structures	Act on any communications or actions received via the ICB or SCC.	Paul Fitzsimmons, Executive Medical Director Supported by Rachel Clint, Head of EPRR	31/12/2025	

Board Assurance Framework

<table>
<tr><td>Risk ID</td><td>2253</td><td>Executive Lead</td><td>Chief Strategy and Partnerships Officer</td><td colspan="2" rowspan="2">Rating</td></tr>
<tr><td>Strategic Objective</td><td colspan="3">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.</td></tr>
<tr><td>Risk Description</td><td colspan="3">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.</td><td>Initial
Current
Target</td><td>9 (L3 x C3)
9 (L3 x C3)
2 (L1 x C2)</td></tr>
<tr><td>CQC Domain(s)</td><td colspan="5">Well-Led</td></tr>
<tr><td>Risk Appetite</td><td colspan="5">Open: Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.</td></tr>
<tr><td>Risk Movement</td><td colspan="5"> 
</td></tr>
<tr><td>Assurance Details</td><td colspan="5">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
• Ali Kennah appointed as joint Chief Nurse
• Strategic People Committee in common established April 2025
• Finance, Sustainability and Performance Committee in Common established July 2025
• ToR for Joint Committee of the Board approved July 2025

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</td></tr>
</table>

Board Assurance Framework

	• Communication and Engagement Plan approved • Strategic case for integration of WHH and Bridgewater approved by both boards and supported by ICB • Proposal to accelerate our transaction approved by both boards and supported by ICB • Draft timeline for an accelerated transaction approved by both boards and supported by ICB •
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	01.08.2025	Joint committees FSPCiC and SPCiC established, along with Joint Committee of the Board
Transaction to become a single organisation accelerated to 1st April 2026	Both Boards approved strategic case and accelerated transaction timeline July 25 FBC in development	FBC due diligence and NHSE review	Lucy Gardner	1.11.25	

Appendix 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/25/10/100**	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	1st October 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	

<table>
<tr><td>LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td>
Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:
<table>
<tr><td>1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
<tr><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td></td><td></td><td></td><td>✓</td></tr>
<tr><td colspan="4">Further Information:</td></tr>
</table>
</td></tr>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td>
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 <u>3 indicators that are both failing and have special cause variation of a concerning nature</u>, these are:

• 15. Complaints – over 6 months old
• 58. Capital Programme – % delivered against plan
• 59. Better Practice Payment Code – % cumulative performance

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

• 13. Mortality ratio – HSMR
• 14. Mortality ratio – SHMI

There are <u>2 indicators that consistently fail and cannot be measured for variation,</u> these are:

• 61. CIP (recurrent) – % delivered against plan
• 63. Bank Reduction – delivery against 10% reduction of 2024/25 plan

All 7 of these metrics were also highlighted in the escalated metrics section at the August 2025 Trust Board meeting, and none have been removed from reporting.

Financial Position
At Month 5 the Trust has recorded a deficit position of £19.4m (before deficit support) which is on plan. After deficit support funding the deficit reduces to £14.8m which is £3.1m worse than plan. This relates to not receiving £3.1m deficit support funding for month 4 and 5.
</td></tr>
</table>

PURPOSE: ***(please select as appropriate)***	Information	Approval x	To note x	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Approve cash support of up to £12.913m from NHSE for the remainder of Q3 2025/26. 2. Note the changes to capital contingency as supported and approved by the Finance, Sustainability and Performance Committee in Common. 3. Note the contents of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance, Sustainability and Performance Committee in Common		
	Agenda Ref.	FSPCiC/25/09/71 FSPCiC/25/09/73		
	Date of meeting	22/09/2025		
	Summary of Outcome	Cash support application supported for approval at Trust Board. 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/25/10/100

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.

While some performance metrics do not fall within the highest-risk category highlighted in the top left of **Table 1**, those that continue to underperform should not be interpreted as improving. The current reporting approach prioritises metrics that are both underperforming and deteriorating, helping to focus attention on urgent issues. It is therefore essential that all consistently underperforming metrics – identified by an ‘F’ icon – are actively monitored and addressed, regardless of trend, to ensure sustained improvement and accountability.

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 Fails the Target (based on the last 7 months)	**CONSISTENTLY FAILING TARGET & DECLINING PERFORMANCE** **Quality** 15. Complaints over 6 months ***(1 complaint- 0 target)*** **Finance** 58. Capital Programme ***(£1.63m - £9.42 target)*** 59. Better Payment Practice Code ***(43% - 95% target)***	**CONSISTENTLY FAILING TARGET & VARYING PERFORMANCE** **Quality** 1.Incidents 8. VTE Assessment ↓ 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 24. Maternity Postpartum Haemorrhage **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 45 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 51. Capped Theatre Utilisation **Workforce** 52. Supporting Attendance	**CONSISTENTLY FAILING TARGET & IMPROVING PERFORMANCE** **Quality** 22. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1h of diagnosis ↓ 26. MUST nutritional assessment completion ↑ **Workforce** 55. PDR compliance	**CONSISTENTLY FAILING TARGET & NO SPC** **Finance** 61. Cost Improvement Programme (recurrent forecast) – % delivered against plan 63. Bank Reduction

	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** 2.Healthcare Acquired Infections (MRSA) 4. Healthcare Acquired Infections (CDI) 5. Healthcare Acquired Infections (Ecoli) 6. Healthcare Acquired Infections (Klebsiella) 7. Healthcare Acquired Infections (PA) 9. Inpatient Falls & harm levels 10. Pressure Ulcers 23. Acute Kidney Injury **Access & Performance** 45. Elective Outpatient Activity 50. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation	**Access & Performance** 36. Diagnostic Waiting Times 6 Weeks	**Finance** 62. Agency Reduction
	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) **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/Not Enough Datapoints/Not Applicable**	**Quality** 13. Mortality ratio – HSMR 14. Mortality ratio - SHMI	**Quality** 3. Healthcare Acquired Infections (MSSA) 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)	**Access & Performance** 34. Type 5 attendances 48. % Patients discharged to their usual place of residence	**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 August 2025 is attached in **Appendix 5**.

The Trust 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 high risk CIP (£6.9m) from the level 1 & 2 CIP plan.
- Delivery of the unidentified system wide savings (£11.2m) (level 3 CIP).
- Ability to mitigate risk in CIP plans has been reduced due to needing to use these schemes to offset Industrial Action and pay award costs in excess of plan due to additional funding not being received.
- Achieving the income plan through core capacity and risk of overperformance not being funded.
- Receipt of deficit support funding.
- Cash level and ability to access revenue cash support.

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

The Trust is currently forecasting a £46.9m deficit against a planned deficit of £28.7m. The variance to plan is due £11.2m of level 3 CIP which currently does not have a plan to deliver and £6.9m of level 1 and 2 high risk CIP.

Cash

The cash balance at the end of August is £11.2m of which £3.6m relates to capital creditors. Given the current cash position and the planned deficit for 2025/26 the Trust requires cash support in Q3 2025/26 of £12.913m. The Finance, Sustainability and Performance Committee in Common discussed and supported the Q3 application for cash support from NHSE. The Trust Board is asked to approve up to £12.913m cash support for Q3 2025/26. Should the cash no longer be required there is no commitment to draw down, however, once the value has been requested an increase is not possible.

Increased cash management measures continue in line with NHSE guidance. As a result, BPPC remains low (50% against a target of 95%, 88% cumulative position in March 2025). Cash days are at 11 days which is a deterioration from last month (16 days) and from April 2025 (18 days) due to the decreasing cash balance.

CIP

At 31 August 2025, the Trust has delivered a CIP of £6.7m which is on plan. However, it should be noted that £4.1m has been achieved from non-recurrent vacancies and 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 £7.1m 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. Currently, the full year effect of the delivered and planned schemes mitigate the non-recurrent schemes into 2026/27.

In addition to the £21.5m CIP, there is a £13.1m target relating to level 3 system CIP schemes. These will be led, coordinated and developed at system level and delivered at Trust level. The Trust is committed to working with the ICS and other System Providers on this.

Capital Programme

The Trust total capital funding consists of £12.44m Capital Departmental Expenditure Limit (CDEL) and £18.24m external funding, a total of £30.68m. The Trust also has £1.49m IFRS16 CDEL.

The Trust capital spend for month 5 is £1.63m which is £4m below the Trust plan of £5.63m. This is mainly driven by the late start of schemes, ward refurbishment paused and replaced with smaller schemes, EPR delays and late confirmation of additional capital. The plan 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 5		**380**
Proposed changes in month		
VAT Recovered		**17**
Emergency Request:-		
Patients meal trollies (approved in May)	- 60	
CSTM MRI Light controller (approved in June)	- 11	
Ultrasound Probe (approved in August)	- 12	
Hot Food Vending Machine (approved in September)	- 22	
Sub Total		**- 105**
Requests supported at CPG		
CO2 Incubator - Microbiology	- 14	
CSTM Rear doors	- 8	
Pharmacy returns project - linked to CIP	- 20	
Halton Education Centre Boiler	- 10	
Sub Total		**- 52**
Contingency as at end of month 5		**240**

The Trust Board is asked to:

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

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, Sustainability and Performance Committee in Common
- Quality & Assurance Committee
- Strategic People Committee in Common

5. RECOMMENDATIONS

The Trust Board is asked to:

1. Approve cash support of up to £12.913m from NHSE for the remainder of Q3 2025/26.
2. Note the changes to capital contingency as supported and approved by the Finance, Sustainability and Performance Committee in Common.
3. Note the contents of this report.

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

		Latest				Previous		
	QUALITY	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	**Assurance**
1	Incidents	0	29	Aug-25		19	Jul-25	F
2	Healthcare Acquired Infections (MRSA)	0 (for 2025/26)	0	Aug-25		0	Jul-25	?
3	Healthcare Acquired Infections (MSSA)	no threshold set	4	Aug-25		3	Jul-25	No SPC
4	Healthcare Acquired Infections (CDI)	60 (for 2025/26)	9	Aug-25		10	Jul-25	?
5	Healthcare Acquired Infections (Ecoli)	79 (for 2025/26)	7	Aug-25		6	Jul-25	?
6	Healthcare Acquired Infections (Klebsiella)	28 (for 2025/26)	1	Aug-25		0	Jul-25	?
7	Healthcare Acquired Infections (PA)	8 (for 2025/26)	2	Aug-25		2	Jul-25	?
8	VTE Assessment	95.00%	94.38%	Aug-25		93.09%	Jul-25	F
9	Inpatient Falls & harm levels	10% reduction from 2024/25	36	Aug-25		43	Jul-25	?
10	Pressure Ulcers	20% reduction from 2024/25	14	Aug-25		9	Jul-25	?
11	Medication Safety Reconciliation within 24 hours	80.00%	33.16%	Aug-25		44.00%	Jul-25	F
12	Staffing - Average Fill Rate	90.00%	N/A - grouped indicator	Aug-25	No SPC	90.43%	Jul-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

13	Mortality ratio - HSMR	No target set	97.71	Aug-25		95.66	Jul-25	No SPC
14	Mortality ratio - SHMI	No target set	104.83	Aug-25		104.15	Jul-25	No SPC
15	Complaints	Zero complaints open over 6 months old/in the backlog	1	Aug-25		3	Jul-25	F
16	Friends and Family (Inpatients & Day cases)	95.00%	96.93%	Aug-25		98.00%	Jul-25	P
17	Friends and Family (ED and UCC)	87.00%	75.87%	Aug-25		69.00%	Jul-25	F
18	Mixed Sex Accommodation Breaches (ITU)	0	11	Aug-25		15	Jul-25	F
19	Sepsis - % screening for all emergency patients.	90.00%	62.00%	Aug-25		55.00%	Jul-25	F
20	Sepsis - % screening for all inpatients	90.00%	79.00%	Aug-25		41.00%	Jul-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%	52.00%	Aug-25		56.00%	Jul-25	F
22	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90.00%	83.00%	Aug-25		82.00%	Jul-25	F
23	Acute Kidney Injury	Less than previous month	128	Aug-25		139	Jul-25	?
24	Maternity Postpartum Haemorrhage	3.70%	5.80%	Aug-25		4.10%	Jul-25	F
25	Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	33%	Aug-25		17%	Jul-25	No SPC
26	MUST nutritional assessment completion	above > 85%	76.26%	Aug-25		79%	Jul-25	F

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

		Latest				Previous		Assurance
	ACCESS & PERFORMANCE	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
27	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (excluding WUTC).	78%	62.87%	Aug-25		62%	Jul-25	F
28	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (including WUTC).	78%	67.42%	Aug-25		67%	Jul-25	F
29	A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	23.03%	Aug-25		20.8%	Jul-25	F
30	Average time in department ED	No Target	392	Aug-25		359	Jul-25	No SPC
31	Ambulance Handovers within 15 minutes	65%	53.04%	Aug-25		58.82%	Jul-25	F
32	Ambulance Handovers within 30 minutes	95%	86.10%	Aug-25		88.66%	Jul-25	F
33	Ambulance Handovers within 45 minutes	100%	91.41%	Aug-25		95.02%	Jul-25	F
34	Type 5 attendances	No Target set	2194	Aug-25	H	2402	Jul-25	No SPC
35	Patients seen in the Fracture Clinic within 72 hours	95%	57.20%	Aug-25	L	90%	Jul-25	?
36	Diagnostic Waiting Times 6 Weeks	95.00%	95.94%	Aug-25	H	96.05%	Jul-25	?
37	Referral to treatment Open Pathways	92.00%	57.00%	Aug-25		57.15%	Jul-25	F
38	Referral to treatment - Number of patients waiting 52+ weeks	0	1497	Aug-25		1619	Jul-25	F

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

39	28 Day Faster Cancer Diagnosis Standard	75%	74.10%	Jul-25		74.00%	Jun-25	F
40	Cancer 31 Day Wait	96%	99.00%	Jul-25		98.00%	Jun-25	P
41	Cancer 62 Day Wait	85%	77.90%	Jul-25		78.40%	Jun-25	F
42	Reduction in Outpatient Follow Ups compared to 19/20 activity	No Target set	85%	Aug-25		81%	Jul-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%	93%	Aug-25		81%	Jul-25	?
46	Super Stranded Patients	Trajectory	152	Aug-25		138	Jul-25	No SPC
47	No Criteria to Reside (NCTR)	No Target set	189	Aug-25		176	Jul-25	No SPC
48	% Patients discharged to their usual place of residence	No Current Threshold	96%	Aug-25	H	97%	Jul-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%	1.42%	Aug-25		1.26%	Jul-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	3	Aug-25		7	Jul-25	?
51	Capped Theatre Utilisation	85%	78.57%	Aug-25		76%	Jul-25	F

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

		Latest				Previous		Assurance
	WORKFORCE	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
52	Supporting Attendance	5.00%	5.77%	Aug-25		6.10%	Jul-25	
53	Turnover	Below 13%	11.68%	Aug-25		12%	Jul-25	
54	Core/Mandatory Training	85.00%	90.72%	Aug-25		91.05%	Jul-25	
55	PDR compliance	85.00%	79.99%	Aug-25		79.41%	Jul-25	

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).
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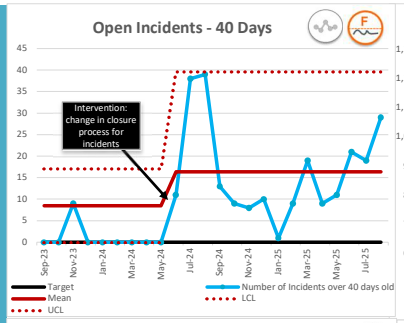
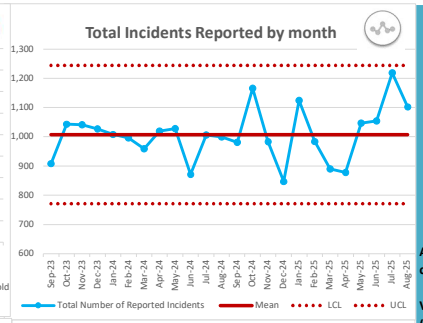
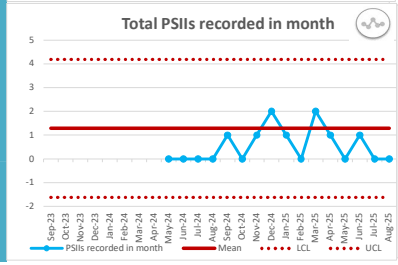
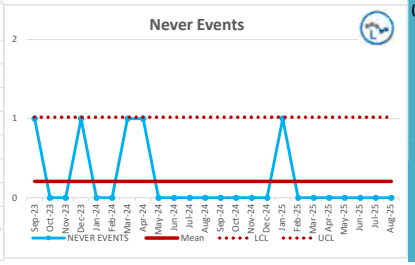
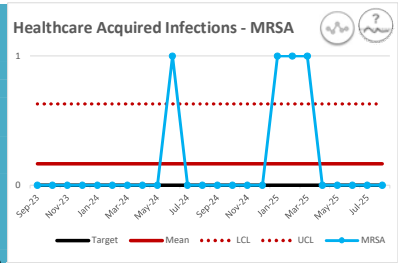
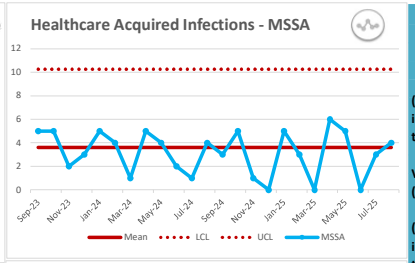
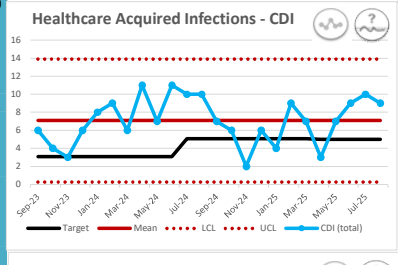
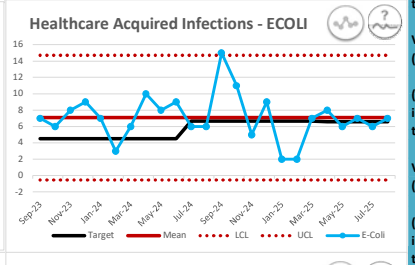
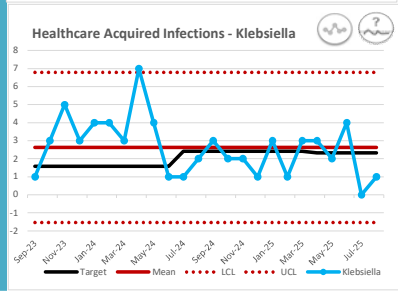
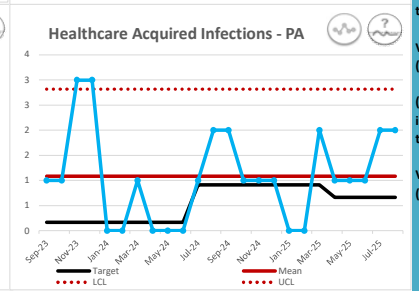
- Consistently passes the target
- Inconsistently passes and fail the target
- Consistently fails the target

		Latest				Previous		Assurance
	FINANCE & SUSTAINABILTY	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
56	Trust Financial Position (£m)	-£3.37	-£3.37	Aug-25	No SPC	-£2.50	Jul-25	No SPC
57	Cash Balance (£m)	£4.19	£11.24	Aug-25	No SPC	£17.42	Jul-25	No SPC
58	Capital Programme (£m)	£9.42	£1.63	Aug-25	L	£0.90	Jul-25	F
59	Better Payment Practice Code	>95%	43%	Aug-25	L	69%	Jul-25	F
60	Cost Improvement Programme - In year (£m)	90% of plan	100%	Aug-25		100%	Jul-25	P
61	Cost Improvement Programme (recurrent) – In year (£m)	90% of plan	39%	Aug-25	L	44%	Jul-25	F
62	Agency Reduction (£m)	£1.21	£1.01	Aug-25	No SPC	£0.80	Jul-25	?
63	Bank Reduction (£m)	£11.38	£13.00	Aug-25	No SPC	£10.01	Jul-25	F

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality Improvement - Trust Position

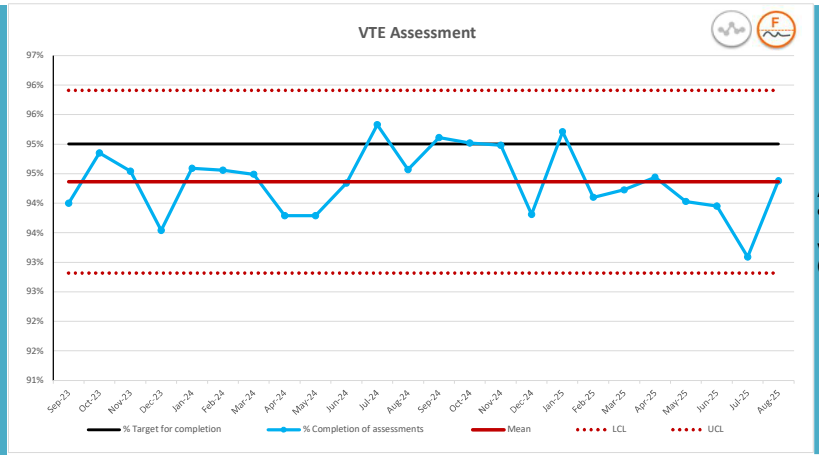
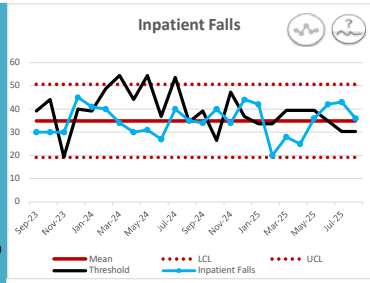
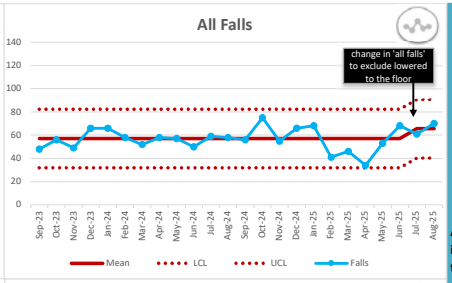
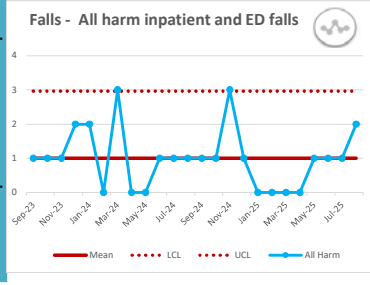
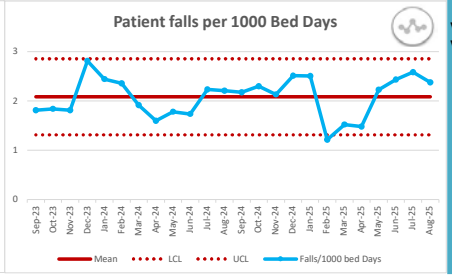
Appendix 2

	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)?
1. Incidents (over 40 days) Target: ZERO Open incidents outside 40 day timeframe and	There was 29 incident over 40 days old.	   	Assurance: The Trust consistently fails the target. Variation: Common cause (normal) variation	No Patient Safety Incident Investigations (PSIIs) or Never Events were identified during August 2025 One incident was reported to the Maternity and Neonatal Safety Improvement (MNSI) programme in August. July saw a rise in reported incidents, which then returned to expected levels in August 2025 29 incidents were open after 40 days. These are predominantly in planned care and estates and facilities	The Executive Team continues to oversee a weekly governance dashboard that monitors trends in reporting and triangulates data from incidents, complaints, claims, and inquests. Incidents that remain open beyond 40 days are escalated daily to the relevant triumvirates, with focused efforts underway to address and resolve these delays. To support earlier intervention, the Datix system now issues alerts at a 30-day threshold, enabling proactive support and monitoring. A daily report is also shared with Care Group Triumvirates, providing visibility of learning responses and action plans to ensure timely follow-up and assurance. Patient Safety Incident Investigations (PSIIs) are reviewed weekly through the Executive-led Safety Oversight Meeting, with appropriate escalation to CBU leads to maintain progress and accountability
2. Healthcare Acquired Infections (MRSA) Target: 0	MRSA cases YTD annual threshold exceeded by 0	 	(MRSA) Assurance: The Trust inconsistently passes/fails 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.	Since April 2024, national changes to HCAI reporting mean cases are now attributed based on the decision to admit rather than the actual admission date. This has led to an increase in cases being assigned to acute Trusts, particularly where patients remain in emergency departments for extended periods prior to formal admission. There has been a regional and national increase in Clostridioides difficile cases, and UKHSA has declared this a national standard incident. Despite the wider trend, the Trust remains a low outlier for C. difficile compared to other North West Trusts as of the end of July 2025. A national rise in MSSA bloodstream infections has also been observed. NHSE is reviewing this trend, and further information is awaited. The Trust is not currently flagged as a high outlier for MSSA or other HCAI rates. Many of these infections are associated with deep-seated sources and may be clinically unavoidable. The increase in Gram-negative bloodstream infections may be influenced by changing population demographics, particularly the growing number of older adults who are more susceptible to infection due to age-related factors and increased healthcare interactions	An action plan is in place to review peripheral cannula dwell times in line with EPIC 3 guidance, alongside a revision of the Trust's cannulation policy in Q3. A training programme for peer ANTT assessors is underway, and efforts are being made through the CBUs to improve competency assessments of ANTT procedures. A CDI prevention action plan is active following a rise in cases in July. Ribotyping of toxin-positive samples identified an outbreak on Ward B14, and enhanced IPC support has been implemented. The Model Ward programme, including the Well Organised Ward campaign, is progressing. A review of patients with recurrent CDI is in progress and expected to conclude in Q3. Swarm huddles are being held for all hospital-onset healthcare-associated cases. The Intra Venous to Oral Switch (IVOS) monitoring programme is in place, and antimicrobial ward rounds have resumed normal activity. A review of Consultant Microbiology staffing has commenced. Plans are being developed to explore the use of probiotics for CDI prevention and to host a system-wide seminar on CDI in October 2025, with the agenda currently being finalised. The Gram Negative Blood Stream Infection Prevention Group was relaunched in August with medical staff membership confirmed and an increased focus on wards reporting two or more GNBSI cases per month. A quality improvement project focused on timely catheter removal following surgery has commenced within the Surgical Specialties CBU.
3. Healthcare Acquired Infections (MSSA) Threshold for 2025/26: no threshold set	MSSA 18 cases YTD no threshold set				
4. Healthcare Acquired Infections (CDI) Threshold for 2025/26: 60	CDI 38 cases YTD annual threshold exceeded by 0	 			
5. Healthcare Acquired Infections (Ecoli) Threshold for	E. coli 34 cases YTD annual threshold exceeded by 0				
6. Healthcare Acquired Infections (Klebsiella) Threshold for 2025/26: 28	Klebsiella spp. 10 cases YTD annual threshold exceeded by 0	 			
7. Healthcare Acquired Infections (PA) Threshold for 2025/26: 8	P. aeruginosa 7 cases YTD annual threshold exceeded by 0				

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality Improvement - Trust Position

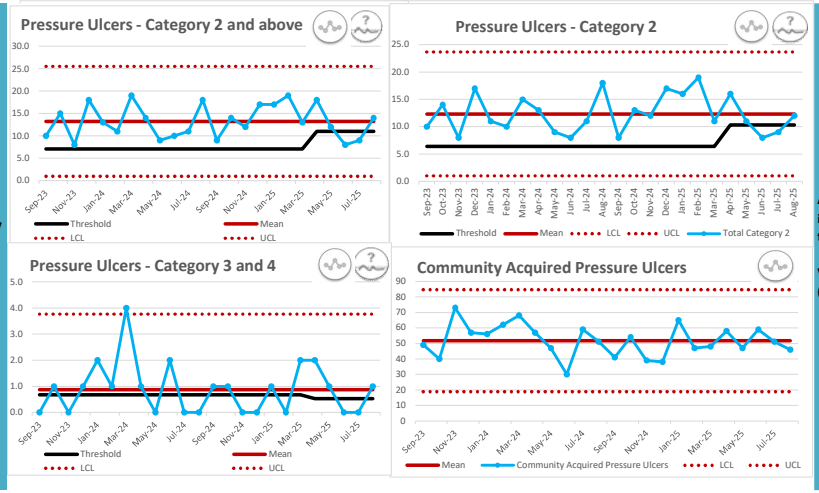
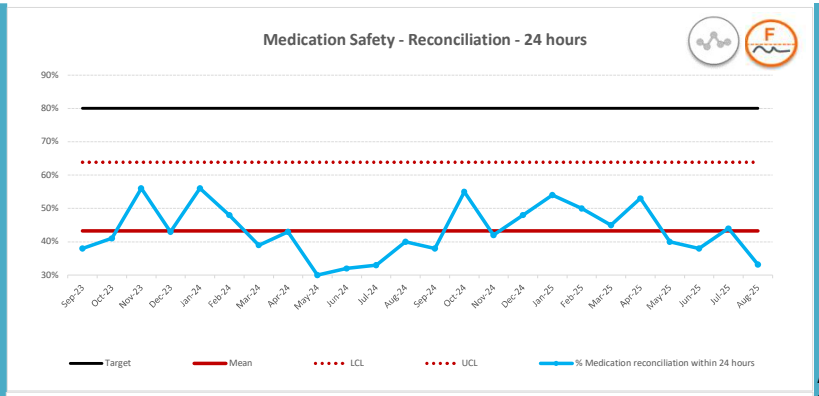
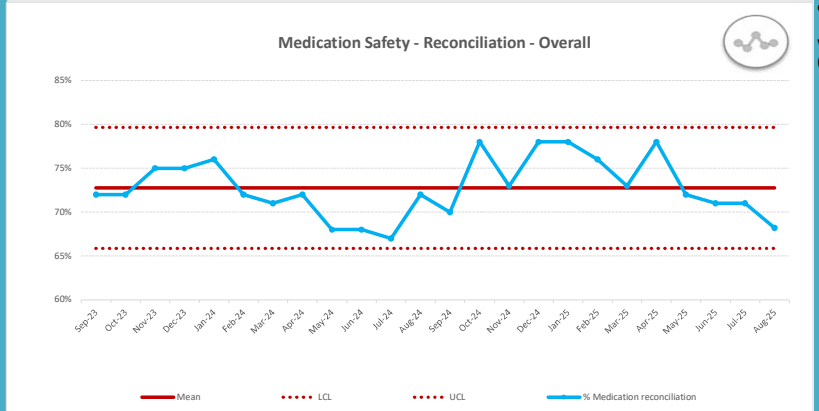
Appendix 2

	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)?
8. VTE Assessment **Target: 95% (quarterly position)**	The Trust did not achieve the required target at 94.38% for VTE assessments in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	VTE risk assessment performance in August 2025 was recorded at 94.38%, which falls below the national mandatory threshold of 95%. However, this represents a positive improvement compared to July.	Ward teams are now encouraged to use real-time data from the GIRFT inpatient ward productivity dashboard to identify and complete outstanding VTE risk assessments. Feedback is regularly obtained from each Clinical Business Unit (CBU) to address non-compliance, using the VTE risk assessment dashboard this is now embedded in the monthly CBU Clinical Governance agenda. Each CBU has developed and is implementing an action plan to address specific reasons for non-compliance, with progress monitored through the Thrombosis Group. The use of real-time data from the ward productivity dashboard is being explored to ensure that the number of outstanding "VTE not completed" assessments is reset to zero during morning board rounds on all working days, aiming to consistently meet the mandatory target of greater than 95%. The Thrombosis Group will continue to monitor compliance data, identify recurring themes and trends, and recommend further areas for improvement.
9. Inpatient Falls & harm levels **Target: 10% reduction from 2024/25**	70 total falls were reported in month. 36 of these were inpatient falls. There was 2 fall(s) in month with harm. There were 395 total falls in 2023/24. There have been 689 total falls YTD in 2024/25. We are expecting a 0% decrease in falls from last year. There were 250 inpatient falls in 2023/24. There have been 405 inpatient falls YTD in 2024/25. We are expecting a 5% decrease in falls from last year.	   	Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause Variation.	In August 2025, there were 36 inpatient falls reported. Of these, 25 resulted in no harm, 10 in low harm, and 1 in moderate harm, which involved a head injury. Additionally, there were 6 falls in the Emergency Department, including one that caused moderate harm with a head injury. Themes identified from falls reviews include challenges in assessing and implementing enhanced care levels, failure to update risk assessments in response to changes in patient condition, and the impact of patient acuity and complexity on fall risk	The findings from the annual Trust-wide falls audit were shared during the August Operational Patient Safety Group (OPSG) meeting, along with an action plan developed in response to the results. In May 2025, the bedside eyesight test was launched, and a three-month dip test is scheduled for completion in September. The outcomes of this test will help determine what further education and training are needed to improve compliance. Throughout September, the Trust will host 'falls week', during which the Patient Safety Improvement Nurse will lead daily educational sessions focused on various falls-related themes and conduct ward walks with the Trust falls alarm representative. When an increase in falls is noted on a specific ward, each incident is reviewed and a thematic analysis is carried out to identify patterns. A local action plan is then implemented to address areas requiring improvement, with oversight provided by the Associate Chief of Nursing and assurance given to the Deputy Chief Nurse.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality Improvement - Trust Position

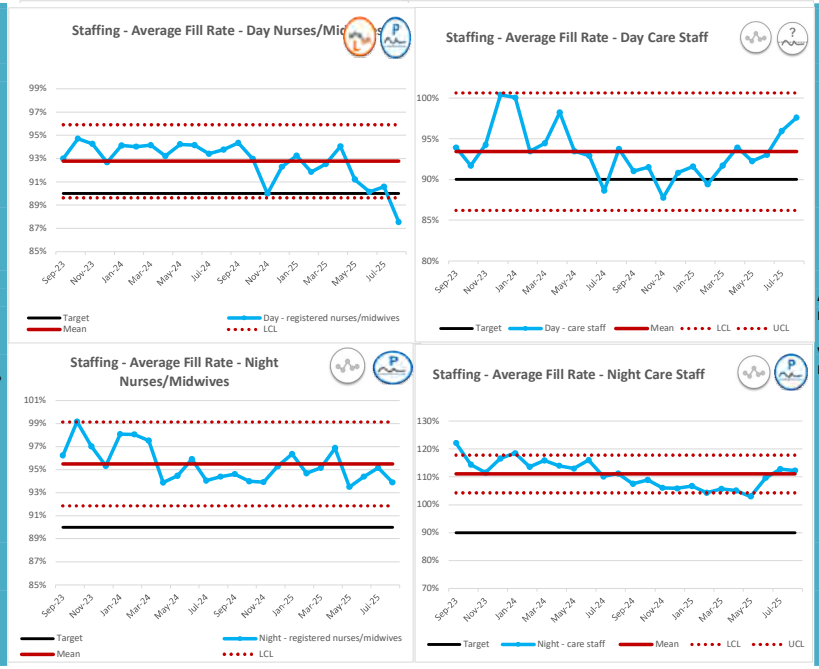
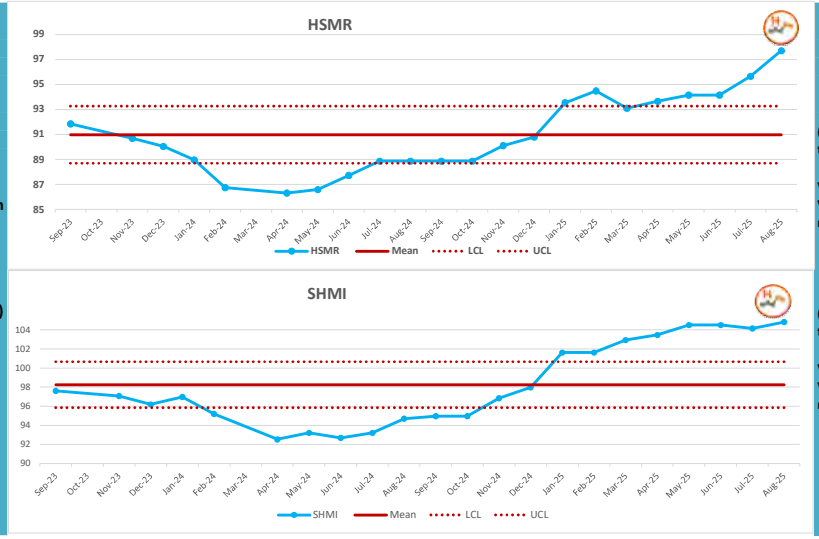
Appendix 2

	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)?
10. Pressure Ulcers (Category 2 and above) **Target: 20% reduction from 2024/25**	**In month there were 12 hospital acquired category 2 pressure ulcers, 1 Category 3 pressure ulcers and 1 Category 4 ulcers in month.** **There were 46 community aquired pressure ulcers in month.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**In August 2025, there were 12 category 2 pressure ulcers reported. One category 4 pressure ulcer developed under a Plaster of Paris cast that had been applied in the Orthopaedic Theatre. Additionally, there were three device-related pressure ulcers: a category 2 caused by a nasogastric tube in ITU, a category 2 in the Neonatal Unit caused by an ID band, and the previously mentioned category 4 ulcer from the POP cast applied in Theatres.** **Individualised care planning based on identified risk is a key theme in pressure ulcer prevention. This involves tailoring prevention strategies to each patient's specific needs, which may include implementing regular repositioning schedules, using appropriate support surfaces, and managing moisture effectively to reduce skin breakdown**	**Actions taken to improve the pressure ulcer position include the implementation of After Action Reviews, with lessons learned shared both at ward level and through the Operational Patient Safety Group. All category 3 and above pressure ulcers now undergo a multidisciplinary team review. Improvement plans have been developed for both the Unplanned Care and Planned Care Groups, with oversight provided by the Associate Chief Nurses. Compliance and review meetings are being held with the Deputy Chief Nurse, where lessons learned are also shared. Essential Healthcare, the provider of pressure relieving mattresses, has added an extra technician on site to check mattress pumps and replace any faulty equipment. In the Emergency Department, film dressings are being applied to patients' heels to help reduce friction and shear damage. To support this, the Tissue Viability Team provides direct assistance to individual wards, helping staff develop and refine care plans to ensure they are responsive to patient needs and aligned with best practice.**
11. Medication Safety **Reconciliation within 24 hours** **Target: 80%**	**Medicines reconciliation was completed within 24 hours of admission for 33.16% of patients. 68.22% of patients had MR completed during inpatient stay.**	 	**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**Pharmacy staffing levels currently do not allow for full coverage across all inpatient areas. To ensure safe and effective use of available resources, pharmacy staff are deployed based on patient activity and acuity. As a result, areas with higher clinical urgency such as the Emergency Department (ED), Acute Medical Unit (AMU), Intensive Care Unit (ICU), and Acute Critical Care Unit (ACCU) are prioritised. Areas such as elective surgical wards and maternity services are considered lower priority for pharmacy resource allocation.** **This approach is supported by audit data. Of the patients who did not receive medicines reconciliation (MR), 77% were located within the Women & Children (W&C) and Surgical Specialties (SS) Clinical Business Units (CBUs), primarily maternity patients in the Birth Suite and Midwifery-Led Unit (MLU). Previous analysis of this cohort has shown that 90% of women were not on any regular medication, which reduces the clinical risk associated with delayed MR.** **Similarly, analysis of surgical patients who did not receive MR revealed that 69% were discharged by day two of admission. In these cases, pharmacy staff reconcile medicines as part of the discharge (TTO) clinical check process, which ensures safe prescribing and dispensing at the point of discharge. This strategy reflects the need to deploy limited pharmacy resources where they can have the greatest impact on patient safety and care outcomes.**	**To support safe and effective medicines reconciliation across all inpatient areas, recruitment is currently underway for 4.7 WTE Band 5 pharmacy technicians and 4 WTE pharmacists. This will help strengthen pharmacy coverage and improve access to medicines reconciliation, particularly in areas currently identified as lower priority due to staffing constraints.** **In the interim, midwives have been asked to record the medicines reconciliation status for patients who are on no regular medication or pregnancy supplements only, in line with the agreed Standard Operating Procedure (SOP). This ensures that appropriate documentation is maintained and that patients' medication needs are still acknowledged, even where pharmacy input is limited.** **Performance in this area is being monitored through the Pharmacy Performance Meeting and the Medicines Safety and Optimisation Group, allowing for ongoing review and improvement. These governance structures help ensure that decisions around pharmacy deployment remain data-driven, patient-focused, and responsive to feedback.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality Improvement - Trust Position

Appendix 2

	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)?
12. Staffing - Average Fill Rate Target: 90%	In month, the average staffing fill rates were: Day (Nurses/Midwife) 87.54% Day (Care Staff) 97.62% Night (Nurses/Midwife) 93.9% Night (Care Staff) 112.29%		Assurance: N/A Grouped Indicator Variation: N/A Grouped Indicator	There has been a reduction in registered nurse (RN) fill rates, primarily due to staff sickness, which has impacted staffing across several inpatient areas. Encouragingly, there has been an improvement in clinical support worker (CSW) fill rates, helping to maintain safe care delivery during this challenging period. Across the Trust, additional beds have been opened in response to increased demand in the Emergency Department (AED), rising patient acuity, and a large number of patients who no longer meet criteria to reside but remain in hospital due to complex discharge needs. These pressures have also led to the need to nurse patients in temporary escalation spaces, which places further strain on staffing and resources.	Staffing across the Trust is closely monitored to ensure safe and effective patient care. Reviews are conducted twice daily by the senior nursing team, with patient acuity and activity levels assessed to support appropriate staffing decisions. Each ward benefits from senior nurse oversight provided by a Matron and Lead Nurse, ensuring consistent leadership and clinical governance. As of August 2025, the Trust's registered nursing vacancy rate stands at 10.63%, which is above the minimum aim of 9%. This increase is largely attributed to the expanded establishment within the Accident and Emergency Department (AED), where a Band 5 vacancy of 33.58 WTE remains. To address this, the vacancy has been readvertised, and interviews for Band 5 positions are scheduled for September 2025, with 10 candidates shortlisted. In addition, third-year student nurses have been appointed and are expected to begin their roles across the Trust, contributing 43.66 WTE to the registered workforce. Specialist recruitment efforts are ongoing in areas with persistent vacancies to ensure the right skill mix is achieved. Unregistered staffing also remains a focus. The vacancy rate for July 2025 is 12.47%, exceeding the Trust's minimum aim of 9%. Recruitment is taking place monthly, alongside targeted campaigns and the appointment of NHSP Clinical Support Worker Development (CSWD) staff. Six healthcare assistants commenced Trust Induction on 8 September, and 15 NHSP CSWD staff began their six-month training programme in August 2025. A further cohort of 15 candidates are currently being interviewed, with plans to start in October 2025.
13. Mortality ratio - HSMR Target: Plan 14. Mortality ratio - SHMI Target: Plan	SHMI and HSMR are not within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 97.71. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 104.83.		(HSMR) Assurance: NA - no target Variation: Special Cause Variation of a concerning nature. (SHMI) Assurance: NA - no target Variation: Special Cause Variation of a concerning nature.	A recent increase in the Summary Hospital-level Mortality Indicator (SHMI) was reviewed in collaboration with the Healthcare Evaluation Data (HED) team and discussed at the Mortality Review Group (MRG). It was considered to be linked to the impact of Same Day Emergency Care (SDEC) activity and will continue to be monitored closely by the Mortality Review Group. Additionally, a focused review was presented at the July 2025 MRG meeting, examining cases coded with fluid and electrolyte imbalances. No major clinical concerns were identified; however, incidental learning related to discharge safety netting was noted and shared through the July MRG newsletter to support wider learning and improvement	The Mortality Review Group (MRG) has established a dedicated workstream to review cases where learning relevant to primary care or community settings has been identified. This initiative aims to strengthen interface issues and create opportunities for feedback to be shared directly with the relevant GP or practice, supporting system-wide learning and improvement. In addition, MRG has launched an orthopaedic-themed workstream to highlight cases where specific areas of concern or learning have been identified. These include pre-operative optimisation, particularly around resuscitation discussions and decision-making; delays in time to surgery; and post-operative medical deterioration, especially where there has been a lack of appropriate speciality input, including palliative care involvement

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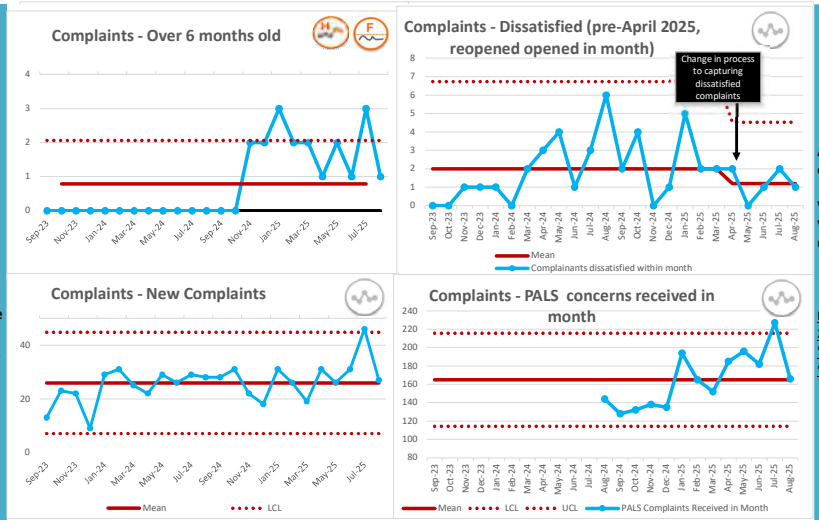
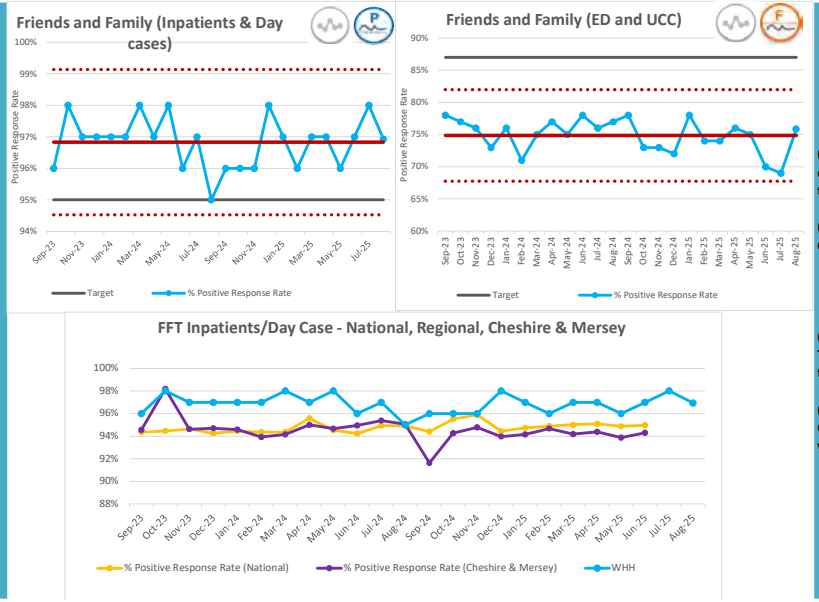
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
15. Complaints **Target: Zero complaints open over 6 months old/in the backlog**	**In month, 46 new complaints were received to the Trust which was an increase of 15 from the previous month. There was 1 case 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.**		**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a concerning nature.** **Please note: Prior to April 2025, the Complaints 'dissatisfied' graph reported 'reopened complaints'.**	**The Trust continues to maintain strong performance in the timely completion of complaints, reflecting our commitment to listening and responding to patient concerns. At the time of reporting, one case has been paused at the patient's request, with a meeting scheduled for 26 September 2025 to support further discussion and resolution**	**At the time of reporting, the Trust had 90 open complaints, all of which are being closely monitored to ensure timely and appropriate responses. Where suitable, complaints are directed to the Patient Advice and Liaison Service (PALS) for local resolution, allowing for quicker and more personalised support.** **To promote open communication and shared understanding, all complainants are offered an initial meeting with the relevant clinical teams, with the option of follow-up meetings after the response letter is received. This approach supports transparency and helps ensure that concerns are fully explored and addressed.** **Each Clinical Business Unit (CBU) has a designated complaints case handler, which helps maintain consistency and accountability in how complaints are managed.**
16. Friends and Family (Inpatients & Day cases) **Target: 95%** **17. Friends and Family (ED and UCC)** **Target: 87%**	**The Trust achieved 96.93% in month for Inpatient & Day case FFT and 75.87% for ED/UCC FFT.**		**(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.**	**In August 2025, the Trust achieved a 97% positive response rate for inpatient and day case services, continuing to exceed the recommended minimum threshold. The Trust's performance remains above both regional and national averages based on the data available to date, reflecting sustained excellence in patient experience.** **For Emergency Department and Urgent Care Centre services, the Trust recorded a 76% positive response rate in the Friends and Family Test for August 2025, marking a notable improvement from the previous month's 69%. Over the past 12 months, the average positive response rate has been 74%, indicating consistent performance. The main themes identified from negative feedback in August include waiting times, staff attitude, the care environment, and communication. These areas will continue to be monitored and addressed through ongoing quality improvement initiatives.**	**Across all areas of the Trust, themes from Friends and Family Test (FFT) feedback are monitored at both Trust and Care Business Unit (CBU) levels using the FFT dashboard. This enables the identification of areas for improvement and the sharing of best practice through the Patient Experience and Inclusion Sub-Committee. Specific actions are developed for each area in response to feedback. Observations from Trust Board members, Governors, Senior Leaders, PLACE assessments, and the Patient Experience Team are shared with wards and departments, with action plans initiated and monitored through established governance structures.** **A Quality Priority has been set in relation to the Accessible Information Standard (AIS) to support patients requiring reasonable adjustments. The Patient Experience and Inclusion Team continues to lead the FFT programme, with a focus on increasing response rates, enhancing reporting capabilities, and transitioning to digital responses to support real-time feedback.** **In the Emergency Department and Urgent Care Centre, targeted efforts are underway to improve patient experience and feedback collection. Opportunities to complete FFT are being expanded through the use of volunteers who assist with completion, collection, and data input. Funding has been approved for fixed FFT stations to be installed at the main entrance, enabling digital feedback from visitors, carers, friends, and family. Volunteers also support patient experience by assisting with drinks rounds, contributing to care, comfort, and nutrition and hydration. Regular walkabouts by the Senior Nursing Team and Patient Experience Team help identify areas for improvement, and opportunities to increase volunteer presence in ED are actively being explored.**

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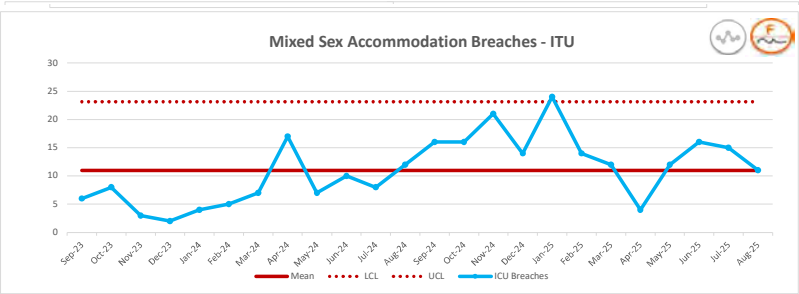
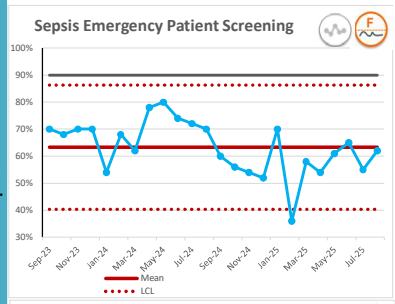
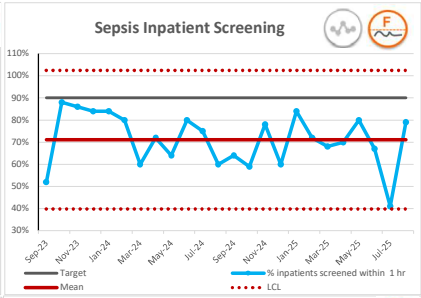
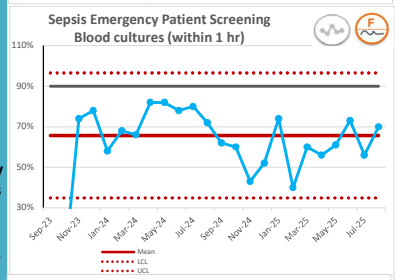
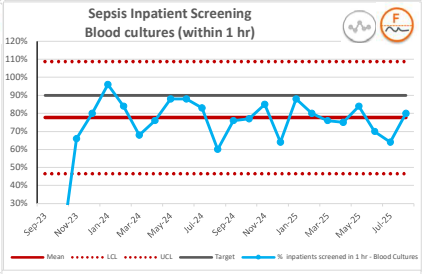
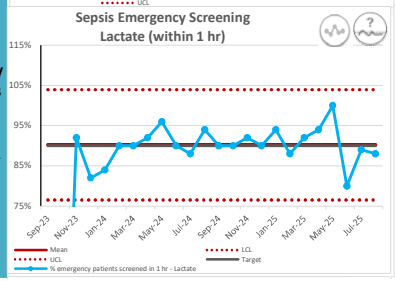
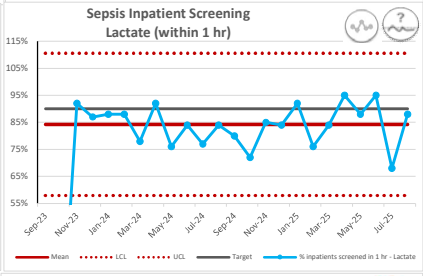
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
18. Mixed Sex Accommodation Breaches (ITU Only) **Target: Zero**	There were 0 mixed sex accommodation (MSA) incident(s) outside of the ITU in month. There were 11 MSA incident(s) within the ITU.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation	In August 2025, there were 11 mixed sex accommodation breaches, all occurring within the Intensive Care Unit. This represents a reduction of four breaches compared to June 2025. No breaches were reported in any other ward areas during the same period. Any delays in discharge contributing to these breaches are escalated to the Patient Flow Team and the Tactical Manager of the day, and are discussed at each bed meeting throughout the day to support timely resolution and minimise further breaches	Work is ongoing within the care group and patient flow teams to ensure that priority is given to stepping down Level 1 patients from the Intensive Care Unit to appropriate ward areas. A contributing factor to current pressures is the number of patients who no longer meet the criteria to reside in an acute hospital bed. In response, a review of the Trust's policy on mixed sex accommodation breaches is currently underway and being updated to reflect current operational challenges and national guidance.
19. Sepsis - % screening for all emergency patients. **Target: 90%** **20. Sepsis - % screening for all inpatients** **Target: 90%**	**The Trust achieved:** • 62% Sepsis screening for all emergency patients with suspected sepsis within 1 hour. • 79% screening for all inpatients with suspected sepsis within 1 hour. **Blood Cultures:** • 70% screening for Emergency patients with suspected sepsis within 1 hour. • 80% screening for Inpatients with suspected sepsis within 1 hour. **Lactate:** • 88% screening for Emergency patients with suspected sepsis within 1 hour. • 88% screening for Inpatients with suspected sepsis within 1 hour.	     	(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.	In August 2025, sepsis screening compliance in the Emergency Department was 62%, with blood cultures taken within one hour reaching 70%. Both metrics show improvement compared to the previous month and remain within expected variation, although there has been a general downward trend in compliance over recent months. Lactate measurement within one hour was 88%, which is a slight decrease from the previous month but still within expected variation. High attendance and occupancy rates in the Emergency Department continue to impact the ability of clinical teams to complete sepsis screening within the recommended timeframe. For inpatient areas, July 2025 audit data showed sepsis screening at 79%, blood cultures at 80%, and lactate measurement at 88% within one hour. All three metrics represent an improvement compared to July 2025. In response, a deep dive into inpatient sepsis performance has commenced to explore the underlying reasons and ensure that appropriate actions are identified and implemented to address any emerging issues or themes	•The Trust Sepsis Policy has been updated to align with current national guidelines across all specialties, including Adults, Paediatrics, and Maternity. A Trust-wide action plan has been developed to improve compliance with the Sepsis Six bundle, and progress is being monitored through the Sepsis Improvement Group (SIG). To support this work, two dedicated working groups have been established one focusing on inpatient areas and the other on the Emergency Department. Each group is overseeing a Test of Change tailored to its clinical setting and will report regularly to SIG. The Quality Improvement Team is actively supporting both projects. In the Emergency Department, key actions include increasing the number of Health Care Support Workers trained to take blood cultures, identifying a Medical Lead for Sepsis, and adjusting the skill mix in specific areas to ensure timely screening by appropriately trained staff. Sepsis is now a regular topic in daily safety huddles to reinforce awareness of the Sepsis Pathway, and teaching sessions for Emergency Department Resident Doctors have been expanded to strengthen clinical knowledge and response. For inpatient areas, the Test of Change involves a review of current sepsis practices across four wards. This aims to identify barriers to completing sepsis screening within the first hour and to determine whether these challenges are consistent across wards or vary locally. The findings will inform targeted actions to address any concerns and improve the timely recognition and treatment of sepsis. For both Inpatients and the Emergency Department, use of the Sepsis Tool is lower than the compliance with screening. This indicates that clinicians are not routinely using the Sepsis Tool even though they may be completing the necessary actions. As part of the Tests of Change described above, a key action is to understand the barriers to clinicians utilising the Sepsis Tool so that changes can be made to make the Tool more accessible and aligned to the needs of clinical staff.
21. Sepsis - % of					

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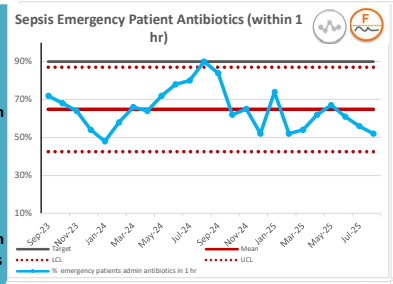
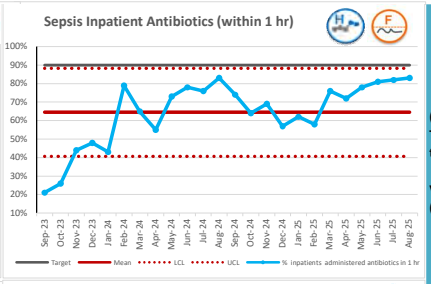
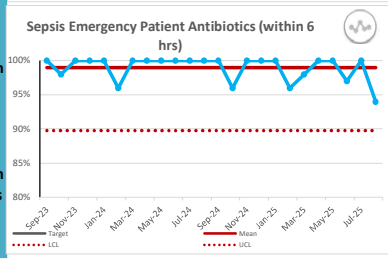
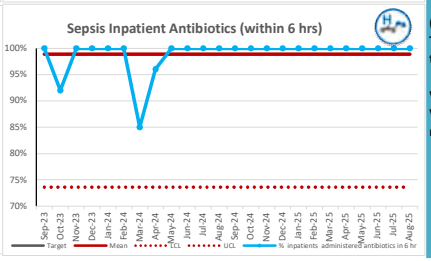
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag **Target: 90%**	**The Trust achieved:** **• 52% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made.** **• 94% of emergency patients with suspected sepsis were administered antibiotics within 6 hours of a diagnosis of sepsis being made.** **• 83% 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.**	   	**(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 an improving nature.**	**In August, 52% of patients in the Emergency Department received antibiotics within one hour. This represents a decrease from the previous month. While the figure remains within expected variation, there is a noticeable overall trend toward lower compliance. However, administration within six hours remained high at 94%, indicating that most patients still received timely treatment within the broader timeframe.** **For inpatients, 62% received antibiotics within one hour in August. This marks a slight improvement from the previous month and, although still within expected variation, reflects a positive trend toward better compliance. Additionally, 100% of inpatients received antibiotics within six hours in July**	**To improve the timeliness of antibiotic administration, several key actions are being implemented. Audit results are being shared with Clinical Business Units (CBUs) to facilitate local learning and enable targeted conversations and education with relevant clinical staff. The Tests of Change will also examine communication processes between staff to identify and address any delays between the prescribing and administration of antibiotics. In addition, the Trust's Medical Lead for Sepsis will deliver further training to Resident Doctors to enhance their understanding of the Sepsis Six key performance indicators and ensure consistent clinical practice**

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

Target: 90%

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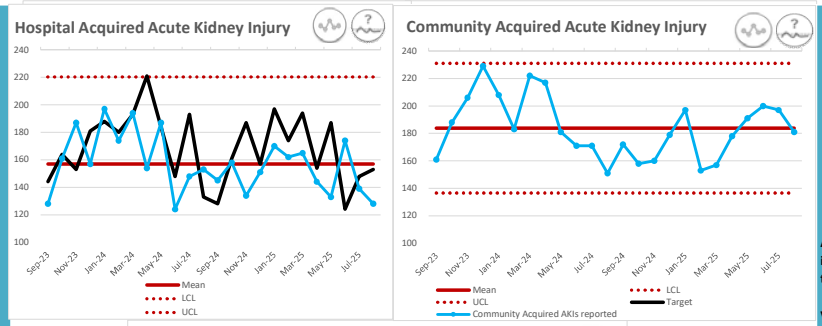
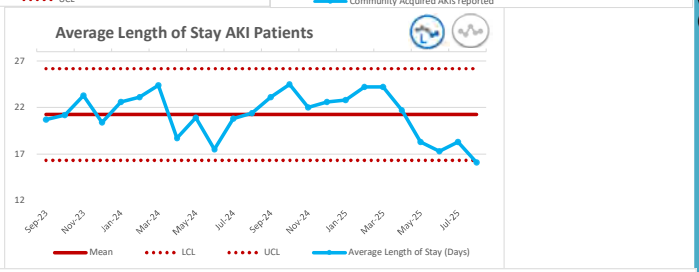
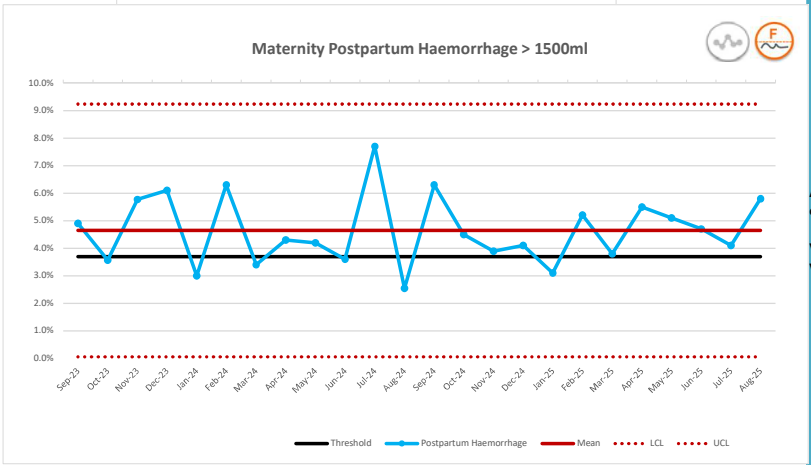
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
23. Acute Kidney Injury **Target: Less than month in previous year**	**There were 128 acute kidney injuries reported in month compared to 139 last month.**	 	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**There was no variation observed in either Length of Stay (LOS) or Hospital-Acquired Acute Kidney Injury (HA-AKI), with both metrics performing below the mean. Notably, HA-AKI was also below the target threshold, indicating strong performance in this area.**	**In July, the number of Acute Kidney Injury (AKI) episodes remained elevated compared to 2024; however, there was a reduction from the previous month, indicating early signs of improvement.** **Ongoing education is being delivered to both medical and nursing teams, focusing on the key principles of AKI management to support early recognition and timely intervention. The Trust has also expanded its early discharge AKI clinics, which now run weekly following the appointment of an additional Renal Consultant. This enhancement aims to improve post-discharge care and continuity for patients recovering from AKI.** **Further efforts include a continued focus on supporting patients after discharge through pharmacy-led medication reviews, ensuring safe and effective prescribing. Trust-wide AKI data is routinely shared at the monthly Deteriorating Patient Group (DPG) meetings to support oversight and drive quality improvement.**
24. Maternity Postpartum Haemorrhage >1500ml **Threshold: < 3.7%**	**There were 5.8% Postpartum Haemorrhages >1500ml in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Common cause variation.**	**Rates of postpartum haemorrhage (PPH) greater than 1500ml continue to fluctuate. An increase in the number of cases was observed in August, although no single theme or underlying cause has been identified. Comparator data from the Cheshire and Merseyside Local Maternity and Neonatal System (C&M LMNS) shows an average rate of 32 cases per 1,000 births across the region. In contrast, the rate at Warrington and Halton Hospitals is currently 39 cases per 1,000 births, which is above the regional average**	**All cases of PPH >1500ml continue to be reviewed individually through established governance processes. In addition, these cases are subject to further scrutiny via the Intrapartum Incident Review Group, which meets regularly to identify patterns and themes. Several actions are now underway, including the sharing of good practice and the implementation of bespoke training for resident doctors focused on the management of the third stage of labour.** **A new regional guideline on PPH has recently been implemented within the service. Warrington and Halton Hospitals colleagues contributed to the regional working group that developed this guideline, and many of the change ideas proposed by the Trust have been incorporated.** **The Trust's position on PPH is reported monthly to the Quality Assurance Committee (QAC), supported by a Statistical Process Control (SPC) chart. Current data shows common cause variation, with some signs of stability.**

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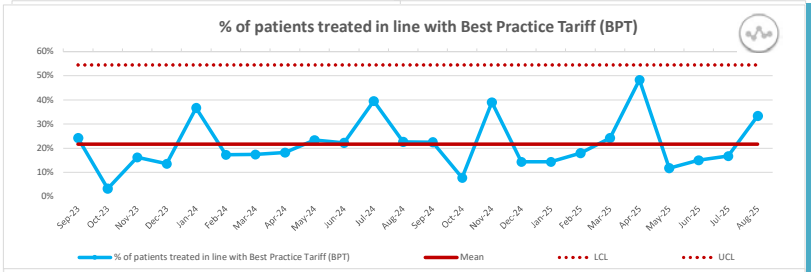
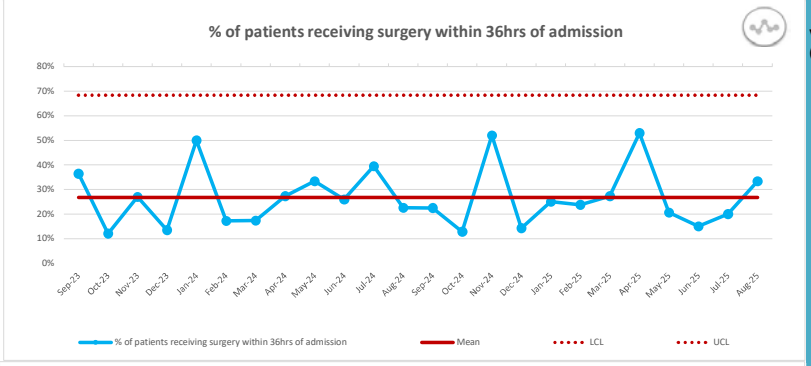
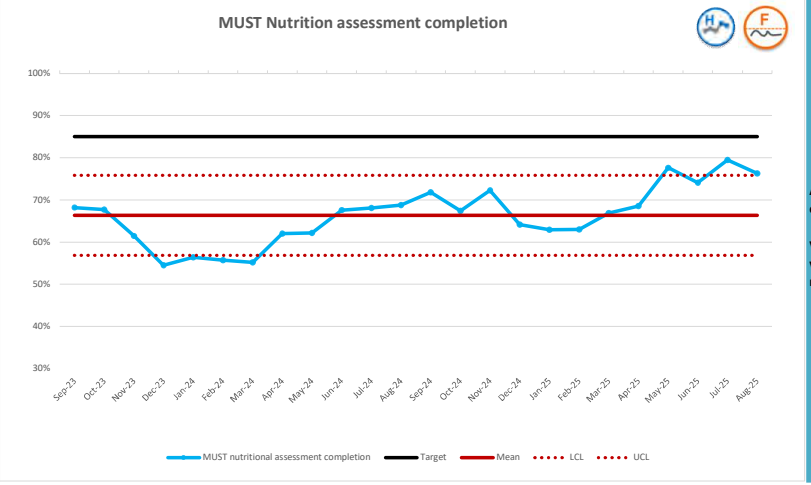
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
25. Fractured Neck of Femur **Target: Best Practice Tariff**	**33.33% of patients were treated in line with Best Practice Tariff (BPT) in Aug-25.**	 	**Variation: Common Cause (Normal) variation.**	**In August, a total of 40 patients were discharged and included in the National Hip Fracture Database, with 36 of them qualifying for the Best Practice Tariff. Most of these patients—32 in total—had been admitted either in July or August. There was a notable improvement in direct admissions from A&E to the orthopaedic ward, rising to 68%, which is a 7% increase compared to July. All outlying patients were successfully transferred to ward A6 during this period, which marks a positive operational achievement.** **However, timely access to surgery continued to be a challenge. Only 33% of eligible patients received surgery within the recommended timeframe, although this did represent a slight improvement from the previous month. The proportion of patients reviewed by a senior Orthogeriatrician within 72 hours remained relatively stable, decreasing slightly from 76% in July to 73% in August. Post-operative mobility on day one declined marginally, with 68% of patients mobilised the day after surgery**	**Performance against KPIs and Best Practice Tariff (BPT) continues to be closely monitored, with regular data presented to both the NOF and PSEC groups. A robust action plan has been submitted to PSEC to drive improvements in outcomes. A new NOF escalation Standard Operating Procedure (SOP) is now live on the intranet policies page, designed to support patients in receiving surgery within the recommended 36-hour timeframe. Bed escalation is being added to this SOP to facilitate faster admissions to the Orthopaedic ward.** **Plans are underway to launch a Hip Fracture Awareness Day in Q3 to improve staff education around the importance of timely and effective NOF care. The ACP Lead recently attended the Hip Fracture Summit, where direct admission to the Orthopaedic ward was widely recognised as a key factor in improving patient outcomes. The Hip Fracture Lead is working closely with the Planned Care Triumvirate and Trust Executives to identify further opportunities for performance improvement.**
26. MUST nutritional assessment completion **Target: above 85%**	**MUST Nutrition assessment completion was 76.26% in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Special cause variation of an improving nature.**	**MUST compliance continues to improve, with ongoing work alongside clinical teams to support further progress. Since the introduction of the LiON dashboard in 2023/24, there has been a 5% increase in six-hourly assessments, a 14% increase in 24-hourly assessments, and a notable 29% improvement in seven-day assessments. These results highlight the positive impact of enhanced data visibility and targeted clinical engagement on nutritional screening performance.**	**The addition of MUST as a clinical indicator on Lorenzo has significantly supported ward teams in identifying patients who require a MUST assessment or reassessment. The system's functionality, which highlights the indicator in orange to signal a 24-hour warning for the seven-day reassessment, has contributed meaningfully to the improvement in this metric.** **The Nutrition, Food & Hydration monthly meeting continues to drive a multi-disciplinary approach to enhancing nutritional support for patients. Clinical Business Units (CBUs) and key stakeholders regularly produce high-level briefing papers that outline local action plans and share quality improvement initiatives across the Trust. MUST remains a quality priority for 2025/26, with ward teams actively presenting compliance data and action plans at Quality Summits to support ongoing improvement.** **Furthermore, MUST is now embedded within the PSIRF approach, particularly in relation to harms such as falls and pressure ulcers, reinforcing its role in patient safety and care quality. These combined efforts reflect a strong organisational commitment to improving nutritional care and ensuring consistent, timely assessments across all wards.**

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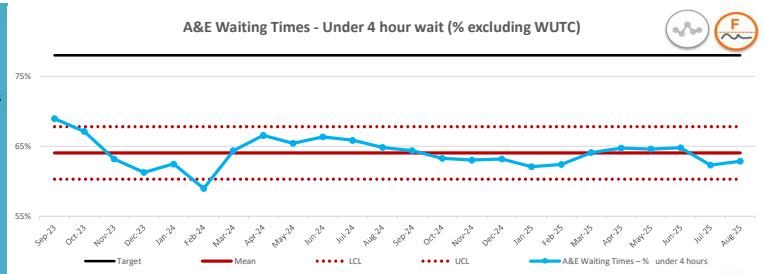
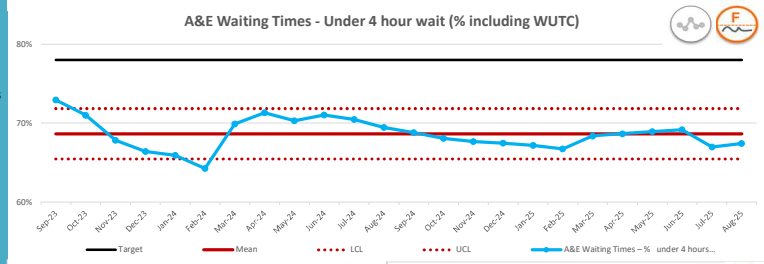
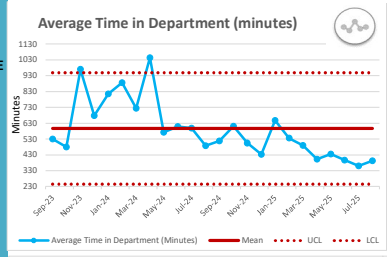
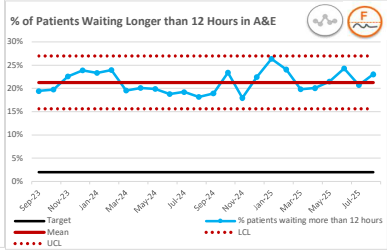
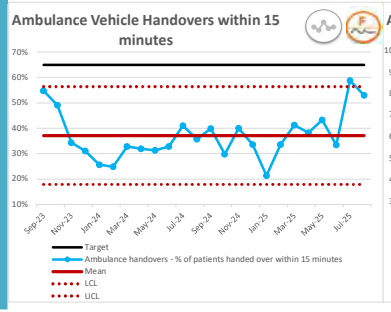
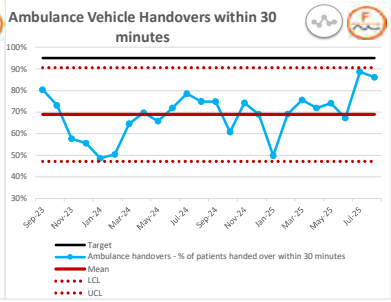
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
27. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Not including WUTC) Target: 78%	**The Trust achieved 62.87% excluding Widnes UTC in month.** **The target is set at 78%, which is the national aspiration for 2025/26**		**Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) variation**	**Performance continues to be negatively impacted by wait to be seen in ED, long length of stay and a overall high bed occupancy.** **The in year Trust target of 78% includes Widnes Type 3 activity which typically contributes a further 4.5%.** **The national constitutional standard remains at 95%.**	**• 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.** **• More intensive support has been provided by the senior leadership to support a reduction in wait to be seen and time to treatment which will support the 4 hour compliance** **• A review of the ED staffing model to realign rota's with demand using the ECIST methodology has been completed**
28. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Including WUTC) Target: 78%	**The Trust achieved 67.42% excluding Widnes UTC in month.** **The target is set at 78%, which is the national aspiration for 2025/26**		**Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) variation**		
29. Average time in department ED No Target	**23.03% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 392 minutes.**		**Assurance: No Target set** **Variation: Common cause (normal) variation**		
30. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge. Target: 2% or less			**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) Variation.**	**12 hour performance continues to be challenged. Key themes 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 2025/26 has been relaunched to support improvement** **A reduction in non admitted breaches has been realised however admitted breaches continue to be a pressure**
31. Ambulance Vehicle Handovers within 15 minutes Target: 65%	**In month the Trust achieved:** **- 53% Ambulance Handovers within 15 minutes (65% target)**		**(15) Assurance: The Trust consistently fails the target.** **Variation: There is Common Cause (normal) Variation.**		
32. Ambulance Vehicle Handovers within 30 minutes Target: 95%	**- 86.1% Ambulance Handovers within 30**		**(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.** **Please note that ambulance handover metrics are now measured to the point of vehicle handover, rather than patient handover.**	

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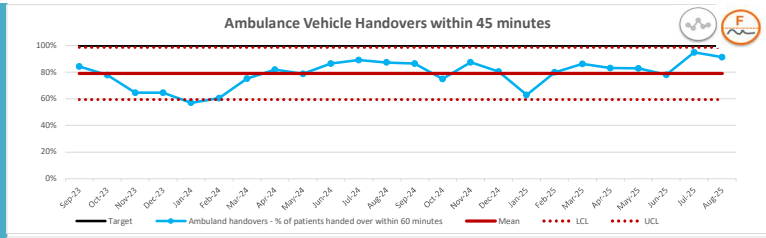
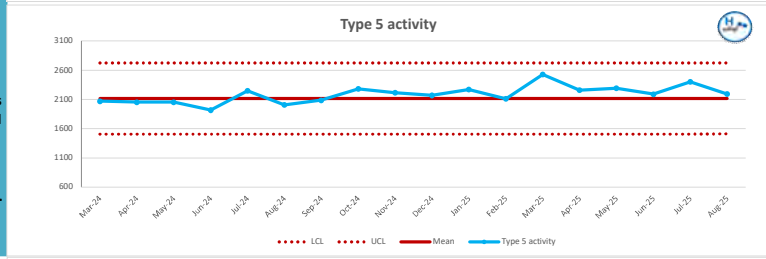
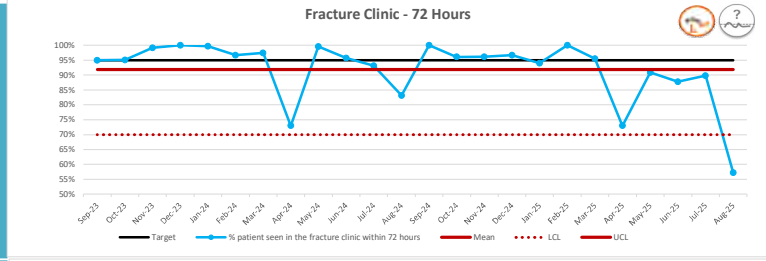
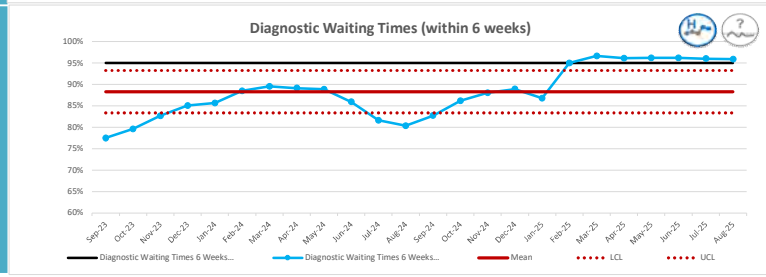
33. Ambulance Handovers within 45 minutes Target: 100%	minutes (95% target) - 91.4% Ambulance Handovers within 45 minutes (100% target)		(45) Assurance: The Trust consistently fails the target. Variation: There is Common Cause (normal) Variation.		
34. Type 5 activity No Target	Pre-November 2024 activity has been estimated as attendances that would be considered a 'Type 5' attendance. In month there were 2194 Type 5 Attendances.		'Type 5' activity includes SDEC and ACC activity. FAU, GAU and PAU are also included within Type 5 Activity from July 2024. 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.	
35. Patients seen in the Fracture Clinic within 72 hours Target: 95%	In month, the fracture clinic saw 87.8% of patients within 72 hours.		Assurance: The Trust inconsistently passes/fails the target. Variation: There is 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 E-Trauma, Workforce constraints have added pressure on this service during the summer
36. Diagnostic Waiting Times 6 Weeks Target: 95%	The Trust achieved 96.19% 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 6 consecutive months	This recovered position will continue to be monitored through Performance review group to ensure continued achievement.

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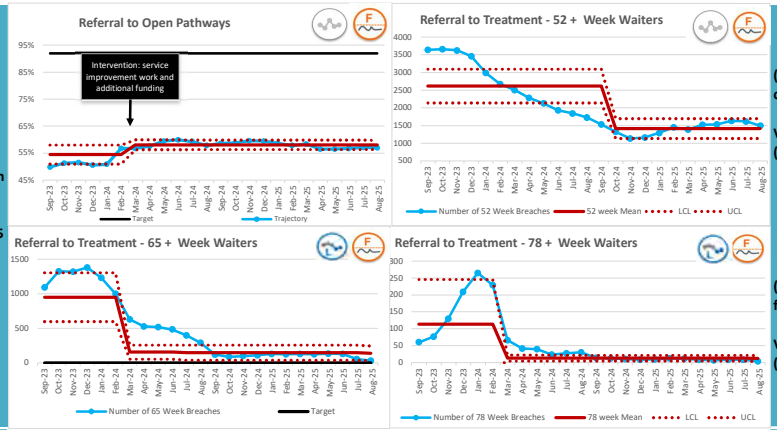
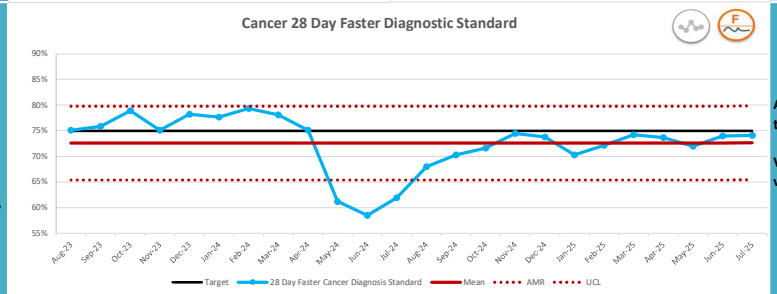
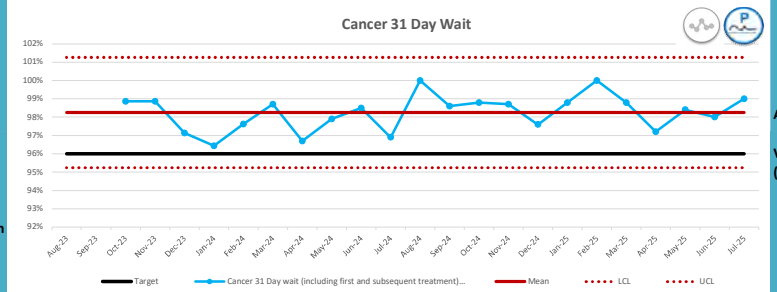
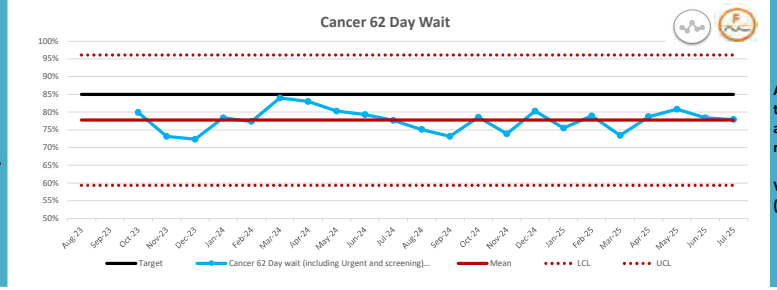
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
37. Referral to treatment Open Pathways Target: 92% 38. RTT - Number of patients waiting 52+ weeks Target: 0	The Trust achieved 57% in month. There were 1497, 52 week breaches, 3, 78 week breaches and 33, 65 week breaches.		(Open Pathways) Assurance: The Trust consistently fails the target. Variation: There is common cause (normal) 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 33 submitted for August. This continues to be within a few specialties, T&O, Gynae, 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 74.1% in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	Performance for the Faster Diagnosis Standard is at 74.1% The Trust is not currently meeting the 28 Day FDS. There are specific issues in the larger volume priority pathways in Lower GI, Gynae and Urology. There are improvement plans in place at tumour site level and agreed trajectories to support these which are being monitored. The Cancer Alliance is also supporting this plan. 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 99% in month for 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 77.9% in month for 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 is at 77.9%%. 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.	

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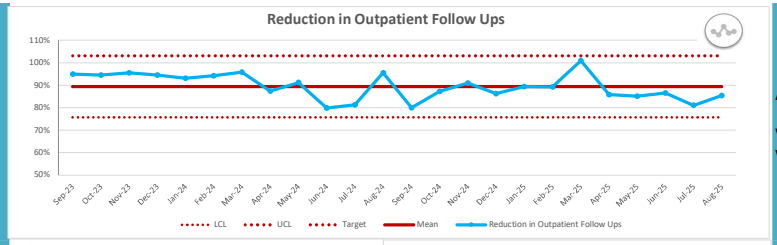
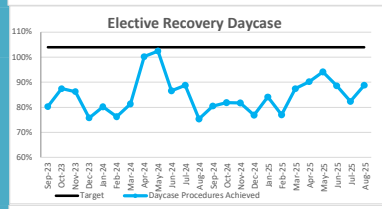
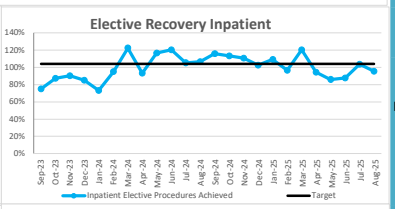
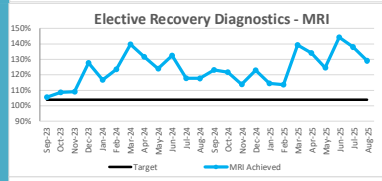
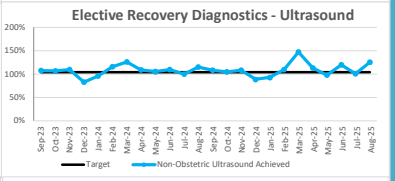
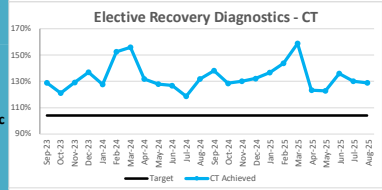
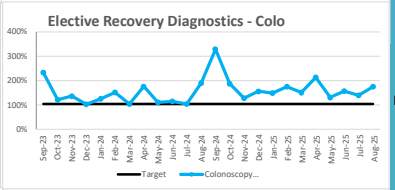
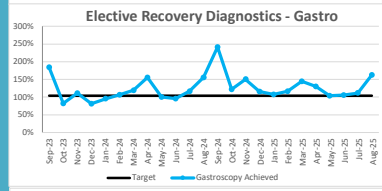
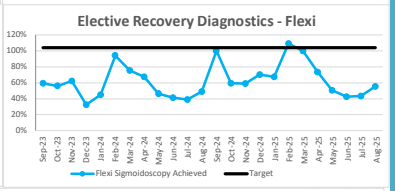
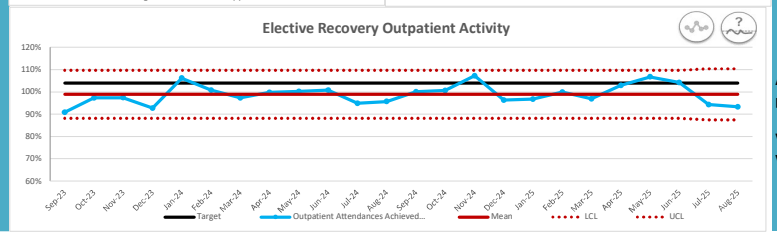
42. Reduction in Outpatient Follow Ups compared to 19/20 activity Target: 75% or less based on 2019/20 activity	**Outpatient follow ups have reduced to 85.37% of 19/20 activity in month.**		**Assurance: N/A Trajectory Not Agreed.** **Variation: Common Cause (Normal) variation.**	**Outpatient follow ups 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 89% of Daycase Procedures and 95.44% of Inpatient Elective Procedures.**	 	**N/A - Grouped indicator.**	**Day case is behind plan predominately as a result of referrals not being received into the Endoscopy Hub this is being addressed through the C&M diagnostic network**	**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:** **129.1% of MRI** **128.84% of CT** **125.34% of Non-Obstetric Ultrasound** **55.56% of Flexi Sigmoidoscopy** **175.23% of Colonoscopy** **163.03% of Gastroscopy**	     	**N/A - Grouped indicator.**	**Radiology modalities remain fully recovered, Challenges in cardiorespiratory remain.**	**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 93.3% of 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.**

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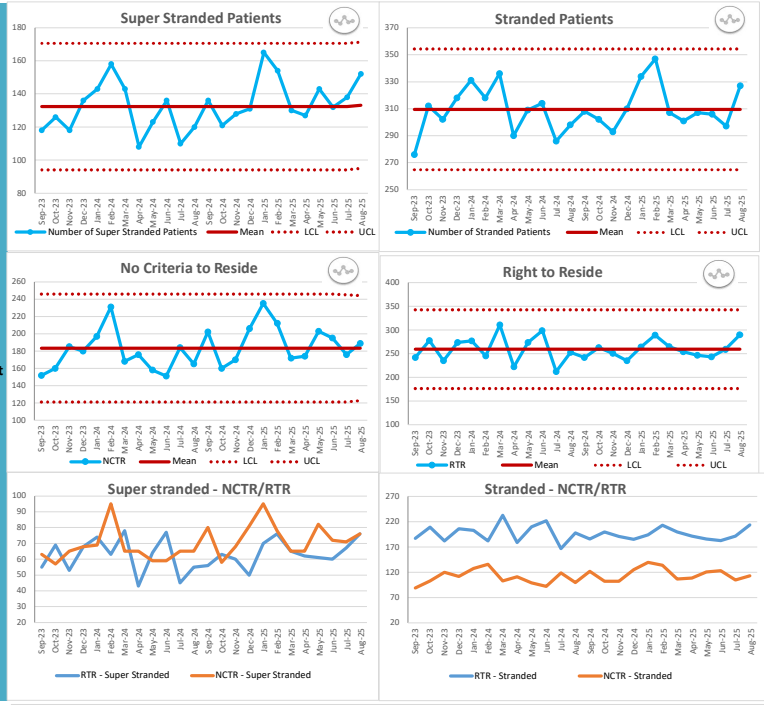
46. Super Stranded Patients Target: Trajectory 47. No Criteria to Reside (NCTR)		(Super Stranded) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (Stranded) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (NCTR) Assurance: N/A Trajectory 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.
There were 327 stranded and 152 super stranded patients at the end of month. A Superstranded Patient Trajectory has not yet been agreed for 2025/26.				

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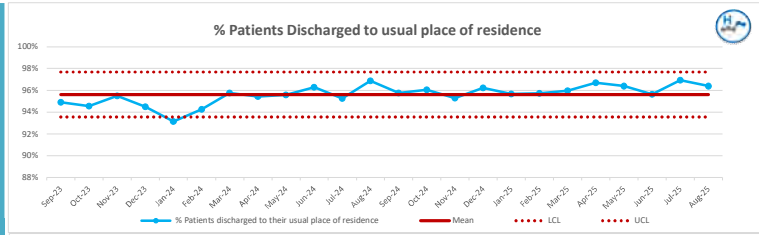
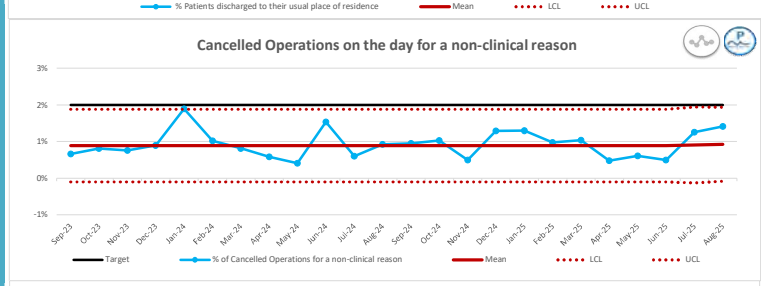
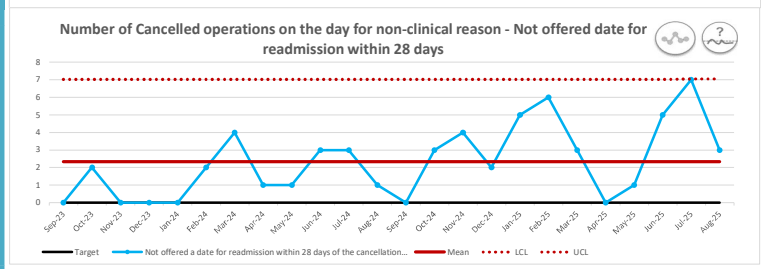
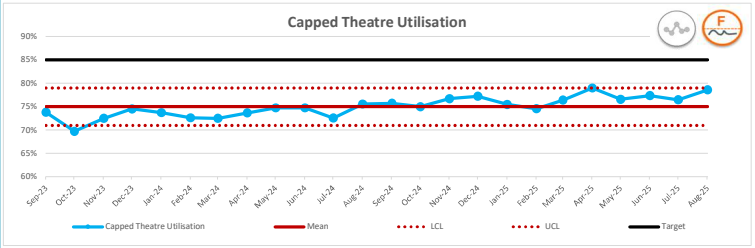
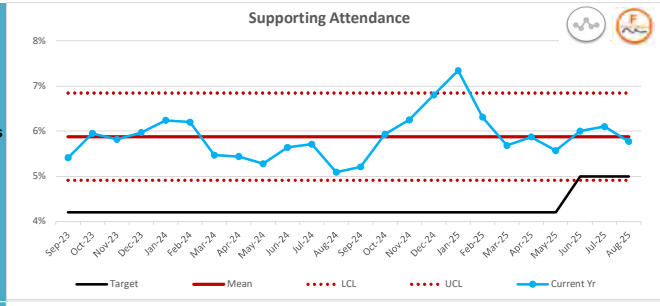
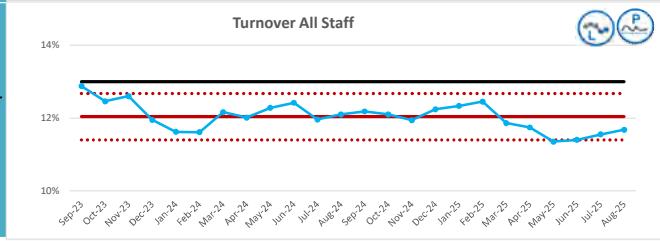
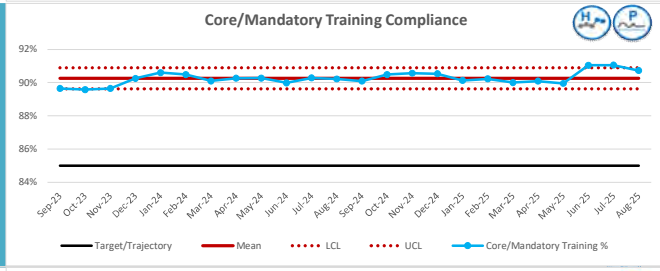
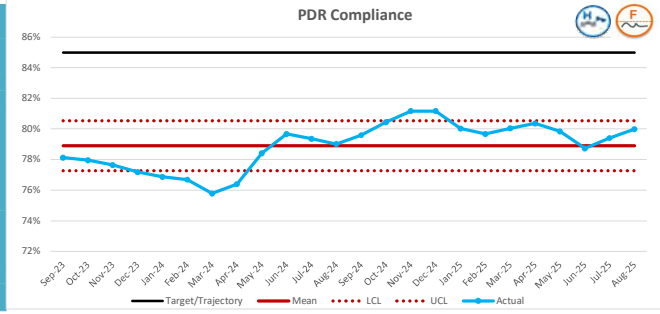
Appendix 2

	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)?
48. % Patients discharged to their usual place of residence Target: No Current Threshold	**96.39% patients in month were discharged to their usual place of residence.**		**Assurance: N/A Trajectory Not Agreed.** **Variation: Special Cause Variation of an improving nature.**		
49. Cancelled Operations on the day for a non-clinical reason Target: Less than 2%	**Cancelled operations for a non-clinical reason was 1.42% in month. 3 cancelled operation were not offered a date for readmission within 28 days.**		**(Cancelled - non-clinical reason) 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.**
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			**(Not offered 28 days) Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (normal) variation.**		
51. Capped Theatre Utilisation Target: 85%	**Capped Theatre Utilisation was 78.57% in month**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) Variation.**	**Capped theatre utilisation is improving following intensive transformation work, challenges remain on the Nightingale site whilst the working out of a reduced theatre template due to the completion of estates work**	**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, Urology & Gynaecology. The transformation team is working with the CBUs and clinical teams to increase the rates.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

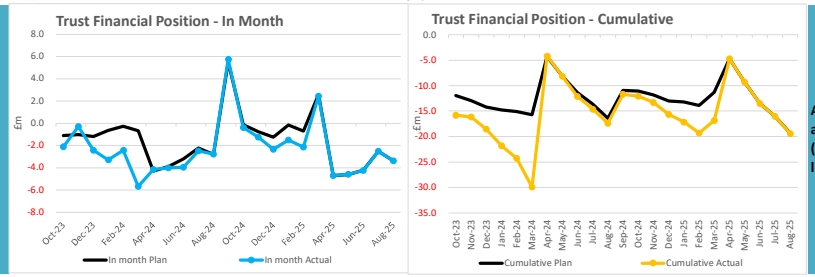
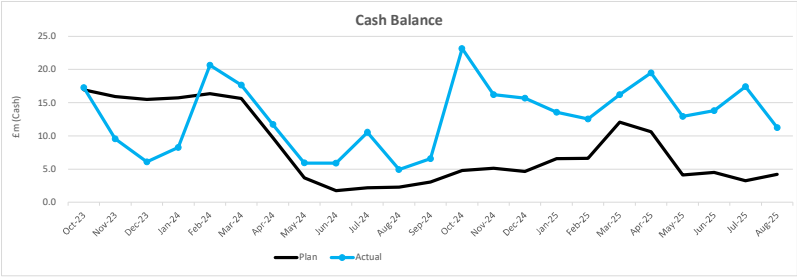
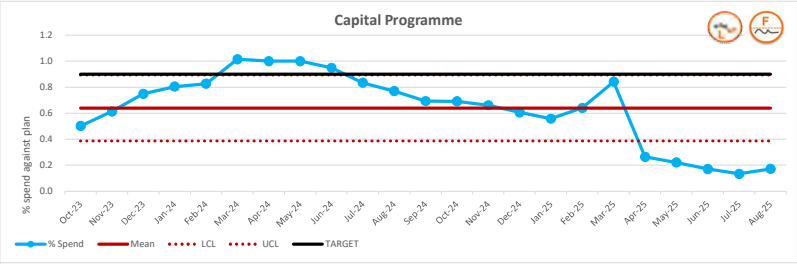
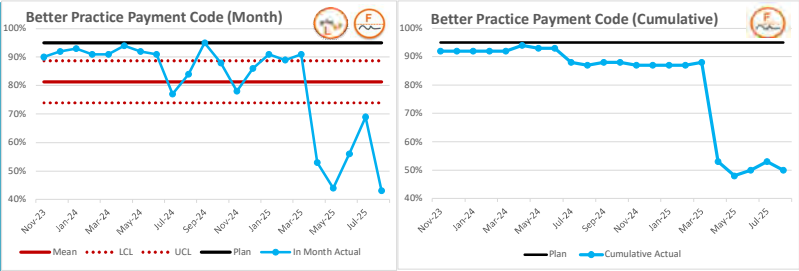
Workforce - Trust Position

Appendix 2

	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 5.77% in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) variation.**	**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 3.27% in August 2025.** **Short-term sickness absence is of concern with data analysis undertaken to identify areas of specific concern across the Trust. Domestics and ED have been identified as specific areas of high short-term sickness absence. The top 5 reasons for absence are gastro, stress/anxiety, cough/cold, pregnancy related and headache.** **Sickness absence is part of the National Oversight Framework (NOF).**	**The 'Improving Attendance Together' initiative is a strategic response to reduce sickness absence by 1%. Led by the People Directorate, it addresses persistent high absence impacting teams, patient care, and financial recovery. The WHH Improving Attendance Plan aims to foster a supportive and healthy work environment that encourages staff to maintain their well-being and attendance. This initiative is designed to address the challenges of absenteeism and promote a culture where employees feel valued and motivated to be present at work.** **There is also a regional C&M project to reduce sickness absence led by the CPO and supported by the CFO.**
53. Turnover **Target: Below 13%**	**The Trust's turnover of all staff was 11.68% in month.**		**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 13%.**	**Work/life balance remains the main reason people leave WHH. The #MyFlex campaign continues to support this.** **Following successfully launching an e-preference rostering approach in two Ward areas and preference rostering into two further clinical areas, options to rollout this approach are being developed. The awaited outcome of the C&M Roster system tendering exercise will help inform this approach.**
54. Core/ Mandatory Training **Target: 85%**	**Core/Mandatory training compliance was 90.72% in month.**		**Assurance: The Trust consistently passes the target.** **Variation: Special Cause Variation of a improving nature.**	**CSTF Mandatory Training compliance is consistently above the Trust target and shows an improving nature.**	**Care Groups to continue to report compliance at Operational People Committee detailing actions they are taking to ensure targets are met.** **Establishment of MLOG to ensure CSTF and role specific training is meeting required outcomes and any new requests for training are approved by EMT due to the financial impact of additional time required of staff to undertake training.**
55. PDR **Target: 85%**	**Annualised PDR compliance was 79.99% in month.**		**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 and staff groups are now achieving appraisal 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 appraisal compliance with Care Groups reporting actions to address the below target compliance. Supporting this, OD are rolling out an appraisal roadshow for areas struggling with compliance. Targeted Trust wide comms plan launched Sept 2025 promoting appraisal, updated guidance forms and a survey to collate improvement feedback.**

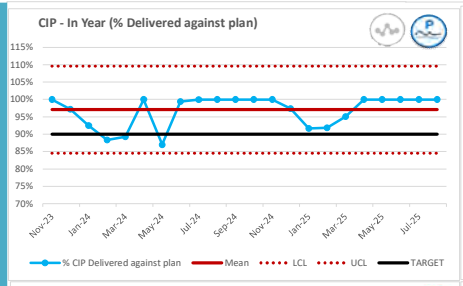
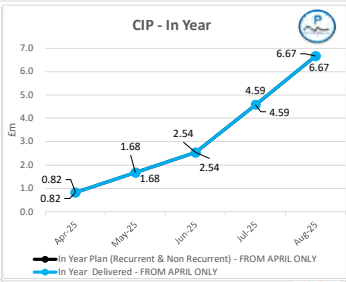
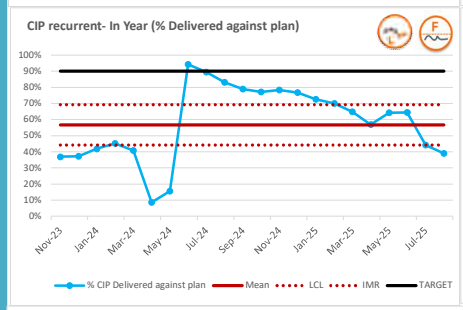
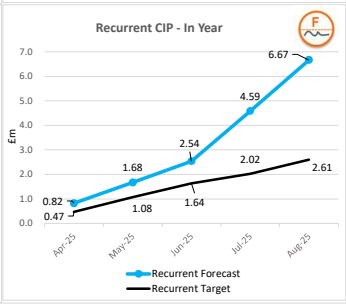
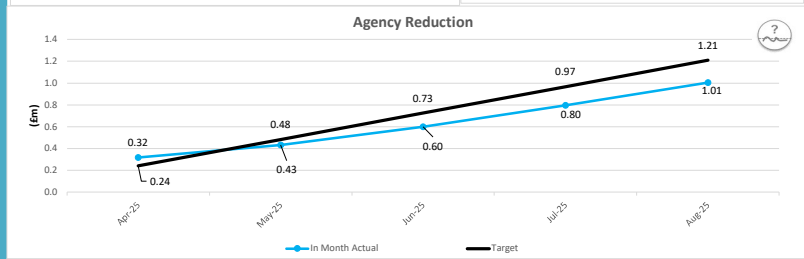
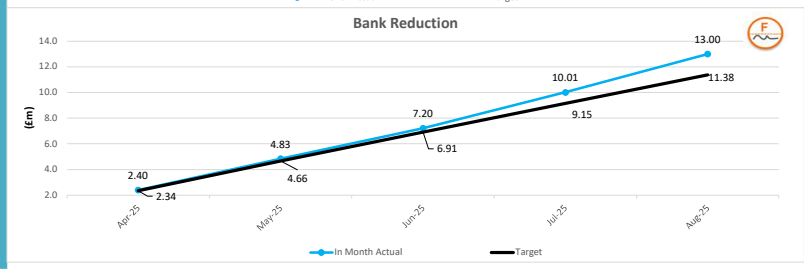
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance and Sustainability - Trust Position

	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)?
56. Trust Financial Position **Target: Plan**		At month 5 the Trust has recorded a deficit position of £19.4m (before deficit support) which is in line with plan.	There is no variation at month 5, the deficit position is in line with plan.	Work is ongoing to identify additional CIP schemes, reduce cost pressures and increase activity delivery to ensure delivery remains on plan.
57. Cash Balance **Target: On or better than plan**		The cash balance at 31 August 2025 is £11.2m.	The current cash balance is £11.2m which is £7m higher than the cash plan. This is predominantly due to a larger than planned cash balance at the end of 2024/25 and the implementation of cash management measures for 2025/26. Of the £11.2m cash, £3.6m is related to capital creditors.	The deficit position has led to the Trust requiring external cash support. A request for £3.972m is required for October 2025 and a further £8.941m for the remainder of Q3, approval is sought from the Trust Board. 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. We are adhering to the ICS cash management MOU as appropriate.
58. Capital Programme **Target: On plan 90%-100%**		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a declining nature.	Capital expenditure at the end of month 5 is £1.6m against a plan of £9.4m. This is mainly driven by the late start of schemes, ward refurbishment paused and replaced with smaller schemes, EPR delays and late confirmation of additional capital. The plan 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 FSPCiC.
59. Better Payment Practice Code **Target: Cumulative performance 95%**		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a declining nature.	Cumulative BPPC performance is 50% 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.	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.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance and Sustainability - Trust Position

	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**	 	**Assurance: The Trust consistently passes the target.** **Variation: Common cause (normal) variation.**	**There is no variation at month 5, CIP delivery 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 identification of additional schemes to mitigate against high risk schemes.** **Additional grip and control from Delivery Unit is supporting CIP achievement.**
61. Cost Improvement Programme (recurrent) – In year performance to date **Target: >90% plan delivered YTD**	 	**Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) variation.**	**£2.6m CIP has been delivered recurrently against the target of £6.7m.** **The Trust aims to deliver CIP recurrently wherever possible and challenges if CIP is not recurrent. Currently, the full year effect of the delivered and planned schemes mitigate the non-recurrent schemes into 2026/27.** **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 expenditure is £1m at month 5 compared to a plan of £1.2m.**	**At month 5, agency expenditure is underspent by £0.2m compared to budget.**	**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 expenditure is £13m at month 5 compared to a plan of £11.4m**	**At month 5 bank expenditure is overspent by £1.6m. £0.8m is due to the impact of Industrial Action, £0.4m due to the impact of the pay award and £0.4m due to A&E Medical staffing vacancies and sickness.** **This is being mitigated through additional income and non pay underspend.**	**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. Substantive recruitment into medical posts has taken place and is expected to continue which will reduce the medical bank spend.**

Appendix 3 – Trust IPR Indicator Overview

Indicator	KPI	Detail	Target	Additional Context
Quality				
Incidents		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.
	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		Number of new complaints.		
	15	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.

Sepsis	**19**	Sepsis Emergency Patient Screening	>=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.
	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 Inpatient Screening Lactate (within 1 hr)	>=90%	
	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 Vehicle Handovers within 15 mins	**31**	% of ambulance handovers that took place within 15 minutes (based on the data recorded on the HAS system).	>65%	National guidance has redefined ambulance handover completion as the point when clinical handover is finished, the patient is on hospital equipment, and the crew is released. In line with this, NWAS has updated its KPIs to measure handover from arrival to vehicle handover (A2VH), replacing the previous arrival to patient handover (A2PH) metrics. These changes aim to improve consistency, operational clarity, and performance reporting.
Ambulance Vehicle Handovers within 30 mins	**32**	% of ambulance handovers that took place within 30 minutes (based on the data recorded on the HAS system).	>95%	
Ambulance Vehicle Handovers within 45 mins	**33**	% of ambulance handovers that took place within 45 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?

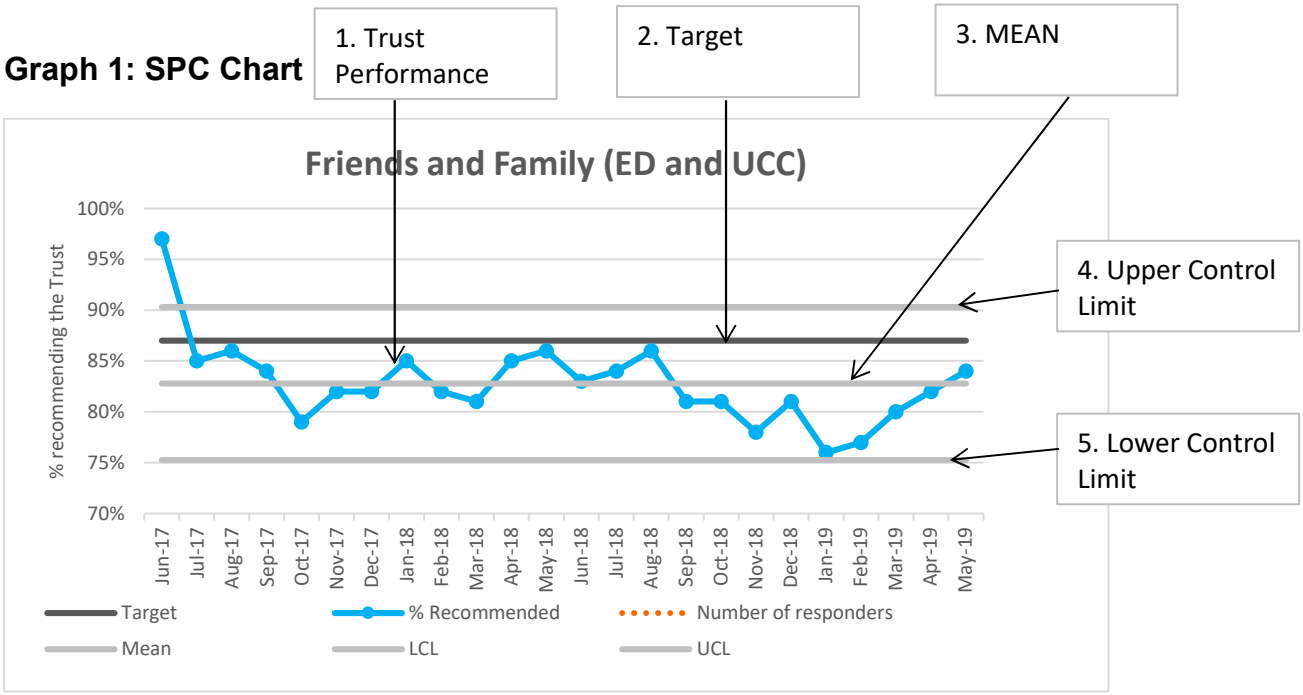
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

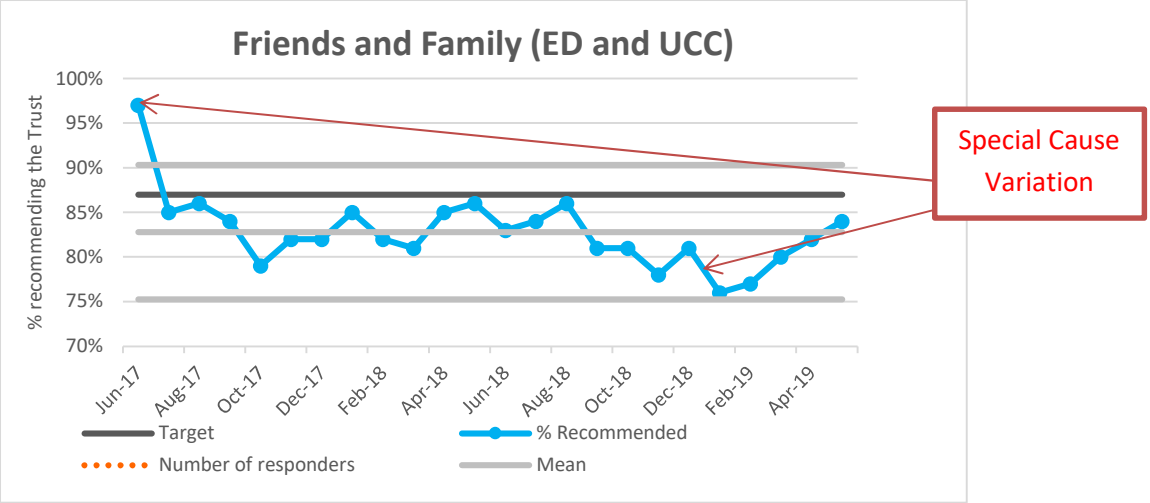


2.1 Interpreting a SPC Chart

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 7 consecutive data points are above or below the mean line.
3. There are more than 6 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

The Trust has introduced the "Making Data Count" variation and assurance icons in 2022/23. 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 7 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 7 months. E.g. if the Trust has consistently passed a target in the last 7 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.

Warrington & Halton Teaching Hospitals NHS Foundation Trust

Appendix 5: Income Statement at 31st August 2025

Income Statement	Annual	Month			Year to date		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income							
NHS Clinical Income	**366,974**	**30,409**	**27,995**	**-2,414**	**151,443**	**145,177**	**-6,265**
Non NHS Clinical Income							
Private Patients	8	1	1	0	3	3	0
Non NHS Overseas Patients	70	6	19	13	29	28	-1
Other non protected	750	63	106	44	313	406	93
Notional Pension Income	0	0	0	0	0	0	0
Sub total	**828**	**69**	**126**	**57**	**345**	**437.410**	**92**
Other Operating Income							
Training & Education	10,663	889	1,565	676	4,443	5,119	676
Donations and Grants	0	0	0	0	0	0	0
Miscellaneous Income	14,919	1,245	1,478	234	6,207	7,030	823
Sub total	**25,583**	**2,133**	**3,043**	**910**	**10,650**	**12,149**	**1,499**
Total Operating Income	**393,385**	**32,611**	**31,163**	**-1,447**	**162,437**	**157,764**	**-4,674**
Operating Expenses							
Employee Benefit Expenses	-284,112	-24,351	-24,811	-459	-123,598	-123,819	-221
Drugs	-23,121	-1,917	-1,727	190	-9,689	-9,129	560
Clinical Supplies and Services	-27,038	-2,363	-2,347	16	-11,845	-11,465	381
Non Clinical Supplies	-47,403	-3,976	-3,901	75	-19,840	-19,361	479
Depreciation and Amortisation	-17,659	-1,472	-1,472	0	-7,358	-7,358	0
Net Impairments (DEL)	0	0	0	0	0	0	0
Net Impairments (AME)	0	0	0	0	0	0	0
Restructuring Costs	0	0	0	0	0	0	0
Total Operating Expenses	**-399,332**	**-34,078**	**-34,257**	**-178**	**-172,330**	**-171,133**	**1,198**
Operating Surplus / (Deficit)	**-5,947**	**-1,467**	**-3,093**	**-1,626**	**-9,893**	**-13,369**	**-3,476**
Non Operating Income and Expenses							
Profit / (Loss) on disposal of assets	0	0	0	0	0	6	6
Interest Income	520	43	138	95	217	633	416
Interest Expenses	-138	-11	-7	4	-57	-54	3
PDC Dividends	-5,501	-458	-458	0	-2,292	-2,292	0
Total Non Operating Income and Expenses	**-5,119**	**-427**	**-328**	**99**	**-2,133**	**-1,707**	**425**
Surplus / (Deficit) - as per Accounts	**-11,066**	**-1,894**	**-3,421**	**-1,527**	**-12,026**	**-15,077**	**-3,051**
Adjustments to Financial Performance							
Less Impact of I&E (Impairments)/Reversals DEL	0	0	0	0	0	0	0
Less Impact of I&E (Impairments)/Reversals AME	0	0	0	0	0	0	0
Less Donations & Grants Income	0	0	0	0	0	0	0
Add Depreciation on Donated & Granted Assets	669	56	55	-1	279	275	-4
Total Adjustments to Financial Performance	**669**	**56**	**55**	**-1**	**279**	**275**	**-4**
Adjusted Surplus / (Deficit) as per NHSI Return	**-10,396**	**-1,838**	**-3,366**	**-1,528**	**-11,747**	**-14,802**	**-3,055**
Deficit Support Funding	-18,327	-1,527	0	1,527	-7,636	-4,582	3,055
Adjusted Surplus / (Deficit) - without deficit support funding	**-28,723**	**-3,365**	**-3,366**	**0**	**-19,383**	**-19,383**	**0**

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

IPR – August 2025 Detail
1st October 2025

Introduction

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:

- **15. Complaints –** over 6 months old
- **58. Capital Programme** – % delivered against plan
- **59. Better Practice Payment Code –** % cumulative performance

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

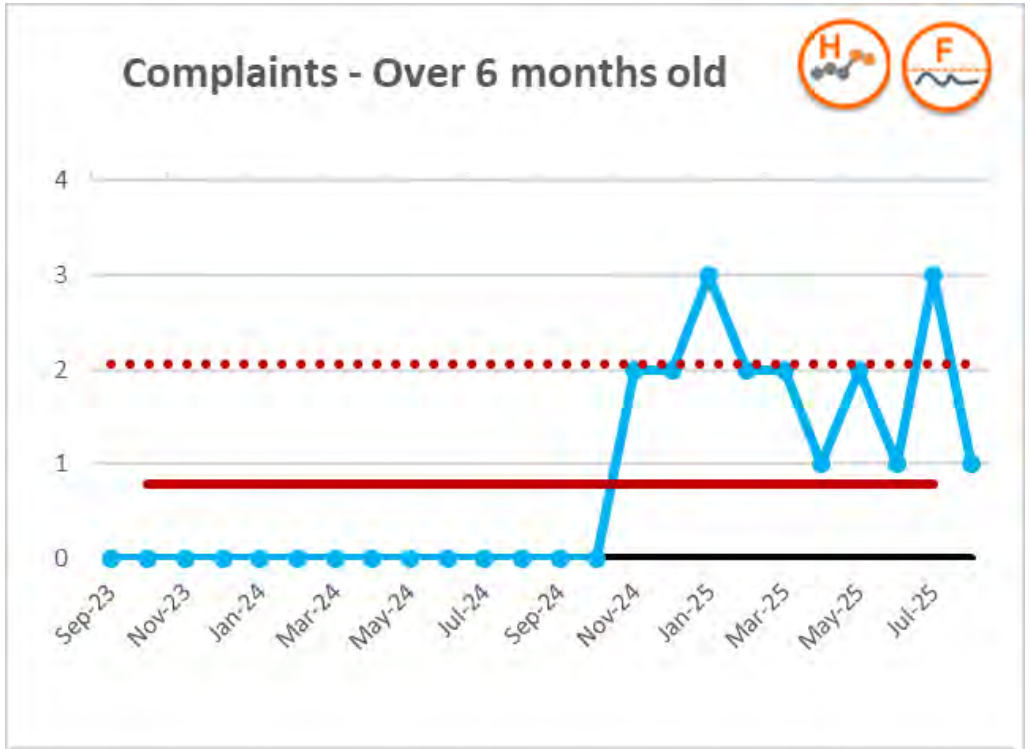
There are **2 indicators that consistently fails and cannot be measured for variation,** these are:

- **61. CIP (recurrent) –** % delivered against plan
- **63. Bank Reduction** – delivery against 10% reduction of 2024/25 plan

August 2025 IPR by Exception - Quality

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

15. Complaints

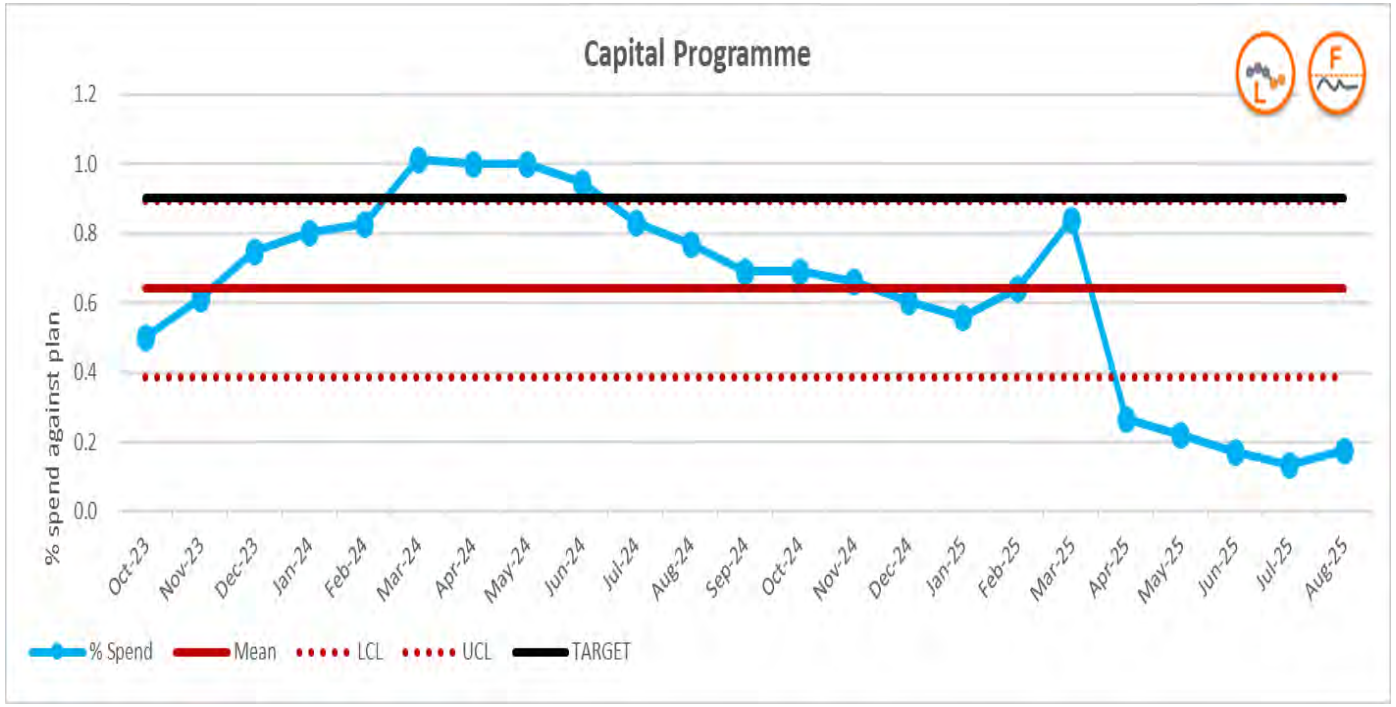


In August there was one complaint over six months old. This complaint was subject to a 'stop the clock' period, initially to allow the complainant time to consider and formulate the specific questions they wished to raise. A further pause was necessary due to scheduling constraints affecting both the complainant and relevant staff, which delayed agreement on a suitable meeting date at the complainant's request. The meeting has now been confirmed and is scheduled to take place on Friday, 26 September 2025.

August 2025 IPR by Exception – Finance

58. Capital Programme – % delivered against plan

Warrington and Halton Teaching Hospitals
NHS Foundation Trust



Capital expenditure at the end of month 5 is £1.6m against a plan of £9.4m.

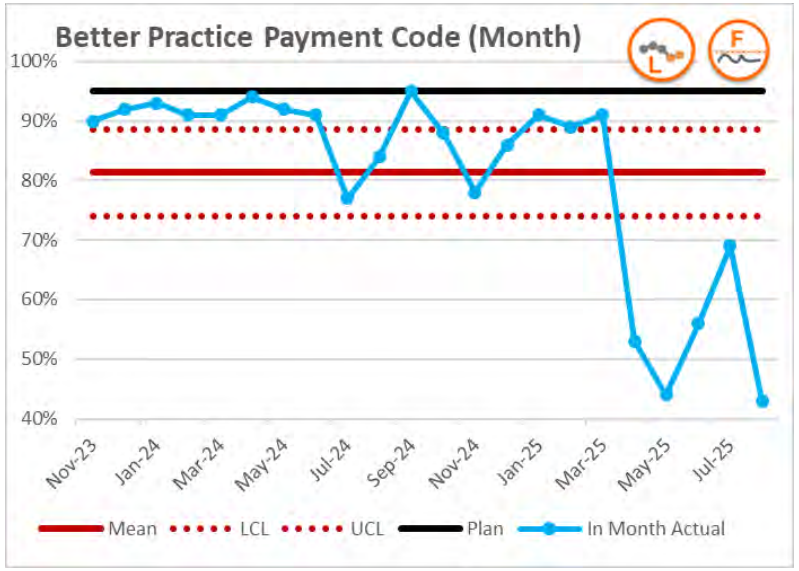
This is mainly driven by the late start of schemes, ward refurbishment paused and replaced with smaller schemes, EPR delays and late confirmation of additional capital. The plan is expected to be fully delivered by year end.

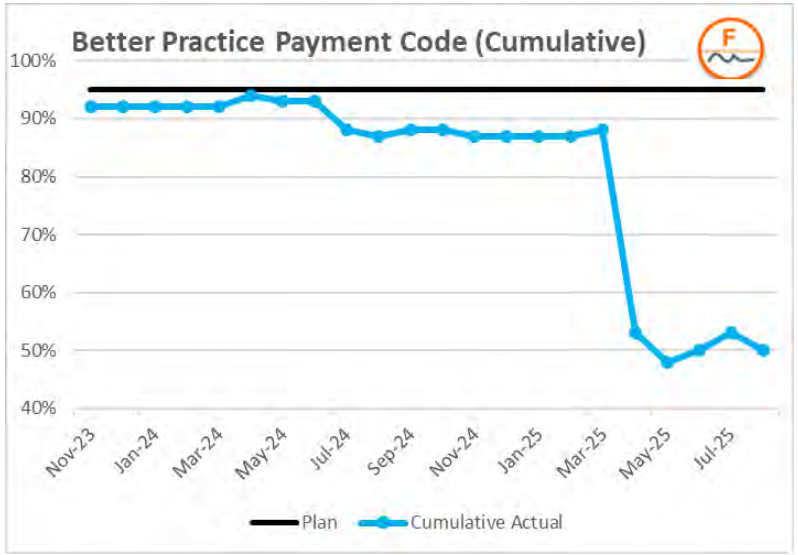
The risk associated with delivering the 2025/26 capital plan is being monitored at CPG and reported to FSPCiC.

August 2025 IPR by Exception – Finance

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

59. Better Practice Payment Code –% cumulative performance





Cumulative BPPC performance is 50% which is below the national target of 95%.

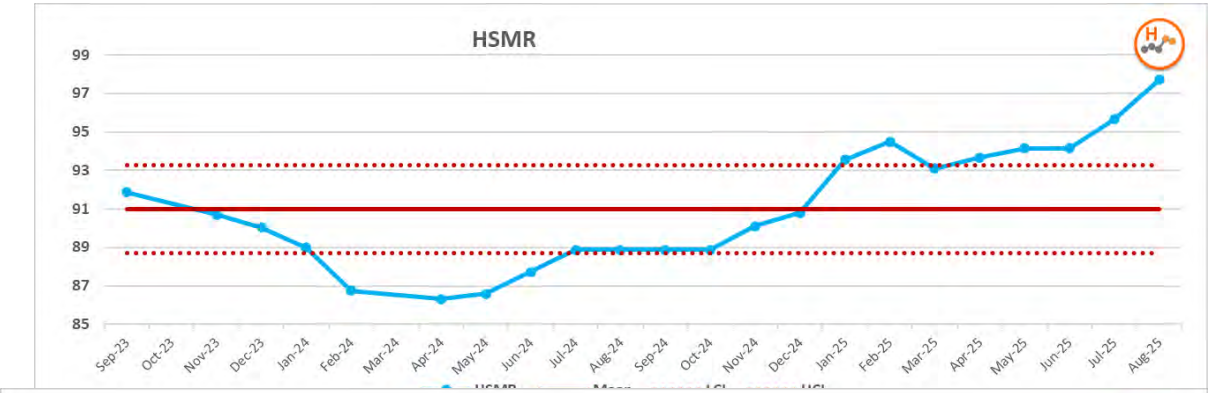
The main reason for this is due to cash management measures put in place to mitigate against the Trust's worsening cash position.

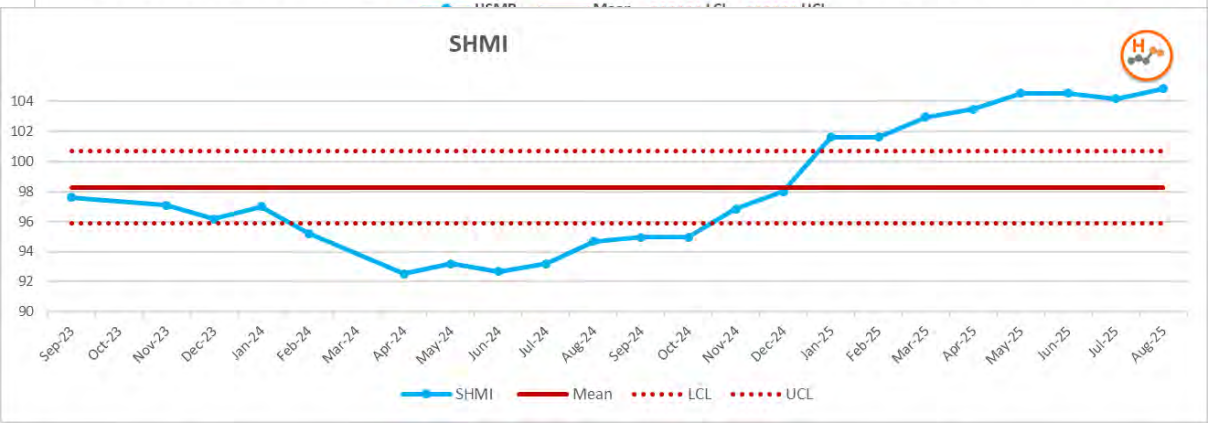
BPPC is being closely monitored, especially due to cash shortages. This includes daily cash monitoring, ensuring wherever possible we pay SME. BPPC is unlikely to reach the 95% target given the cash position of the Trust.

August 2025 IPR by Exception - Quality

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.

August 2025 IPR by Exception – Finance

61. CIP – % delivery against plan (recurrent)

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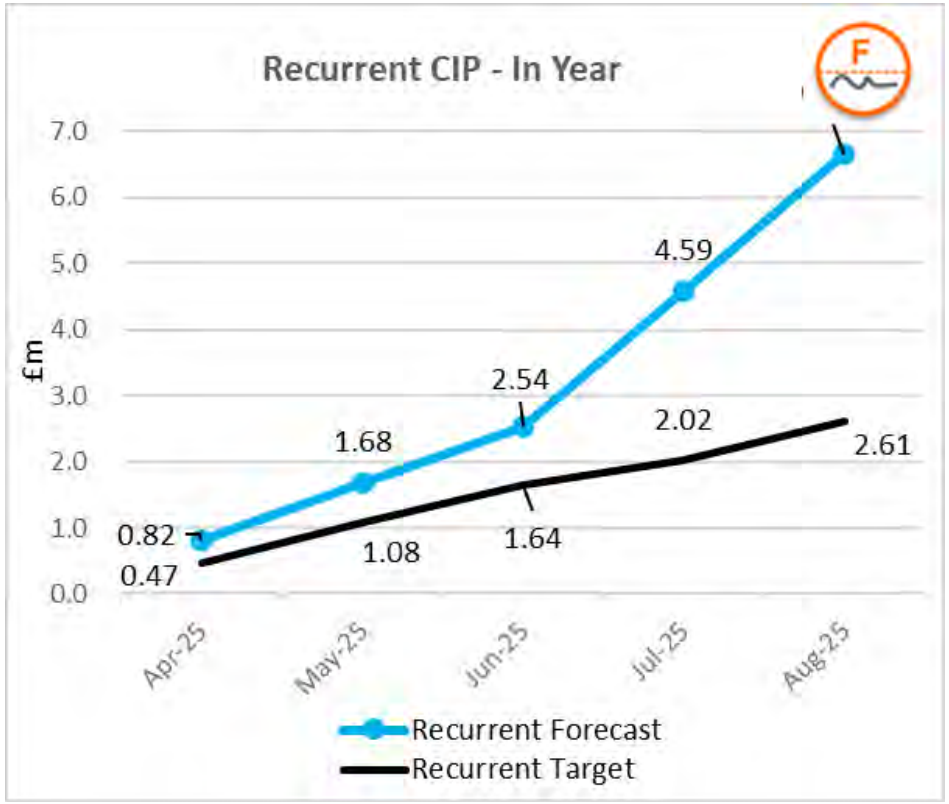
NHS Foundation Trust



£2.6m CIP has been delivered recurrently against the target of £6.7m.

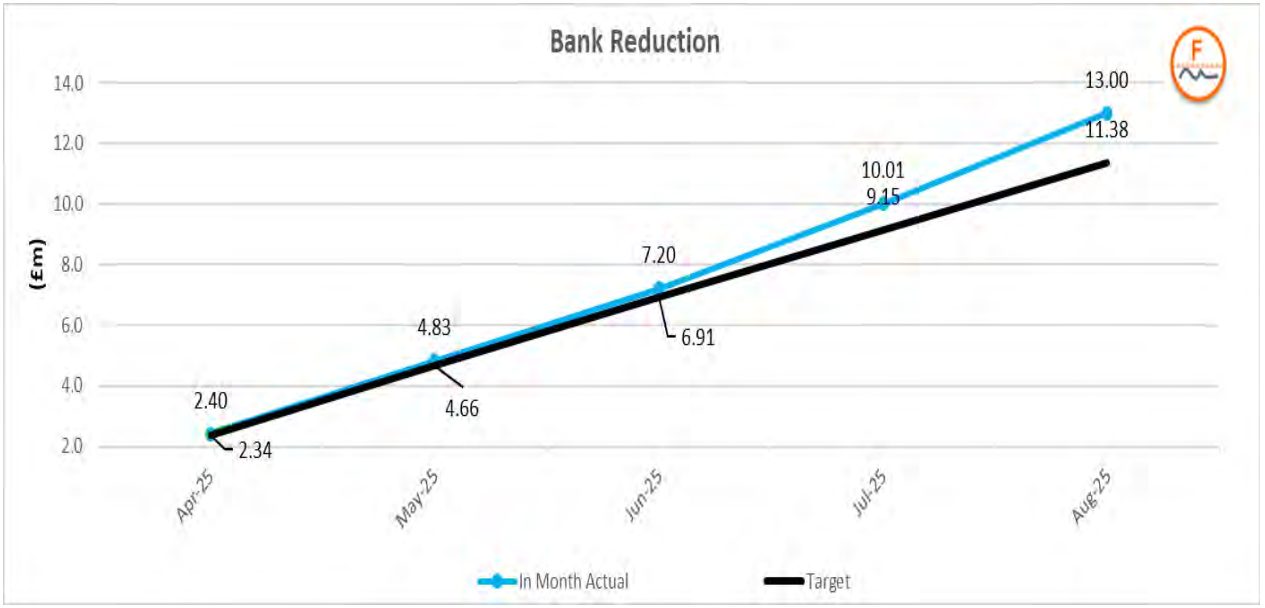
The Trust aims to deliver CIP recurrently wherever possible and challenges if CIP is not recurrent. Where recurrent CIP has not been realised, efforts have been made to deliver the CIP on a non-recurrent basis rather than not achieving at all. Currently, the full year effect of the delivered and planned schemes mitigate the non-recurrent schemes into 2026/27.

In 2025/26 the delivery unit has been supporting delivery of the CIP programme. This includes ensuring CIPs are recurrent with quality impact assessment and has oversight of Care Group cost pressures.

August 2025 IPR by Exception – Finance

63. Bank Reduction - delivery against 10% reduction of 2024/25 plan

Warrington and Halton Teaching Hospitals
NHS Foundation Trust



Bank expenditure is £13.0m at month 5 compared to a plan of £11.4m (overspend of £1.6m).

£0.8m is due to the impact of Industrial Action, £0.4m due to the impact of the pay award and £0.4m due to A&E Medical staffing vacancies and sickness.

This is being mitigated through additional income and non pay underspend.

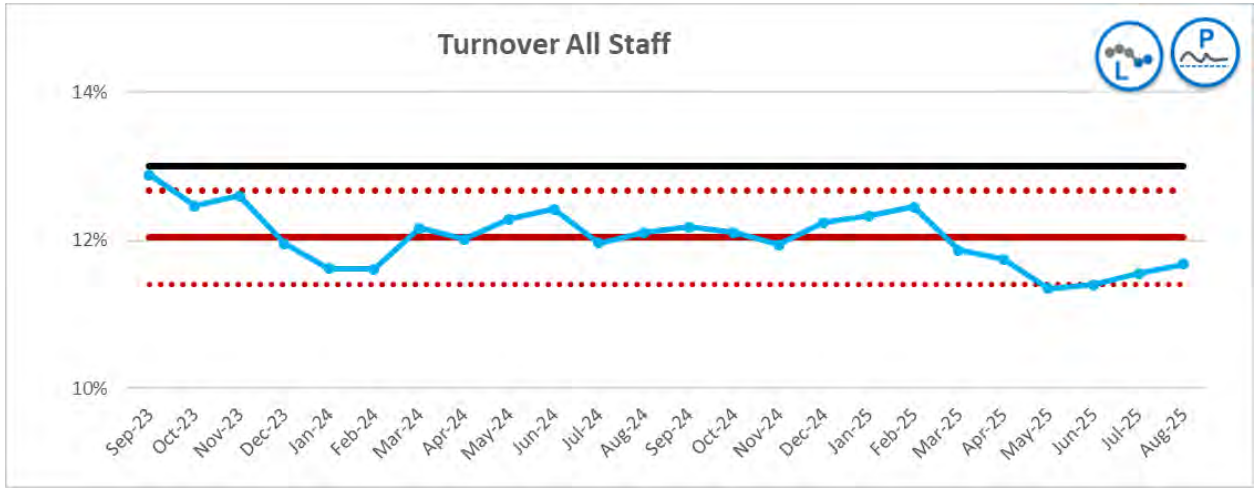
Substantive recruitment into medical posts has taken place and is expected to continue which will reduce the medical bank spend.

Improving metrics

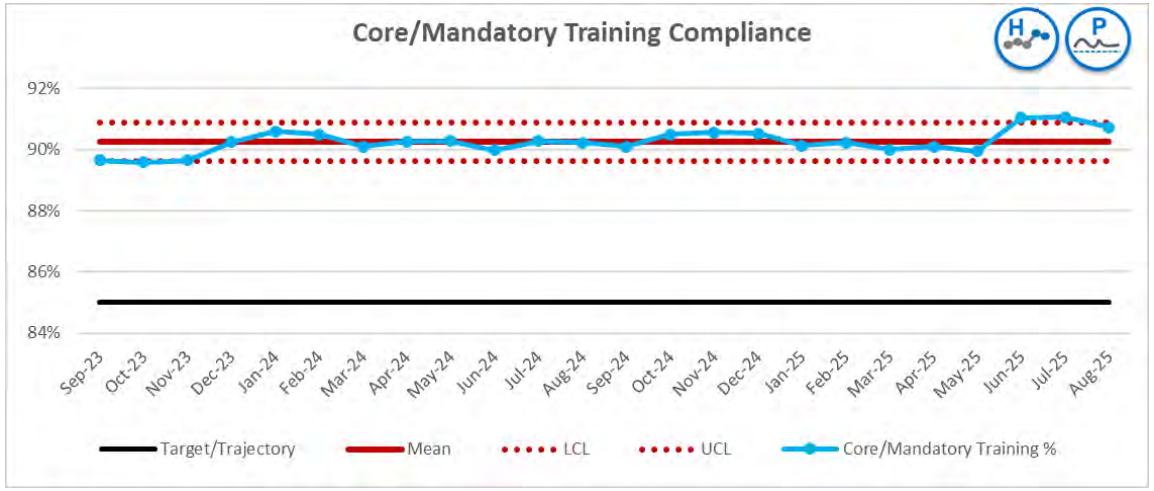
Metrics consistently passing target & maintaining/improving performance

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

53. Turnover



54. Core/Mandatory Compliance



- Turnover continues to improve as the Trust focuses on retention through schemes such as #MyflexWHH. It is also recognised that nationally in the NHS, the number of vacancies has reduced, resulting in reduced movement of staff.
- CSTF training compliance continues to be a key focus of the Trust with compliance monitored via OPC.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Recommendation

The Trust Board is asked to note the actions being taken in relation to these 7 IPR indicators.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/10/100a (i)	Meeting	Trust Board	Date Of Meeting	01 October 2025

Date of Meeting	12 August 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/25/07/078	**Hot Topic – Ligatures**	The Committee received a presentation noting • A total of 33 incidents were reported via Datix over the past 12 months • Trust-wide ligature risk assessments have been completed across all relevant environments. • A cluster review is scheduled for Quarter 3 to identify additional learning and improvement opportunities. • Trauma-Informed Care training has been successfully launched across the Trust. • The "About Me" card initiative is set to launch in September, promoting personalized trauma informed care. • A comprehensive action plan is in place to address findings and support ongoing improvements	**Moderate The committee acknowledged work commenced.**	**Substantial: Review via Quality Assurance Committee monthly in Maternity Paper.**	**Follow up November QAC as part of the Mental Health Update**
QAC/25/08/111	**Patient Safety and clinical Effectiveness Sub Committee**	An update from Patient Safety and Clinical Effectiveness Sub-Committee (PSCESC) was provided to the Committee.	**Moderate**	**Substantial**	**Update to QAC September 2025**

	(PSCESC) Report.	Key areas to note • Chronic Pain: An action plan is to be presented at the next PSCESC Meeting. No new patients are currently being initiated on injection regimes. • Fractured Neck of Femur: A mortality alert has been received by the Trust. A weekly Executive Oversight Meeting has been established to monitor and address concerns. • Cancer Services: Progress has been noted against the existing action plan. However, further assurance is required regarding the escalation of cancer tracking issues. • Cardiology: An emerging risk has been identified related to delays in actioning results. A Standard Operating Procedure (SOP) is currently being developed to mitigate this risk. • Risk Register: Long-standing risks are under active review through Risk Summits, ensuring appropriate scrutiny and management of risks	**Assurance has been received regarding progress to date; however, sustained improvements are required to ensure long-term impact and consistency.**	**Monthly oversight at QAC** **Executive oversight monthly of all fragile services is conducted through PSCESC**	
QAC/25/08/112	**Fractured Neck of Femur**	The Committee received a report noting • Concerns regarding mortality linked to Neck of femur highlighted • Overview of metrics, slight improvement noted	**Limited** **An in-depth review of Best Practice Tariff (BPT) metrics is required. While some slight**	**Substantive** **Oversight at QAC Biannually Monthly at Patient Safety**	**Update to PSCESC in September 2025**

		• Compared to NFD metrics WHH remains above expected national average benchmark	**progress is evident, further improvements are necessary to meet expected standards and ensure sustained compliance.**	**and Clinical Effectiveness (PSEESC)**	
	ED Position	The Committee received a presentation noting • 4-Hour Target: Performance has deteriorated • Ambulance Handover Times: Significant improvement observed • Triage Times: Notable improvement achieved • 12-Hour Total Time in Department: A decline in performance has been noted, requiring further investigation and targeted action. • Quality Improvement Limited oversight of current initiatives, with no demonstrable impact identified to date. • Medication incidents remain above the mean compared to the previous quarter, highlighting an ongoing area of concern	**Limited** **Limited assurance of ability to address areas of poor performance, Further evidence of outputs of Quality Improvement projects required.**	**Substantive** **Monthly Oversight at QAC**	**Update to QAC September 2025**
QAC/25/08/118	**Typing Back log update**	The Committee received a report noting • 12,575 records noted to be in backlog a number typed but awaiting approval • Administrative/Clerical Group developed to identify solutions • AI solutions being explored along with an “Administrative pool” of staff	**Limited** **An update in relation to timeframes for improvement was requested**	**Substantive Oversight at PSCESC Monthly. To be seen bimonthly at QAC**	**Report to QAC in October 2025**

QAC/25/08/120	**Sepsis High Level Briefing Paper**	The Committee received a report noting • An improvement noted in Blood Culture KPI in the Emergency Department • Challenges continue with other ED metrics such as Lactate and time to be seen by a clinician. • Inpatients improvements in several metrics, except blood cultures which has reduced in July 2025. • Improvement plan in place	**Moderate** **The committee awaiting sustainable improvement to be demonstrated.**	**Substantive** **Oversight at QAC Quarterly**	**Present to QAC in November 2025.**

The Committee also received the following items.
QAC/25/08//110 Compliance Report
QAC/25/08/114 New Approach to 7 Day Hospital Service
QAC/25//08/115 Quality IPR
QAC/25/08/116 Quality Improvement Progress Report
QAC/25/08/117 Maternity Update
QAC/25/08/119 Learning from Experience Report
QAC/25/08/120 Sepsis High Level Briefing Q1
QAC/25/08/121 Infection Prevention and Control Report Q1
QAC/25/08/122 MIAA Theatre Safety Audit
QAC/25/07/123 Clinical Audit Report

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*

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/10/100a (ii)	Meeting	Trust Board	Date Of Meeting	1 October 2025

Date of Meeting	9 September 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/25/09/134	**Hot Topic – MH Requirements in ED Section 136**	The Committee received a presentation noting • Briefing on section 136 and mental health assessment requirements • Overview of Cheshire and Merseyside position. Noting 136 patients are being taken to acute sites as only 4 136 units in Cheshire and Merseyside. • Instruction from ICB all acute Trusts to become "a place of safety" • Overview of potential risks with implementation • Acceptance Tool, Policies, SOPs, legal frameworks in development • Informed the ICB WHH would not be ready to meet the implementation date of 31 July 2025. Date to be agreed.	**Moderate** **The committee acknowledged work commenced.**	**Substantial: Review via Quality Assurance Committee Quarterly in Mental Health Update. Bimonthly oversight via Mental Health Steering Group.**	**Follow up November QAC as part of the Mental Health Update**
QAC/25/09/137	**Patient Safety and clinical Effectiveness Sub Committee**	An update from Patient Safety and Clinical Effectiveness Sub-Committee (PSCESC) was provided to the Committee.	**Moderate** **Assurance has been received**	**Substantial**	**Update to QAC September 2025**

	(PSCESC) Report.	Key areas to note • 5 fragile services remain under review of the fragile services programme. • Cardiology – shown improvement. Additional consultant approved. • Chronic Pain – SOP in development, • NOF – improvements noted, monthly oversight by Patient Safety and Clinical Effectiveness. • Cancer – progress required, histology project has been delayed expecting to go live in September • Audit on implementation of surveillance not received – expected next month • Urology – Medical capacity remains challenged. • Plans in place to address key issues.	**regarding progress to date; however, sustained improvements are required to ensure long-term impact and consistency.**	**Monthly oversight at QAC** **Executive oversight monthly of all fragile services is conducted through PSCESC**	
QAC/25/09/138	**Fractured Neck of Femur**	The Committee received a report noting • Overview of BPT performance for August 2025 seen, improvements noted. • Detailed review of patients achieving the prompt surgery standard. • Increased numbers of patient being seen who are admitted with a Fractured Neck of Femur. Average time to surgery was 40 hours in August compared to 47 hours in July. • Improvements in the number of patients transferred to the Orthopaedic ward timely.	**Limited** **Small improvements noted by the Committee. More detail requested on medically fit. SPC charts and aim to be quantified.**	**Substantive** **Oversight at QAC monthly.** **Monthly at Patient Safety and Clinical Effectiveness (PSEESC)**	**Update to PSCESC in October 2025**

QAC/25?09/139	**ED Improvement update**	The Committee received a presentation noting • Behind plan on 12 trajectory currently. However, improvements seen. Reduction seen from average of 56 breeches per Day to 37 per day. • Increase in ambulances. • Plans and clear trajectories in place. • Plan to focus on Medication management throughout Q3.	**Moderate** **Clearer plans noted with some improvements in performance Further evidence of outputs of Quality and safety required.**	**Substantive** **Monthly Oversight at QAC**	**Update to** **QAC September 2025**

The Committee also received the following items.

QAC/25/09/131 Patient Story
QAC/25/09/142 New Approach to 7 Day Hospital Service
QAC/25//09/136 BAF
QAC/25/09/141 PPH update
QAC/25/09/140 Mental Health update
QAC/25/09/143 Maternity Update
QAC/25/09/120 Sepsis High Level Briefing Q1
QAC/25/09/144 Learning from Deaths
QAC/25/09/145 Quality Priorities
QAC/25/09/146 Quality Strategy Update
QAC/25/09/147 Quality Impact Assessment High level briefing
QAC/25/09/148 High Level Enquiries
QAC/25/09/149Infromation Governance and Corporate Records Q1 Update

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

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/10/100b (i)	Meeting	Trust Board	Date of Meeting	1 October 2025

Date of Meeting	Wednesday 18 August 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/25/08/090	**Deep Dive: Bullying and Harassment**	**Adam Harrison-Moran, Head of Strategic Workforce Development & Culture** The Committee received a deep dive on the progress made to eradicate bullying and harassment across the Trust as an output of the NHS Staff Survey results in 2024. The Committee noted the triangulation of data from the survey, employee relations and Freedom to Speak Up to develop a combined programme called “See it. Report it. Stop it”. The Committee noted that a refreshed active bystander programme has been implemented with Trust wide training and development offers. Members noted that updates on the delivery of the programme will be reported bi-annually.	The Committee received **assurance** on the delivery of the anti-bullying and harassment work which has been implemented, noting that delivery is underway but may not be seen through survey results until 2026/27.	The Committee received **assurance** on the governance of anti-bullying and harassment.	February 2026

SPCIC/25/08/091	**Hot Topic: Leng Review**	**Manav Jain, Consultant / Richard Briggs, Consultant** The Committee received an update on the Leng Review and its impact on current Physician Assistants (PA) and Physician Assistants in Anaesthesia (previously Associates). The update included the background and current procedures for PAs at WHH including changes which have been applied on receipt of the NHS England letter. The Committee agreed that extensive work has been completed to ensure pastoral support has been put in place following the initial recommendations which had to be put in place. Members noted and received assurance that a thorough action plan is in place and an update on progress and staff experience was requested in four months' time.	The Committee received **assurance** on the delivery of Leng Review.	The Committee received **assurance** on the governance of the Leng Review.	December 2025

SPCIC/25/08/092	**Chief People Officer Report**	**Jennie Dwerryhouse, Deputy Chief People Officer** The Committee received the monthly Chief People Officer report, of which the Committee focused attention on the detailed analysis on the Band 2 to Band 3 Healthcare Support Worker programme. Members received an update through an equality, diversity and inclusion lens and it was positively received that there were no disparities by protected groups identified as part of the programme.	The Committee received **assurance** on delivery of the Band 2 to Band 3 programme through an equality, diversity and inclusion lens.	The Committee received **assurance** on the governance of the Band 2 to Band 3 programme.	Not required
SPCIC/25/08/094 (ii)	**Better Care Together: Organisational Change Framework**	**Adam Harrison-Moran, Head of Strategic Workforce Development & Culture / Hayley Heard, Deputy Director of Strategy and Partnerships** The Committee received the Organisational Change Framework for the Better Care Together programme. The Committee noted this has been co-developed by both Trusts in conjunction with Staff Side partners and is being published and launched in August 2025. The Committee discussed formats of communication, ensuring the information is clearly available to all staff and demonstrates the processes which will be undertaken. The Committee discussed the intricacies of TUPE law and staff consultation and requested	The Committee received **moderate assurance** on delivery of the Organisational Change Framework, noting this has not been applied as staff consultation has not yet commenced.	The Committee received **assurance** on the governance of the Organisational Change Framework and processes applied to ensure a consistent, fair and safe consultation process.	May 2026

		an update on how 'meaningful' consultation has been undertaken in May 2026.			
SPCIC/25/08/096 (i)	**Workforce Race Equality Standard**	**Adam Harrison-Moran, Head of Strategic Workforce Development & Culture** The Committee received the Workforce Race Equality Standard (WRES) report for 2024/25, including an update on the 2023/24 action plan and the revised plan for 2024/25 and 2025/26. The Committee noted that the report and subsequent plan for improvement was codeveloped with the Multi-Ethnic Staff Network. Members noted improvements in metrics but still an outlier in the experience of Black, Asian and Minority Ethnic staff in comparison to White staff. Members noted that the Black, Asian and Minority Ethnic workforce has grown to 19.32%, with significant gains in clinical and medical roles and Board representation rising to 12.6%. However, reports of harassment, bullying and discrimination against Black, Asian and Minority Ethnic staff have increased and notable disparities persist between staff experiences. Members noted as per previous items that work is underway to address this. The Committee approved the report and subsequent plan as part of their delegation from the Trust Board. The Committee noted this would be shared with the Trust Board in October 2025.	The Committee received **assurance** on delivery of the WRES in 2024/25 and subsequent action plan for improvement.	The Committee received **assurance** on governance of the WRES in 2024/25 and subsequent action plan for improvement.	August 2026

SPCIC/25/08/096 (iii)	**Workforce Disability Equality Standard**	**Adam Harrison-Moran, Head of Strategic Workforce Development & Culture** The Committee received the Workforce Disability Equality Standard (WDES) report for 2024/25, including an update on the 2023/24 action plan and the revised plan for 2024/25 and 2025/26. The Committee noted that the report and subsequent plan for improvement was codeveloped with the Disability Awareness Staff Network. Members noted improvements in metrics but still an outlier in the experience of disabled staff compared to non-disabled staff. Members noted that disability declaration rates have risen to 5.16% and the proportion of staff not declaring their status has decreased. Disabled applicants are now slightly more likely to be appointed than non-disabled applicants and staff survey results show reductions in harassment, bullying and pressure to work when unwell. The Committee approved the report and subsequent plan as part of their delegation from the Trust Board. The Committee noted this would be shared with the Trust Board in October 2025.	The Committee received **assurance** on delivery of the WDES in 2024/25 and subsequent action plan for improvement.	The Committee received **assurance** on governance of the WDES in 2024/25 and subsequent action plan for improvement.	August 2026
SPCIC/25/08/100	**Terms of Reference and Cycle of**	**Jan McCartney, Director of Corporate Governance (BCH)**	The Committee received **assurance** on	The Committee received **assurance** on	March 2026

	Business (Four Month Review)	The Committee approved the Terms of Reference and Cycle of Business as part of the planned review four months into the Committee commencing with a few alterations to support joint working on safer staffing from September 2025 onwards. The Committee noted positive progress and assurance with opportunities for joint reporting to commence over the 2025/26 period.	delivery of the Strategic People Committee in Common.	governance documents associated with the Strategic People Committee in Common.	

Other reports received by the Committee:

- SPCIC/25/08/093 – Workforce Brief on National, Regional, ICB or Local Workforce Issues
- SPCIC/25/08/095 – Workforce Equality, Diversity and Inclusion Strategy Update
- SPCIC/25/08/097 – Safer Staffing Report
- SPCIC/25/08/098 – Midwifery Staffing Report – Q1 – **approved for submission to Trust Board**

Chairs Logs received by the Committee:

- SPCIC/25/08/102 – Workforce Review Group

Assurance Key:

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

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

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*

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/10/100b (ii)	Meeting	Trust Board	Date of Meeting	1 October 2025

Date of Meeting	Wednesday 17 September 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/25/09/109	**Deep Dive: Theatres Culture Work**	**Neil Gregory, Associate Director of Planned Care** The Committee received a full update on work undertaken within Theatres since the commencement of the cultural improvement programme. Members noted a series of safety events and the allocation of Theatres as a 'developing' service under the Trust Culture Plan. Members noted positive improvements such as the introduction of 'STOP' moments within the department, aimed at creating a multi-disciplinary immediate approach to safety. This was a positive welcome and further work to monitor the volume of 'STOP' moments were being considered. Additionally, bespoke psychological safety and culture workshops have been implemented across all staff groups with a specific Culture Improvement Programme for the Medical and Dental workforce.	The Committee received **assurance** on the delivery of the Theatre culture improvement programme, noting that there is more to do.	The Committee received **assurance** on the governance of Theatre culture improvement programme, specifically noting the triangulation of data and staff groups.	No specific review date

		Overall, the Committee noted that there is more to do but highlighted the significant progress made to date and the alignment with quality and patient outcomes. Further updates on progress will report through the Bi-Annual Culture Paper.			
SPCIC/25/09/110	**Hot Topic: Nursing and Midwifery Profiles**	**Tania Strong, Assistant Director of People and OD (BCH) / Laura Hilton, Associate Chief People Officer (WHH)** The Committee received an update on the national workstream to align nursing and midwifery profiles. The Committee noted a joint working programme between Bridgewater Community Healthcare and Warrington and Halton Teaching Hospitals. The Committee discussed the national, regional and local implications of this programme and specifically highlighted the requirement to work across the Cheshire and Merseyside ICB for consistency. Members agreed this approach. Members noted that a risk management process is in place and this needs to be continually monitored and addressed due to the timeframes for the programme. Overall, the Committee noted the volume of work required to complete this programme.	The Committee received **moderate assurance** on the delivery of the Nursing and Midwifery Profile programme due to the challenges with timelines and internal / external pressures.	The Committee received **assurance** on the governance of the programme with updates being provided to the Committee at regular intervals.	Q3 2025/26

SPCIC/25/09/115	**Better Care Together Update**	**Lucy Gardner, Chief Strategy and Partnerships Officer (WHH) / Michelle Cloney, Chief People Officer (WHH) / Paula Woods, Director of People and OD (BCH) / Adam Harrison-Moran, Associate Chief People Officer (WHH)** The Committee received an update on the programme delivery for integration. The update consisted of: • Overall programme • Workforce integration • Corporate service integration • Communications and engagement The Committee specifically noted an increase in sickness absence reporting at BCH with discussions aligned to integration. Members noted that further staff engagement exercises are planned, including responding directly to staff feedback on organisational form. The Committee noted that addressing some of these concerns will aim to support staff.	The Committee received **moderate assurance** on delivery of the Better Care Together integration programme. Specifically aligned with rising sickness absence and its implication on staff experience.	The Committee received **assurance** on the Better Care Together integration programme and steps being taken to ensure a fair, consistent approach.	October 2025
SPCIC/25/09/119	**General Medical Council Survey 2024**	**Paul Fitzsimmons, Medical Director** The Committee received an update from the Medical Director on the GMC Survey 2024. Members noted the detailed report and analysis of the key findings. Specifically, members noted the breakdown of the data by speciality and area with actions to follow to improve the findings and address the impacts that have been identified. Members noted some external influences which could have an impact on the data and results.	The Committee received **moderate assurance** on delivery of the GMC Survey 2024 with actions to improve on findings.	The Committee received **assurance** on governance of the GMC Survey 2024.	No specific review date
SPCIC/25/09/120	**Revalidation Report (WHH)**	**Paul Fitzsimmons, Medical Director** The Committee received the annual revalidation report for WHH. The Committee noted the findings of	The Committee received **assurance** on	The Committee received **assurance** on	No specific review date

		the report and were assured that actions were being taken to address any gaps. The Committee discussed the similarities and differences between the WHH and BCH report and were updated by the Medical Director that work is underway to align systems and reporting for the future. The Committee noted that there were no immediate risks. The Committee approved the report for onward circulation to Trust Board.	delivery of the revalidation process for Medical and Dental staff at WHH.	governance of the revalidation process.	

Other reports received by the Committee:

- SPCIC/25/09/111 – Board Assurance Framework and Corporate Risk Register
- SPCIC/25/09/112 – Chief People Officer Report
- SPCIC/25/09/113 – Workforce Brief on National, Regional, ICB or Local Workforce Issues **(MARS item approved by Committee for NARC approval)**
- SPCIC/25/09/114 – Workforce Integrated Performance Reports
- SPCIC/25/09/116 – Culture Plan 2025-2027 Bi-Annual Updated
- SPCIC/25/09/117 – Safer Staffing Report
- SPCIC/25/09/118 – Guardian of Safe Working Hours Report (Q1)

Chairs Logs received by the Committee:

- SPCIC/25/09/122 – Workforce Review Group
- SPCIC/25/09/123 – Operational People Committee

Assurance Key:

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Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/10/100c(i)	Meeting	Trust Board	Date Of Meeting	1 October 2025

Date of Meeting	26 August 2025
Name of Meeting & Chair	Finance, Sustainability and Performance Committee in Common, Chaired by Tina Wilkins
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
FSPCiC/25/ 08/36	**Deep Dive – CIP Delivery Unit** **• Delivery Unit** **• Workforce** **• Level 3 CIP** **• Productivity**	The Committee in Common received the presentation noting:- • The functions of the Delivery Unit and key areas of review for both BAU CIP and Level 3 with a focus on delivery and overspending areas. • Combined CIP challenge of £27m BAU and £16m level 3 • Workforce review – Planned Care and CSS achieved CIP at Month 4, Unplanned Care behind plan, there is risk of delivery in the remainder of the year and QIA sign off required all to reach 100% sign off (89% at 21 August). • Suggested schemes have been provided by the ICS to deliver the level 3 CIP. ICS to circulate what they are expecting each Trust to deliver, this will be checked to ensure they are in addition to BAU CIP. Involvement across the Trust in ICS work at Nurse and Medical meetings with Finance and HR support. • Grip and control checklist to be brought back once completed. • Outpatients – DNA remains a challenge for the Trust, new to follow up ratio improving and clinic template work has increased slots by 15% • Theatres – improvement in capped utilisation is still in the lower quartile compared to peers. Plan has been achieved in Planned Care; however, overall ERF underperformance has meant that this can't be transacted. Late starts continue to be an issue, the	The Committee received **moderate** assurance based on delivery of the BAU CIP plan	The Committee **noted** and discussed the report receiving **moderate** assurance given recurrent plans in place are not delivering to expectations	**FSPCiC September 2025**

		reasons for this are multifactorial and continues to be an area of focus. • Non-Elective Length of Stay – There are constraints due to NCTR continue to focus on criteria led discharge, deconditioning and pathway review.			
FSPCiC/25/ 08/37	**Hot Topic • Tier 1 & 2**	The Committee in Common received the presentation noting:- **UEC – Tier 1** • The Trust has had notification that it will remain in Tier 1 based on 12 hour time in department (June data 111/111) and 4 hour performance (June data 105/134). • Programme of work in place via a meeting with the Chief Operating Officer, Chief Nurse and Medical Director to determine reasons for performance and actions to improve. • Looking at a model for patients to be seen, triaged and return the next day rather than waiting in A&E overnight reducing breaches. **Elective – Tier 2** • Tiering based on long waiters, RTT performance against plan and how the Trust is tracking against 52 week waiters. Validation undertaken which has determined that the Trust is to be placed in Tier 2. • First Tier 2 meeting to take place in October with quarterly reviews.	The Committee received **no** assurance	The Committee received **moderate** assurance	**FSPCiC September 2025**
FSPCiC/25/ 08/38	**Corporate Performance Report**	The Committee in Common received the report noting:- • ED 4 hour performance 67.34%, and remains a concern • Percentage of patients waiting over 12 hours remains a challenge • DM01 performance achieved the national standard for the fifth consecutive month (96.05%). • Cancer performance – 98% 31 day wait consistently achieved, 78.4% 62 day wait continues to be a challenge, 28 day Faster Diagnosis has increased slightly to 74% although is not currently meeting the target.	The Committee received **moderate** assurance given some metrics are not achieving	The Committee **noted** the report and is **assured** around level of detail reported	**FSPCiC September 2025**
FSPCiC/25/ 08/42	**Cash Support Update**	The Committee in Common received the report noting:- • Notification of the September cash application is pending • Support for cash support request of up to £8.591m for October which includes the September submission amount in case not approved	The Committee received **moderate** assurance due to the Trust financial position and	The Committee **noted** the report, is **assured** and **supported** the cash	**Trust Board September 2025**

		• Support for further mitigation options (using capital funds and non-payment of the September PDC dividend) if required.	requirement for cash support.	support request and the mitigations	
FSPCiC/25/ 08/44	**Finance Report**	The Committee in Common received the report noting:- • Month 4 deficit position is on plan at £16m (before deficit support funding (DSF)), after DSF the deficit is £11.4m (£1.5m worse than plan). • PwC action log being addressed and responded to, some Trusts to be in intensive support, expected that WHH will also be in this category. • Agency is below plan, bank is above plan due to medical vacancies. • Risk adjusted forecast excluding DSF has been submitted at a £45.1m deficit compared to a plan of £28.7m. The variance consists of £10.7m level 3 CIP, risk assessed CIP delivery based on PFR percentages of £5.2m and £0.5m PDC dividend increase.	The Committee received **moderate** assurance recognising achievement of plan to date but risk of overall plan delivery	The Committee **noted** the report and is **assured**	**FSPCiC September 2025**

Items for noting

FSPCiC/25/08/40	*Monthly CIP Updates – Month 4*
FSPCiC/25/08/41	*Cost Pressures*
FSPCiC/25/08/43	*Costing*
FSPCiC/25/08/45	*Pay Assurance Report*
FSPCiC/25/08/46	*Benefits Realisation Q1 Update*
FSPCiC/25/08/47	*Integration Update*
FSPCiC/25/08/48	*WHH Revenue Requests (supported for approval by Trust Board)*
FSPCiC/25/08/49	*Capital Expenditure and Schemes over £500k – supported and approved the movement in capital contingency*
FSPCiC/25/08/50	*Monthly Productivity Update*
FSPCiC/25/08/51	*Elective Recovery Update*
FSPCiC/25/08/52	*Medical Workforce Review Group Q1 Report*
FSPCiC/25/08/53	*Reports / minutes from the Delivery Unit*
FSPCiC/25/08/54	*EPRR Group minutes*
FSPCiC/25/08/55	*Digital Services High Level Briefing and Digital Board Minutes*
FSPCiC/25/08/58	*Any Other Business – Winter Plan*

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NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/10/100c (ii)	Meeting	Trust Board	Date Of Meeting	1 October 2025

Date of Meeting	22 September 2025
Name of Meeting & Chair	Finance, Sustainability and Performance Committee in Common, 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
FSPCiC/25/ 09/63	**Deep Dive –Delivery Unit**	The Committee in Common received the presentation noting:- • Amalgamation of pay and non-pay meetings • All schemes now fully developed with improvement in delivery of CIP in 2025/26 compared to 2024/25 • Non-recurrent vacancies supporting the position will be reviewed to check if can be made recurrent • Level 3 CIP schemes under review, risk of double counting as BAU CIP • Changes implemented by the Delivery Unit include recovery plans being put in place with Care Groups with escalation to EMT • High risk CIP at £6.9m at month 5 (reduction from £8.4m in month 4)	The Committee received **moderate** assurance based on delivery of the BAU CIP plan	The Committee **noted** and discussed the report receiving **moderate** assurance given recurrent plans in place are not delivering to expectations	**FSPCiC October 2025**
FSPCiC/25/ 09/64	**Hot Topic • PwC Update (incl Level 3 CIP)**	The Committee in Common received the presentation noting:- • Level 3 CIP will be led, coordinated and developed at system level and delivered at Trust level • Executive discussion on Level 3 CIP including stopping overtime/bank/ agency/WLI/Insourcing/Outsourcing, not opening escalation in winter and closing wards • List of schemes also provided by the ICB (£3.6m), review being undertaken to determine if they are achievable, RAG rated red at this stage as robust QIA required to determine if they can go ahead • A number of external reviews underway and being responded to including NHSE, ICB and PwC reviews	The Committee received **no** assurance	The Committee received **moderate** assurance given full plans not being in place	**Private Trust Board October 2025**

		• PwC letter received of risk stratification, the Trust is classed as high risk			
FSPCiC/25/ 09/66	**Corporate Performance Report**	The Committee in Common received the report noting:- • ED 4 hour performance 68%, and remains a concern (114 out of 124) • Percentage waiting over 12 hours remains a challenge (111 out of 112) • Improvement trajectories required • RTT performance 57%, 52 week wait is the biggest challenge, forecast to improve by the end of Q3 • Strong performance in 62 day and diagnostic performance nationally • Cancer performance – 97% 31 day wait consistently achieved, 77% 62 day wait continues to be a challenge, 28 day Faster Diagnosis is 74% and is not currently meeting the target.	The Committee received **moderate** assurance given some metrics are not achieving	The Committee **noted** the report and is **assured** around level of detail reported	**FSPCiC October 2025**
FSPCiC/25/ 09/67	**Monthly CIP Update – Month 5**	The Committee in Common received the report noting:- • £6.7m CIP delivered at month 5 in line with plan, however £2.6m delivered recurrently. FYE of non-recurrent schemes will ensure recurrent delivery. • Income performance at month 5 is 95.2% at flex position, therefore, no cash releasing efficiencies have been realised in relation to the elective improvement productivity schemes. • All schemes now fully developed however delivery risk remains with £6.9m in high risk (£8.4m in month 4).	The Committee received **moderate** assurance based on delivery of the BAU CIP plan	The Committee **noted** and discussed the report receiving **moderate** assurance given recurrent plans in place are not delivering to expectations	**FSPCiC October 2025**
FSPCiC/25/ 09/69	**Finance Report**	The Committee in Common received the report noting:- • Month 5 deficit position is on plan at £19.4m (before deficit support funding (DSF)), after DSF the deficit is £14.8m (£3.1m worse than plan). • Bank not meeting 10% reduction, due to Industrial Action and the impact of the pay award. • Risk adjusted forecast (likely case) excluding DSF has been submitted at a £39.9m deficit compared to a plan of £28.7m. The variance consists of £10.7m level 3 CIP, risk assessed CIP delivery based on PFR percentages of £2.2m and £0.5m PDC dividend increase.	The Committee received **moderate** assurance recognising achievement of plan to date but risk of overall plan delivery	The Committee **noted** the report and is **assured**	**FSPCiC October 2025**

		• If CIP risk adjustment was based on £6.9m high risk CIP rather than PFR percentages this would move the worst case scenario to £46.8m			
FSPCiC/25/ 09/71	**Cash Support Update**	The Committee in Common received the report noting:- • September cash application approved by NHSE • Notification of the October cash application is pending and cash management measures continue to be in place • Support for cash support request of up to £12.913m for the remainder of Q3	The Committee received **moderate** assurance due to the Trust financial position and requirement for cash support.	The Committee **noted** the report, is **assured** and **supported** the cash support request	**Trust Board October 2025**
FSPCiC/25/09/74	**Monthly Productivity Update**	The Committee in Common received the report noting:- • Theatres – improvement in theatre productivity over the last few months, scheduling improvement has driven this with activity being delivered within core resources. Capped utilisation now at 80%. Late starts continue to be an issue, the reasons for this are multifactorial and continues to be an area of focus. Sessional uptake tends to be low during the summer months, expectation is that this will improve in September.	The Committee received **moderate** assurance given the progress that has been made	The Committee **noted** and discussed the report receiving **moderate** assurance given plans in place are not delivering to expectations	**FSPCiC October 2025**

Items for noting

FSPCiC/25/09/65 *Board Assurance Framework*
FSPCiC/25/09/70 *Cost Pressures*
FSPCiC/25/09/72 *Revenue Request (supported for approval by Trust Board)*
FSPCiC/25/09/73 *Capital Expenditure and Schemes over £500k – supported and approved the movement in capital contingency*
FSPCiC/25/09/75 *Elective Recovery Update*
FSPCiC/25/09/76 *Winter Plan*
FSPCiC/25/09/78 *KPMG Update*
FSPCiC/25/09/80 *Operational Plan timeline update*
FSPCiC/25/09/82 *Delivery Unit Update*
FSPCiC/25/09/83 *SIRO Report*

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

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

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/10/100d	Meeting	Trust Board	Date Of Meeting	1 October 2025

Date of Meeting	1 October 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/25/08/42	**Committee Assurance Reports – Quality Assurance Committee**	There was robust discussion in relation the Quality Assurance Committee (QAC) report – this related to; • Typing Backlog – it was agreed that this be drawn to the attention of the Quality Committee that Audit had raised concerns about this and that an update be provided to a future meeting. It was noted that a Deep Dive on this would take place at QAC on 14.10.25 • Fractured Neck of Femur (#NOF) – it was agreed that there was the need for ongoing scrutiny of this services and continued monthly reporting to QAC with focus on theatres, physiotherapy and MDT care.	**Moderate** – The Committee expressed concerns regarding the measures being taken to address the Typing Backlog as well as ongoing issues related to delays in surgery and mobilisation for fractured neck of femur patients, emphasising the need for continued scrutiny of this service	***High*** **-** the Committee received high assurance on the governance within the Quality Assurance Committee.	**Updates to be received at QAC meeting on 09.09.25**
AC/25/08/48	**Anti Fraud Progress Report**	The Committee received a report that highlighted that the anti-fraud work plan is progressing as planned, with all areas (Assure, Understand & Prevent, Respond) rated 'Green'. Compliance with NHS counter fraud	**High –** The Committee received assurance that there are no significant	**High -** The Committee received assurance robust processes are in	**Update to be provided to Audit**

		standards remains strong, with a “green” rating across all 12 components	weaknesses or delays were identified, and recommendations are being actioned	place for fraud prevention, detection, and response, with regular checks, staff awareness, and management action tracking	**Committee in February 2026**
AC/25/08/50	**Review Losses & Special Payments**	The Committee received a report detailing performance compared to the previous year, showing a reduction in losses, mainly due to fewer drug losses and a change in a specific drug’s stability period from 24 hours to 30 days. The reduction in drug losses was noted as a positive development, addressing a previously identified concern.	**Substantial –** the Committee agreed that improvements had been made and there was clear and measurable progress.	***High* -** the Committee received high assurance of embedded process	**Update to be provided to Audit Committee in November 2025**
AC/25/08/52	**Medical Job Planning**	The Committee received a report highlighting the positive progress in signed off job plans and compliance that had been identified as an action from a MIAA audit. It was agreed that discussion with the Chair of Strategic People Committee in Common take place to review how this could be linked into an agenda item at a future meeting.	**Substantial –** the Committee agreed that improvements had been made and there was clear and measurable progress.	***High* -** the Committee received high assurance with strong leadership engagement and embedded governance	**n/a**

Other agenda items:
AC/25/08/41 – Board Assurance Framework
AC/25/08/44 – Committee Chair’s Annual Report
AC/25/08/44 – Progress Report on Internal Audit Actions
AC/25/08/45 – Internal Audit Progress Report
AC/25/08/46 – Internal Audit Follow Up Report
AC/25/08/47 – Global Internal Audit Standards Briefing
AC/25/08/49 – Report and Update External Audit
AC/25/08/51 – Review of Quotation & Tender Waivers
AC/25/08/53 - Renewal of Disposals and Condemnations of Assets Policy
AC/25/08/54 - Risk Management Annual Report Update
AC/25/08/55 - On Call and Overtime Annual Update Report
AC/25/08/57 – NW Skills Development Network Bi-Annual Report
AC/25/08/58 – ICON Programme Bi-Annual Report

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*

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/10/100(e)	Meeting	Trust Board	Date Of Meeting	1 October 2025

Date of Meeting	18 September 2025
Name of Meeting & Chair	Charitable Funds Committee, Chaired by Steve McGuirk
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
CFC/25/09/15	**Charity Impact Story**	The committee heard an impact story detailing the benefit that charity funding brings, with a presentation from Forget Me Not Unit's Emily Thompson (Activities Coordinator) and Julie Davies (Housekeeper).	**The Committee received high assurance as hearing first hand the positive impact the charity can make**	**The Committee received high assurance as committee members hear directly the positive impact**	**December 2025**
CFC/25/09/16	**Fundraising Report and Quarterly Workplan**	CFC noted the quarterly fundraising report, including updates on key campaigns, Bridgewater SLA, legacy donations, and progress against the charity's three-year strategy. **Lead:** Kate Henry / Helen Higginson	**The Committee received substantial assurance as the Charity is on track for delivering against its strategy**	**The Committee received high assurance as performance is monitored at each meeting of the Committee and a Charity Leadership meeting has been established**	**December 2025**
CFC/25/09/17	**Charity Annual Impact Report**	CFC received and approved the charity's annual impact report, setting out key achievements in 2024/25. **Lead:** Hayley Smith	**The Committee received substantial assurance as**	**The Committee received high assurance as annual reporting**	**September 2026**

			plans for the year 24/25 had been delivered	**processes are in place and working well**	
CFC/25/09/18	**Finance Report**	CFC noted the financial position for Q1 (1 April to 30 June 2025): • Income is £143k against a plan of £75k, £68k above plan. • Expenditure (overheads) is £27k against a plan of £28k, £1k below plan. • Expenditure (disbursements of funds) is £56k in quarter 1. • The net fund balance is £669k. • The balance after commitments for purchases, reserves and overheads is £156k. **Lead:** Tina Littler	**The Committee received substantial assurance as income is ahead of plan**	**The Committee received high assurance as sufficient processes and reporting are in place**	**December 2025**
CFC/25/09/19	**Bid Applications**	Two bids were approved by CFC: • Uplift to a previous bid for equipment purchases for Clinical Haematology/PIU • ITU waiting room refurb (approved subject to confirmation as to whether or not it could be funded from Trust capital). An update was provided on bids under £5k approved since the last committee meeting, either by the director of comms and engagement (up to £1k) or by execs (up to £5k). **Lead:** Helen Higginson	**The Committee received high assurance that the approved bids will be delivered and any unspent funds returned**	**The Committee received high assurance as the application process is robust, proportionate, and aligned with the Governing Document**	**December 2025**
CFC/25/09/22	**Annual Report & Accounts (DRAFT)**	CFC received the draft Annual Report and Accounts for 2024/25, prepared in accordance with Part 8 of the Charities Act 2011 and the Statement of Recommended Practice. For the year ending 31 March 2025 the Charity generated income of £452k and incurred expenditure of £280k. This has decreased the balance of funds by £172k. As at 31 March 2025 the balance of funds held was £609k.	**The Committee received substantial assurance as plans for the year 24/25 had been delivered**	**The Committee received high assurance as annual reporting processes are in place and working well**	**December 2025**

		The independent examination is due to commence in September 2025 and the final version of the Annual Report and Accounts for 2024/25 will be presented at the Q2 Charitable Funds Committee in December 2025. **Lead:** Tina Littler			

The committee also received reports on:

- **CFC/25/09/19** - Able Table new appeal proposal
- **CFC/25/09/20** - Review of Reserves Policy
- **CFC/25/09/21** - Charity Risk Register & Risk Statement
- **CFC/25/09/23** - Committee Chair's Annual Report to Trust Board

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*

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/10/101**			
SUBJECT:	**Fragile Clinical Services**			
DATE OF MEETING:	1 October 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.			Y
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** ***Y***
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A*** ***Y***
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A** ***Y***
	Further Information:			

<table>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td colspan="3">This paper serves 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:

Orthopaedics – Fractured Neck of Femur
Urology
Cancer Services
Chronic Pain Service
Cardiorespiratory/Cardiology Services

Services de-escalated from Fragile Services oversight since last report:
None

Services entering Fragile Services oversight since last report:
None</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">Trust board is asked to:
• Note the current list of Fragile Services, associated clinical risk and high-level progress updates
• Note that National Hip Fracture Database data has identified hip fracture mortality as a concern and receive assurance that the service is under direct executive oversight with weekly performance meetings and monthly reporting to QAC. Improvement in mortality has been seen in published data or Q1 2025
• Note the overall improving position in Cardiology with a lack of progress on the remaining action to deescalate from fragile services oversight which has been escalated for intervention
• Receive further Fragile Service Oversight reports</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Choose an item.</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td>Date of meeting</td><td colspan="2"></td></tr>
<tr><td>Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="3">Choose an item.</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	Fragile Services Oversight	AGENDA REF:	BM/25/10/101

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

None

3. SERVICES ENTERING FRAGILE SERVICES OVERSIGHT SINCE LAST BOARD

None

4. SERVICES REMAINING UNDER FRAGILE SERVICES OVERSIGHT

Orthopaedics – Fractured Neck of Femur

Summary

In June the Trust has received a mortality alert letter from the National Hip Fracture Database following annualised casemix adjusted mortality leaving the expected range in Q4 2024/25

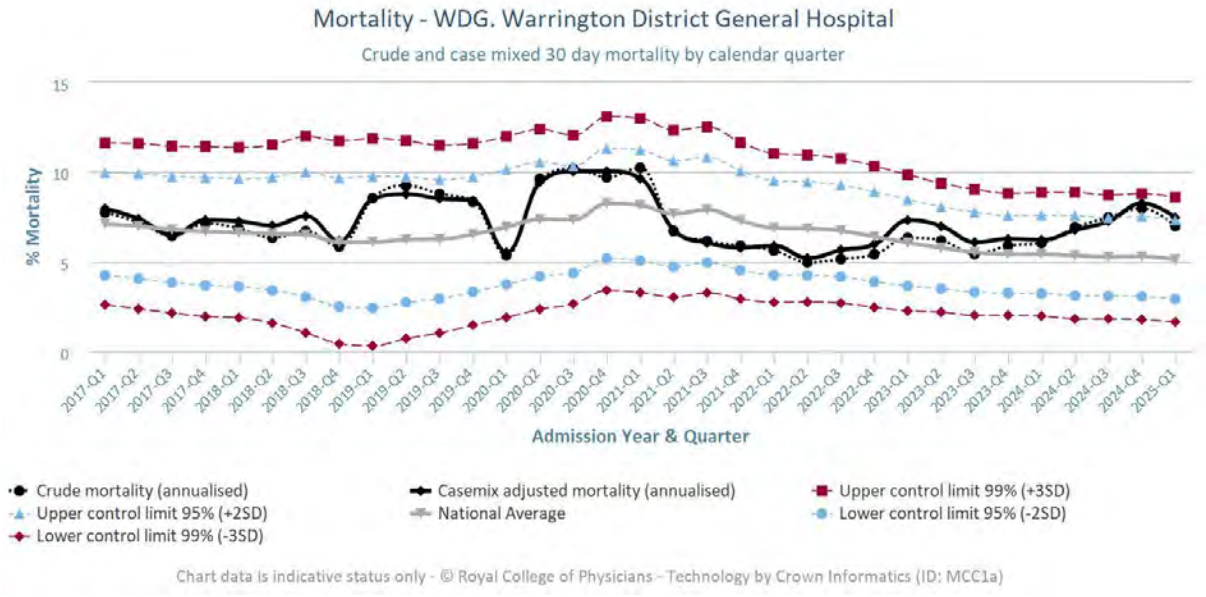
Prompt surgery and prompt mobilisation remain an unresolved quality and performance issue.

The Trust had received a mortality alert from the National Hip Fracture Database as Case mix adjusted and crude mortality for fractured neck of femur moved out of predicted range in the reporting quarter Q4 2024/25 and are above the 95% control limit.

Improvement has been seen in the latest data reported (Q1 2025) showing annualised case mix adjusted 30-day mortality as 7.5%, upper control limit 95% (2SD) 7.3%, national average 5.1%

Crude mortality for Q1 2025/26 has returned to be within expected limits

Figure 1 – Hip Fracture Crude and Case Mix Adjusted Mortality



On review of the National Hip Fracture Database metrics underperformance persists in 'prompt surgery' and 'promptly out of bed' metrics, these performance deficits may be the driver for increased mortality and increased pressure sores.

An urgent recovery plan has been produced by the Care Group with weekly reporting to relevant executive directors on improvement and following presentation to QAC as a Deep Dive the service will report to QAC on a monthly basis until QAC is assured that improvements in performance are sustained.

Urology

Summary

Improving outpatient waiting list position, sustained improvement in diagnostic waits (Transperineal Biopsy, Flexible Cystoscopy), service remains fragile from staffing and resultant capacity / demand profile perspectives

Emergent staffing risk from possible consultant staff retirements in next 12 months

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

- P2 – waiting list has reduced over the last quarter

- P3 & P4 waiting lists have shown a positive reducing trend after recent increases
- Transperineal prostate biopsy position shows sustained improvement, with (sustained reduction in undated waiting list patients from >120 to <20)
- Surveillance cystoscopy position very significantly improved from peak, with waiting list now fewer than 25 patients (from a peak >200)
- Tier 2 doctor staffing issues remain a challenge, though have improved with one doctor returning to the on-call rota

  Completed Actions
  - Increased endoscopy cystoscopy capacity by 40/week
  - 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.
  - Prostate triage nurse now in place supporting effective and timely management within the prostate pathway

  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 – no wait at present
  - Specialist nurse delivered cystoscopy training underway with 2 nurses now practitioners undertaking an independent list each week
  - WLI and outsourced sessions approved where required to support activity and safety

  Ongoing improvement plan actions:
  - Urology Cancer Deep Dive output – MDT and surveillance improvement work required – underway as part of cancer improvement plan – reporting to PSCESC and QAC
  - Further expansion of nurse specialist cystoscopy and training to facilitate nurse led TP biopsy
  - Discussion with Chester regarding future of PCNL list
  - CD, AMD and MD have met to discuss long term staffing sustainability plan, detailed demand and capacity and financial modelling underway

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

Progress against initial actions has not been timely, and following escalation to the MD has resulted in a change of clinical lead with additional support put in place to allow the actions to be completed in the next reporting period.

Completed Actions

- Pharmacy review of all opioid recommendations
- No new patients have been commenced on facet joint or trigger point injections
- SOP for Opiate and Gabapentoid initiation developed and proceeding through governance

Initial actions (weeks 0-8)

- Service Gap analysis against NICE guidelines
- 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.

Cancer Services

Summary

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**

Completed actions

- Updated robust SOP for cancer pathway escalations implemented
- Updated Consultant Upgrade process with single point of access
- ICE referral for ED Suspected Cancer/Diagnosed Cancer live August 2025
- Mapping and baseline assessment of tumour site specific cancer surveillance pathways – report to EMT and QAC October 2025

Ongoing improvement plan actions:

- Complete standardisation of Cancer MDTs across Trust
- Assurance audits of cancer escalation and cancer tracking effectiveness - report to Executive Team and QAC October 2025
- Delay in automated referrals/upgrades of malignancy identified via histology results – escalated to report to PSCESC Oct 2025
- Scoping for automation of referrals/upgrades from radiology reports
- Optimisation of tumour site specific surveillance pathways

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 – outstanding issue is assurance regarding plan for management of 'Awaiting Results' patient access plan backlog which predominantly sit with a single consultant.

There has been insufficient progress with this action and following discussion at PSCESC in Sept 2025 this has been escalated for Deputy MD intervention

- 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

    - Revenue request for additional consultant completed – funded by job planning efficiencies and WLI reduction – delivers CIP
    - ‘Awaiting Results’ access plan management SOP developed and progressing through governance to ratification

- 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:

    - Assurance required regarding plan for validation and clinical review of ‘Awaiting Results’ access plan backlog

5. RECOMMENDATIONS

Trust Board is asked to:

- Note the current list of Fragile Services, associated clinical risk and high-level progress updates
- Note that National Hip Fracture Database data has identified hip fracture mortality as a concern and receive assurance that the service is under direct executive oversight with weekly performance meetings and monthly reporting to QAC. Improvement in mortality has been seen in published data for Q1 2025
- Note the overall improving position in Cardiology with an intention to deescalate from fragile services oversight once assurance is received regarding the management of the ‘awaiting results’ patient backlog
- Receive further Fragile Service Oversight reports

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/10/102**			
SUBJECT:	Compliance Assurance Report Q1 2025/26			
DATE OF MEETING:	01 October 2025			
AUTHOR(S):	Ali Kennah, Chief Nurse			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse			
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 paper provides an update on the Trust's CQC preparedness and broader quality compliance activity. Key priorities include the completion of Single Assessment Frameworks (SAFs), ongoing evidence collation, and targeted support to Clinical Business Units through the newly established Compliance Panel and biweekly CQC Compliance Summits. Preparations are progressing for a potential Well-Led inspection, underpinned by a comprehensive CQC Preparedness Plan scheduled for review and approval at the August QCOG meeting.			

	The paper also outlines the current position regarding open CQC enquiries and associated response activity. The Trust remains committed to continuous quality improvement, robust regulatory compliance, and full readiness for an anticipated CQC Well-Led inspection		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this paper		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/25/08/110**	
	Date of meeting	12 August 2025	
	Summary of Outcome	Noted at Quality Assurance Committee for reporting to Trust Board	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

Trust Board

SUBJECT	Compliance Update Q1 2025/26	AGENDA REF:	BM/25/10/102

1. BACKGROUND/CONTEXT

The CQC is the independent regulator of Health and Adult Social Care in England. Their role is to make sure both Health and Social Care Services provide people with safe, effective, compassionate, high-quality care and they encourage care services to improve. The CQC monitor, inspect and regulate services and publish findings. Where poor care is found, the CQC have powers to act, including implementing enforcement notices, if deemed appropriate. Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) continues to make sure it provides people with safe, effective, caring, and responsive services and that it is well led.

Monitoring, measuring and assessing levels of service is necessary, not only to gain the assurance required for WHH to meet all regulatory objectives, but in addition, to provide appropriate assurance in the form of evidence, to support other inspections and assessments, as well as seek to gain accreditations, re-accreditations, and quality standards of excellence recognitions.

A Quality Compliance Oversight Group (QCOG) meets monthly to monitor overall performance and to ensure compliance and assurance objectives are achieved.

2. QUALITY COMPLIANCE OVERSIGHT GROUP OVERVIEW

The Quality Compliance Oversight Group (QCOG) continues to provide oversight of key areas related to regulatory and quality assurance. Progress is being made across several workstreams, including the completion of outstanding self-assessments, development of supporting evidence directories, and strengthening of policy positions. A particular focus remains on CQC preparedness. To support robust governance, the Terms of Reference and Cycle of Business for QCOG were reviewed and approved on 23 July 2025 (see Appendices 1 and 2).

Preparations for a potential Well-Led inspection are ongoing, with a comprehensive CQC Preparedness Action Plan scheduled for presentation at the August 2025 QCOG meeting. In addition, the Trust is scheduled for an IR(ME)R inspection on 20 August 2025, with assurance provided that preparatory actions are on track.

In Maternity Services, steady progress continues against the CQC “Must Do” and “Should Do” actions. Notable improvements include enhanced compliance with mandatory training, implementation of NICE guidance and development of transitional care pathways. Maternity policy processes are also being considered for wider adoption across the Trust.

Mock inspections focusing on safeguarding and medicines management have been completed, with resulting reports expected in August and September 2025, respectively.

A Compliance Panel has been established to provide strategic oversight and assurance in relation to CQC preparedness. The panel will:

- Review and assess the quality of evidence submitted by Clinical Business Units (CBUs) against the CQC domains.
- Evaluate a range of data, including:
    - Self-assessment frameworks and supporting documentation,
    - Quality dashboard metrics,
    - Peer review outcomes,
    - Ward accreditation reports,
    - Evidence of quality improvement activities and associated outcomes.
- Identify assurance gaps.
- Provide support and guidance on action plan development based on panel feedback.
- Recommend targeted interventions to drive improvement.
- Review CBU presentations to identify examples of good practice and highlight areas requiring support.
- Approve ward accreditation reports and outcomes.

Twelve active CQC enquiries are currently being managed. A thematic review is planned and will be reported to QCOG on a monthly basis going forward.

Policy compliance remains stable at 82%. Efforts continue to strengthen governance structures, ensure oversight of the Risk Register, and maintain weekly improvement monitoring.

Care Groups are actively progressing their Single Assessment Frameworks (SAFs), with each expected to provide assurance in line with the revised QCOG Cycle of Business. Evidence collation and progress tracking remain priority areas.

Next Steps:

- Presentation of the CQC Preparedness Action Plan at the August 2025 QCOG.
- Finalisation and review of mock inspection reports.
- Ongoing updates to SAF evidence submissions.

The next QCOG meeting is scheduled for 23 July 2025.

2.1 CQC ENGAGEMENT MEETING OF 31 MARCH 2025 UPDATE

A CQC Engagement meeting took place on 17 July 2025 where key Executive and Senior Trust colleagues met with CQC representatives to discuss regulatory updates, service developments, and ongoing quality improvements. CQC updated on their national restructure, confirming the introduction of four Chief Inspectors and clarified that the upcoming IR(ME)R inspection (scheduled for 20 August 2025) will not count towards the

region’s 60 rated inspections. The Trust presented an overview of the Older Persons Short Stay Unit (OPSSU), demonstrating early impact through improved flow from ED, reduced deconditioning, and shorter lengths of stay, with national benchmarking underway.

Quality updates included a discussion on Maternity staff sickness and turnover, where the Trust described mitigations including targeted investment in triage, improved culture work, and succession planning following the planned departure of the Director of Midwifery. MUST compliance has seen recent improvement due to increased clinical oversight and weekly walkarounds, with senior leadership support. The Trust also provided an overview of the fragile services programme.

Ligature risk management was discussed in detail, including Core24 support, relaunch of the ligature policy, enhanced training, and assurance from recent environment assessments. Updates were also given on audiology performance and FTSU culture improvements (with an increase in disclosures from 21 to 66 disclosures noted from recent board papers).

Further updates were provided on the Runcorn Living Well Hub, including service registration plans, and the integration programme with Bridgewater, with a focus on aligning governance and inspection planning ahead of the April 2026 merger. The Trust also showcased innovation in dermatology services, using AI-supported triage to streamline patient pathways.

Actions from the meeting included a request from the CQC to visit OPSSU at the next Engagement Meeting and sharing of presentations provided at the meeting in relation to health inequalities, Runcorn Health and Education Hub and fragile services paper.

The next CQC Engagement Meeting is scheduled for 16 October 2025.

2.2 UPDATE ON SINGLE ASSESSMENT FRAMEWORK AND COMPLIANCE FRAMEWORK OF ASSURANCE

Work is ongoing in relation to the Single Assessment Framework (SAF), with the process recently reviewed to ensure timely delivery and appropriate assurance to QCOG. All Clinical Business Units (CBUs) have completed their self-assessments, with the exception of two areas within the Urgent and Emergency Care (UEC) — Runcorn Urgent Treatment Centre and the Emergency Department Ambulatory Care Unit. Both areas are receiving targeted support to complete their assessments by end of August 25.

The current focus is on compiling supporting evidence directories across all areas. To drive progress, a biweekly CQC Compliance Summit will be launched from August 25.

The single assessment framework process has been reviewed and will be supported as follows

Step 1 – Self-Assessment Completion and Scoring
Updated Single Assessment Framework (SAF) scores have been collated. Results are available for review at both ward/department level and across Clinical Business Units

(CBUs). This enables teams to understand their compliance against the CQC's Key Questions and Quality Statements.

Step 2 – Evidence Directory Compilation
Evidence directories will be compiled to support the SAF and provide assurance against self-assessed scores. These will serve as a reference source for validation and review.

Note: Progress against Steps 1 and 2 will be monitored via newly introduced bi-weekly CQC Compliance Summits. These summits will oversee SAF completion and initiate action plans to address any identified gaps.

Step 3 – Compliance Panel Review
A weekly Compliance Panel will review the SAF outcomes and associated evidence. The panel will assess the robustness of submitted evidence, provide guidance to CBUs, and support the development of targeted action plans to drive quality improvements.

Step 4 – Mock Assessment
Mock assessments will be undertaken within wards/departments, guided by the SAF scores and evidence. The assessment will focus on areas of both risk and strength, testing the reliability of self-assessed outcomes and identifying areas for improvement or good practice.

Step 5 – Feedback and Action Planning
Following the mock assessment, detailed feedback will be shared with relevant teams. Action plans will be finalised and implemented, with oversight and monitoring through QCOG in line with the agreed cycle of business.

Step 6 – Follow-Up Mock Assessments
Follow-up mock assessments will be scheduled as appropriate to review progress, test improvements, and ensure readiness for formal inspection

2.3 UPDATE ON THE MOCK ASSESSMENT PROGRAMME

The Trust has undertaken two mock assessments to date, focusing on Safeguarding and Medicines Management. External assessors were engaged to enhance the quality and objectivity of the assessments, which included:

- Information requests
- Interviews with key colleagues
- Focus groups
- On-the-day ward and departmental visits

Formal feedback will be provided to both departments following the assessments. The Safeguarding report is scheduled for presentation in August 2025, with the Medicines Management report to follow in September 2025.
The 2025/26 CQC mock assessment schedule will be reviewed and adjusted as needed, based on priorities identified through the biweekly CQC Compliance Summits and Compliance Panel discussions.

2.4 CQC ENQUIRIES AND NOTIFICATIONS

CQC Annual update 2024/25

	Q1	Q2	Q3	Q4	Total
Digestive Diseases				4	4
Specialist Surgery				1	1
Women's and Children's				2	2
Urgent & Emergency Care		1		3	4
Medical Care				1	1
Integrated Medicine & Community				1	1
Clinical Support Services					
Trust-wide				2	2
TOTAL Enquiries for 2024/25					15
Never Events	0	0	0	1	1
IRMER	0	0	0	0	0
MRSA	0	0	0	0	0
RIDOR	0	0	0	0	0

Two enquiries from 2024/25 remain open, pending closure by the CQC as detailed below.

Q2

Category	Query	Comments
Opened 30.7.24 CAS-506098 Complaint – ISR	196155 (2232/22151) Concerns re: patient care in ED **PSII 196155**	PSII completed Headache proforma requested as cited in action plan to conclude Document has now been updated to ensure reference to the Walton Centre guidance, this document was reviewed and ratified at the ED Governance meeting on 9 July 2025. **Information with CQC – Awaiting notification this can be closed**

Q4

Category	Query	Comments
Opened 10.2.25 CAS-764344 MRSA Outbreak	Notification of MRSA bacteraemia and CPE outbreak Ward A5GU sent to the CQC on 6.2.25.	Post Infection review copy requested by CQC 09/05/25. Copy sent 09/05/25 **Information with CQC – Awaiting notification this can be closed**

CQC Annual update 2025/26

	Q1	Q2	Q3	Q4	Total
Digestive Diseases					0
Specialist Surgery	1				1
Women's and Children's					0
Urgent & Emergency Care	3	1			4
Medical Care	1				1
Integrated Medicine & Community					0
Clinical Support Services		1			1
Trust-wide		2 (1: A & B Wards only)			2
Bridgewater	0	1			1
TOTAL Enquiries for 2025/26					10
Never Events	0	0			0
IRMER	0	0			0
MRSA	0	0			0
RIDOR	3	0			3

There have been 10 enquiries raised during quarters 1 and 2 of 2025/26 which remain open and are at various stages of response as detailed below.

Q1 enquiries (2025/26) to date

Category	Query	Comments
Opened 12.05.25 CAS-881098 MH patient in UEC for 170 hrs waiting for transfer to MH bed	The enquiry relates to an alleged long stay for a mental health patient in UEC. The enquiry wanted to address if an event like this did occur (170 hr wait) and, if so, a timeline to be shared showing the patient's journey whilst in UEC, and identifying the support given to them throughout their stay.	2 possible patients that may match the details for this enquiry. Timeline for both completed from nursing perspective. Information requested from ED colleagues– additional information has been requested from Core24. Draft response in progress.
Opened 16.05.25 CAS-899008 UEC privacy, dignity and IPC concerns	Account of a recent experience from a former nurse who attended Warrington UEC. Discharged and then recalled due to a diagnosis error. Experience following her return visit.	Privacy, dignity and IPC concerns. Investigation initiated with UEC. Information requested to support response to be drafted
Opened 21.05.25 CAS-905105 Care and Treatment	Care and Treatment concern for a family member who was admitted following a heart attack. Medical errors have been queried.	Information received including complaint, draft response undergoing quality assurance prior to submitting to CQC
Opened 22.05.25 CAS-903889 Alleged unsafe discharge	Notification from a care provider alleging an unsafe discharge. Request to provide Discharge Policy and	Fact finding underway.

	address specific issues relating to medications and dressings.	
Opened 06.06.25 CAS-927627 Care, treatment and staffing	Query in relation to appropriate staffing levels, Multiple MET calls and alleged concerns in relation to a MH patient	Draft response in progress. draft response undergoing quality assurance prior to submitting to CQC.

Q2 enquiries (2025/26) to date

Category	Query	Comments
Opened 15.07.25 CAS-986791 Ligatures	Alerted to 2 ligature deaths within the Trust that have been reported on the StEIS system. One incident occurred in March 2025 and one in June 2025.	STEIS information sent for 2 cases 203630PSII and 2061471PSII Outcome of investigations to be shared once concluded.
Opened 17.07.25 CAS-988111 Anonymous concerns (Medication, IPC and Care)	Relates to the following wards - A9,A6,A7,B14,A8,B12,B19 Concerns raised in relation to timing of personal care and medication rounds. Would like assurance in relation to staffing levels	Lead nurses of wards cited have been sighted on the enquiry and fact finding underway to support a response
Opened 17.07.25 CAS-985185 Pressure Ulcer Concerns *Bridgewater*	**Bridgewater case enquiry** - *There is a culture between district nursing team leaders and tissue viability nurses where leaders are telling nurses not to incident report as pressure ulcers and to list as "trauma" when completing Ulysses incident reporting.* *It has been noted that on many occasions pressure ulcers have been recorded as trauma and then later reported and recorded as pressure ulcers upon further deterioration of the wound.* *This has been happening since 2022*	Bridgewater colleagues undertaking an audit to review concerns.
Opened 21.07.25 CAS-988871 Complaint	CQC aware of ongoing complaint relating to patient JS and request outcome of complaint	Complaints team notified and will share response once finalised Response due by 14/10/25 risked as High for ISR
Opened 21.07.25 CAS-984156 Complaint	CQC aware of ongoing complaint relating to patient SA and request outcome of complaint	Complaints team notified and will share response once finalised Response due by 04/09/25

2.5 HEALTH & SAFETY INSPECTIONS

The Trust is anticipating an unannounced Environmental Health inspection at the Halton site. Full findings will be shared once the inspection has taken place, and the results have been received. WHH has undertaken a mock EHO inspection and is progressing actions created as a result of these inspections.

3. CQC PLAN NEXT STEPS

Next steps in relation to CQC preparedness are detailed below.

- Review and approval of the CQC Preparedness Plan at the August QCOG meeting, which will include:
    - Updated mobilisation plans, including communication protocols for the day of inspection
    - Launch of biweekly CQC Compliance Summits
    - Introduction of weekly compliance walk rounds
    - Preparation for Trust Board members, including a mock interview programme
    - Implementation of a comprehensive communications plan to promote Trust-wide CQC awareness
- Finalise and present the Safeguarding Mock Assessment Report at the August 2025 QCOG
- Finalise and present the Medicines Management Mock Assessment Report at the September 2025 QCOG
- Continue effective management of all ongoing CQC enquiries

4. RECOMMENDATIONS

The Trust Board are asked to note the contents of this report.

Appendix 1 – Terms of Reference

QUALITY COMPLIANCE OVERSIGHT GROUP
TERMS OF REFERENCE

1. PURPOSE

The purpose of the Quality Compliance Oversight Group is to drive the cultural and operational improvements needed for the Trust to maintain a 'Good' CQC rating and progress towards 'Outstanding'. Through robust performance management of CQC action plans and other assigned plans, the Group will monitor and address regulatory breaches, 'must' and 'should' do actions, and oversee compliance with the CQC Single Assessment Framework and other regulatory requirements. The Group reports to the Executive Team, ensuring clear accountability for oversight and delivery.

2. FREQUENCY OF MEETINGS

Meetings shall be held monthly.

3. QUORUM

To ensure the Quality Compliance Oversight Group is compliant, attendance is required by:

- Chair / Deputy Chair
- Representation from Planned Care, Unplanned Care and Clinical Support Services.
- Head of Compliance

4. MEMBERSHIP

- Chief Nurse (Chair)
- Chief Operating officer/Deputy Chief Executive (Deputy Chair)
- Executive Medical Director/Deputy Medical Director
- Chief People Officer
- Care Group (two to be nominated for each Care Group and at least one member in attendance)
- Director of Communications
- Deputy Chief Nurse, Director of Clinical Governance
- Deputy Director of HR&OD
- Company Secretary/Associate Director of Corporate Governance
- Associate Director of Quality
- Head of Compliance
- Associate Director Estates and Facilities
- Chief Pharmacist
- Finance Team representative
- Transformation Team representative
- Patient Experience and Inclusion representative
- Associate Chief of Nursing (Corporate)
- Specialist Leads co-opted to meeting, as appropriate:
    - End of Life Care
    - Resuscitation Lead
    - Safeguarding Lead
    - Training & Development
    - Infection Prevention Control (IPC)
    - Head of Therapies

Attendance at the meeting via MS Teams is acceptable. Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum.

5. AUTHORITY

The Group is authorised by the Executive Team to carry out any activities within its Terms of Reference and may request information it needs from any employee with expectations of full cooperation to support the Group's work.

6. REPORTING

Assurance will be provided to the Executive Team monthly.
Assurance will be provided to the Quality Assurance Committee via a quarterly compliance report.

7. DUTIES & RESPONSIBILITIES

The Group will undertake the following duties:

- Ensure robust SMART action plans are in place, to address all recommendations for the Trust outlined in the CQC report.
- Give priority to 'Must do' and 'Should Do' recommendations and actions within the Trust.
- Review and analyse key performance indicators related to quality and compliance.
- Oversee the management of the Framework of Assurance ensuring Care Group engagement.
- Oversee Executive Led improvement work streams for those core services that require improvement and provide assurance of sustainability e.g. fragile services.
- Ensure there is an assessment of resources required to implement CQC action plans, and that this is aligned with the financial planning cycle.
- Ensure that any resource implications are costed and considered in line with Trust SFIs,
- Ensure that where the Trust cannot implement a recommendation, this is risk assessed and escalated appropriately, as per Trust Risk Management Systems.
- Provide assurance to Executive Directors, the Board of Directors and Quality Assurance Committee on quality and compliance matters
- Ensure the organisation complies with relevant regulatory requirements.
- Ensure the clinical audit and internal audit cycles align to CQC action plans, where appropriate, to confirm that actions taken are effective and sustainable.
- Ensure that output from the group links with other workstreams under the Trust's Quality Assurance Pillars, supporting a coherent strategy for Maintaining Good and Moving to Outstanding (e.g. Quality Academy, Workforce Groups, Patient Experience).

Duties of members:

- Members will communicate key updates and requirements to their respective areas or teams, ensuring accountability and engagement across the Trust.
- Members will escalate risks, barriers, or delays to the Chair promptly to enable timely resolution.
- Proactively monitor the performance of all key actions.
- Ensure appropriate preparation for engagement meetings and follow up on actions arising from those meetings.
- Ensure a comprehensive CQC evidence directory for each Care Group is developed, ensuring it is routinely reviewed and updated.

- Plan and undertake a programme of Mock Assessments (inspections) and ensure resulting actions are completed.
- Ensure a clear training/engagement plan is in place to address any changes to the CQC framework.
- Monitor compliance with CQC enquiries and ensure they are managed and responded to in a timely manner.

8. ATTENDANCE

A record of attendance will be kept; attendance of 75% per year is expected from all members.

Members unable to attend must send a deputy who is able to make decisions on their behalf.

9. ADMINISTRATIVE ARRANGEMENTS

The Group will have secretarial support and support from the Corporate Nursing and Governance Directorate within the Trust.

- The Terms of Reference will be reviewed annually in March.
- A Cycle of Business will be approved by members annually in March.

Unless prior agreement is reached with the Chair of the group, the agenda and papers will be sent out 5 working days before the date of the meeting. No papers or presentations will be tabled at the meeting without prior approval of the Chair.

10. REVIEW / EFFECTIVENESS

The Quality Compliance Oversight Group will undertake a review of its term of reference, membership and cycle of business on an annual basis

TERMS OF REFERENCE REVISION TRACKER

Name of Committee:	Quality Compliance Oversight Group
Version:	V3
Implementation Date:	
Review Date:	
Approved by:	
Approval Date:	

REVISIONS			
Date	**Section**	**Reason on Change**	**Approved**
1.7.25	**Full review of Terms of reference in all sections**	Updated and reviewed to ensure fit for purpose, ensuring clear expectations thus enabling a high functioning meeting.	

TERMS OF REFERENCE OBSOLETE		
Date	**Reason**	**Approved by:**

Appendix 2 – QCOG - Cycle of Business

OPENING BUSINESS	Lead	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
Apologies for absence	Chair	√	√	√	√	√	√	√	√	√	√	√	√
Declarations of Interest	Chair	√	√	√	√	√	√	√	√	√	√	√	√
Minutes of the last meeting	Chair	√	√	√	√	√	√	√	√	√	√	√	√
Matters Arising / Action Log	Chair	√	√	√	√	√	√	√	√	√	√	√	√
STANDING ITEMS	**Lead**												
Engagement Meeting Update	Chair					√			√				√
CQC Must Do's and Should Do's - Action owners may be asked to present key areas of concern as and when required to ascertain assurance	Head of Compliance	√	√	√	√	√	√	√	√	√	√	√	√
Fragile Services Update	Service Lead	√	√	√	√	√	√	√	√	√	√	√	√
Mock Inspection Update	Head of Compliance	√	√	√	√	√	√	√	√	√	√	√	√
Ward Accreditation Update	Associate Chief of Nursing	√	√	√	√	√	√	√	√	√	√	√	√
CQC Enquiries	Head of Compliance	√	√	√	√	√	√	√	√	√	√	√	√
Policy Position	Deputy Director of Governance	√	√	√	√	√	√	√	√	√	√	√	√
CARE GROUP UPDATES													
Unplanned Care • Updates required on the Status of Framework of Assurance and evidence repository for Clinical Business Units • Escalation of risk, barriers	Associate Director of Unplanned Care Associate Chief Nurse	√			√			√			√		
Planned Care • Updates required on the Status of Framework of Assurance and evidence repository for Clinical Business Units	Associate Director of		√			√			√			√	

• Escalation of risk, barriers	Planned Care Associate Chief Nurse												
Clinical Support Services • Updates required on the Status of Framework of Assurance and evidence repository relevant departments • Escalation of risk, barriers	Associate Director of Clinical Support Services			√			√			√			√
Paediatrics and Gynaecology • Updates required on the Status of Framework of Assurance and evidence repository relevant departments • Escalation of risk, barriers	Associate Director of Planned Care Associate Chief Nurse		√			√			√			√	
Maternity • Updates required on the Status of Framework of Assurance and evidence repository relevant departments • Escalation of risk, barriers	Directory of Midwifery		√			√			√			√	
Well Led • Updates required on the Status of Framework of Assurance and evidence repository relevant departments • Escalation of risk, barriers	Company Secretary / Director of Corporate Governance	√			√			√			√		
GOVERNANCE													
Annual Cycle of Business	Chair	√	√	√	√	√	√	√	√	√	√	√	√ **Formal review**
Terms of Reference – For informal review per meeting – Formal review annually (March)	Chair	√	√	√	√	√	√	√	√	√	√	√	√ **Formal review**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO THE TRUST BOARD

AGENDA REFERENCE:	**BM/25/10/103**	
SUBJECT:	**Quality Strategy 2025-2027 Updates**	
DATE OF MEETING:	1 October 2025	
AUTHOR(S):	Ernesto N. Quider, Associate Director of Quality	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse	
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 OF DIRECTORS OF DIRECTORS 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; 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. **#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. **#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	**Yes**	**No**	**N/A**
		✓		

	victimisation, and other prohibited conduct.			
	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 provides the Board of Directors with an update on the implementation progress of new Quality Strategy in line with Trust Strategy and linked with domains of quality and defined in our Annual Quality Priorities 25/26. 1. Patient Safety 2. Clinical Effectiveness Patient Experience			
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**	
RECOMMENDATION:	The Trust Board of Directors are asked to note the contents of this report.			
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			

BOARD of DIRECTORS

SUBJECT	Quality Strategy 2025-2027 Updates	AGENDA REF:	BM/25/10/103

1. BACKGROUND/CONTEXT

This paper provides the Board of Directors with an update on the implementation progress of the newly launched Quality Strategy 2025-2027 which is aligned with the Trust Strategy, linked with our annual Quality Priorities 25/26.

1. *Patient safety* – quality care is care which is delivered so as to reduce the risk of avoidable harm to patients and a culture of support, openness and honesty when something has gone wrong.

2. Patient experience – quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect. The patient experience domain of quality also embraces accessibility, understood in the sense that we must provide services in an inclusive way that recognises the diversity of our population.

3. Clinical effectiveness – quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes.

2. KEY ELEMENTS

The Quality Strategy 2025-2027 (see separate document) outlines our commitment to prioritise quality and safety above all else. In line with the recommendations presented to and approval by the Quality Assurance Committee in Quarter 4, the strategy has been developed with high-level engagement plan and improvement actions are monitored in the annual Quality Priorities as detailed in a separate paper.

It is recommended WHH will not identify further Quality Strategic Goals in addition to Quality Priorities as in previous years. This will enable clear focus on a smaller number of areas that are focused and aligned to the Trust's Quality Strategy and key areas of risk and continuous improvement.

The selected annual Quality Priorities (see separate report) which have been thematically reviewed from previous stakeholders' consultation surveys and discussed with senior leaders in Care Groups and Corporate services in various meetings are aligned with the domains of quality and CQC key lines of enquiry in order to build on the progress made with the National Quality Board's (NQB) Shared Commitment to Quality and the improvements we have achieved for the past three years.

We will expand our engagement in Q3- Q4 through the annual business planning process and gain further views of Care Groups and CBUs leaders and that of our commissioners and

regulators in monitoring progress and improvements in preparation for annual setting of Quality Priorities.

What are we aiming to achieve:
The vision for quality for the next three years and beyond in line with our integration plan with Bridgewater Community Healthcare NHS Foundation Trust:
1. Improving our people's health outcomes and enhancing their quality of care,
2. Ensuring care is safe and effective, with support available when and where it is needed most,
3. Delivering a caring and responsive patient experience every time.

What will this mean for our patients, people and system partners:
The overarching vision of this new Quality Strategy will be based on the life stage framework (i.e.., start well, live well and age well) as highlighted in the NHS Long Term Plan to better meet the needs of patients and their families as we implement our bold vision supported by specific programmes of work within domains of quality, which will be linked to Quality Priorities and other regional and national strategic context:

- Improving Patient and service users experience (to be aligned with our Patient Experience and Inclusion strategy)
- Improving safety culture in line with national patient safety strategy
- Improving value by utilising quality improvement (QI) methodology and establishing high-impact priority programmes
- Enhancing quality of care by addressing health inequalities

- Improving staff experience making WHH a great place to work and receive high quality and exemplary safe services.

The collaborative approach of developing this strategy will ensure that there are links to the Trusts' enabling strategies and corporate support- People, Digital, Estates, Finance and Communications and Engagement teams. The Quality Strategy is summarised further within this document (see ***Quality Strategy on a Page below***).

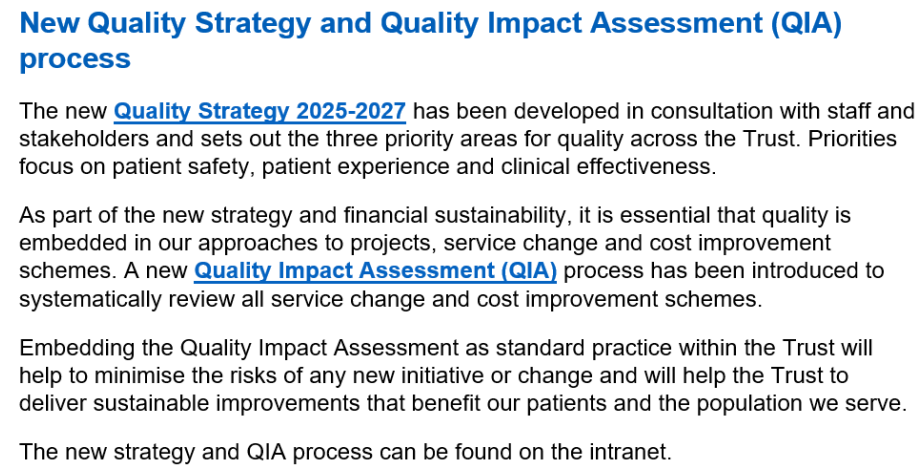
Summary of key progress updates as of Q1-Q2:

I. <u>Communications and engagement-</u>

A. **WHH intranet page** for enabling strategies has been developed with the list of updated enabling strategies including Quality Strategy for ease of access by staff across the Trust – link to intranet page: Strategy

B. **Staff newsletter via The Week** was published on 30 May 2025 to increase awareness of the new Quality Strategy and Quality Impact Assessment process.

Fig. 1 Screenshot of the The Week newsletter to all staff



New Quality Strategy and Quality Impact Assessment (QIA) process

The new **Quality Strategy 2025-2027** has been developed in consultation with staff and stakeholders and sets out the three priority areas for quality across the Trust. Priorities focus on patient safety, patient experience and clinical effectiveness.

As part of the new strategy and financial sustainability, it is essential that quality is embedded in our approaches to projects, service change and cost improvement schemes. A new **Quality Impact Assessment (QIA)** process has been introduced to systematically review all service change and cost improvement schemes.

Embedding the Quality Impact Assessment as standard practice within the Trust will help to minimise the risks of any new initiative or change and will help the Trust to deliver sustainable improvements that benefit our patients and the population we serve.

The new strategy and QIA process can be found on the intranet.

II. Quality Priorities monitoring and evaluation-

The Quality Priorities for 2025/26 have been agreed as outlined below with defined measures included in a separate report. A monthly review meeting is held with designated priority leads since the start of this financial year.

Patient Safety

1. Ensure that all patients within the Emergency Department (UEC) receive timely assessment and treatment resulting in improved patient experience and improved clinical outcomes.
2. Improve access and productivity in elective care as per national operational planned guidance.
3. We will use quality improvement methods to improve provision of harm free care to our patients with a focus on preventing and reducing harms from pressure ulcers and malnutrition.

Patient Experience

4. Reduce Health Inequalities inline with CORE20+5 for Children, Adults and Young People.
5. Improve the experience and care provided for patients with a Learning Disability and impaired Mental Health.
6. Implementation of Accessible Information Standard relating to communication and reasonable adjustments to improve Patient Experience.

Clinical Effectiveness

7. Delivery of the Trust wide improvement programmes across all Care Groups aligning to GIFRT recommendations to support timelier and more effective patient care.
8. Reduce Cancer Waiting Times
9. Improve Theatre Safety Culture using whole quality system approach and robust governance process.

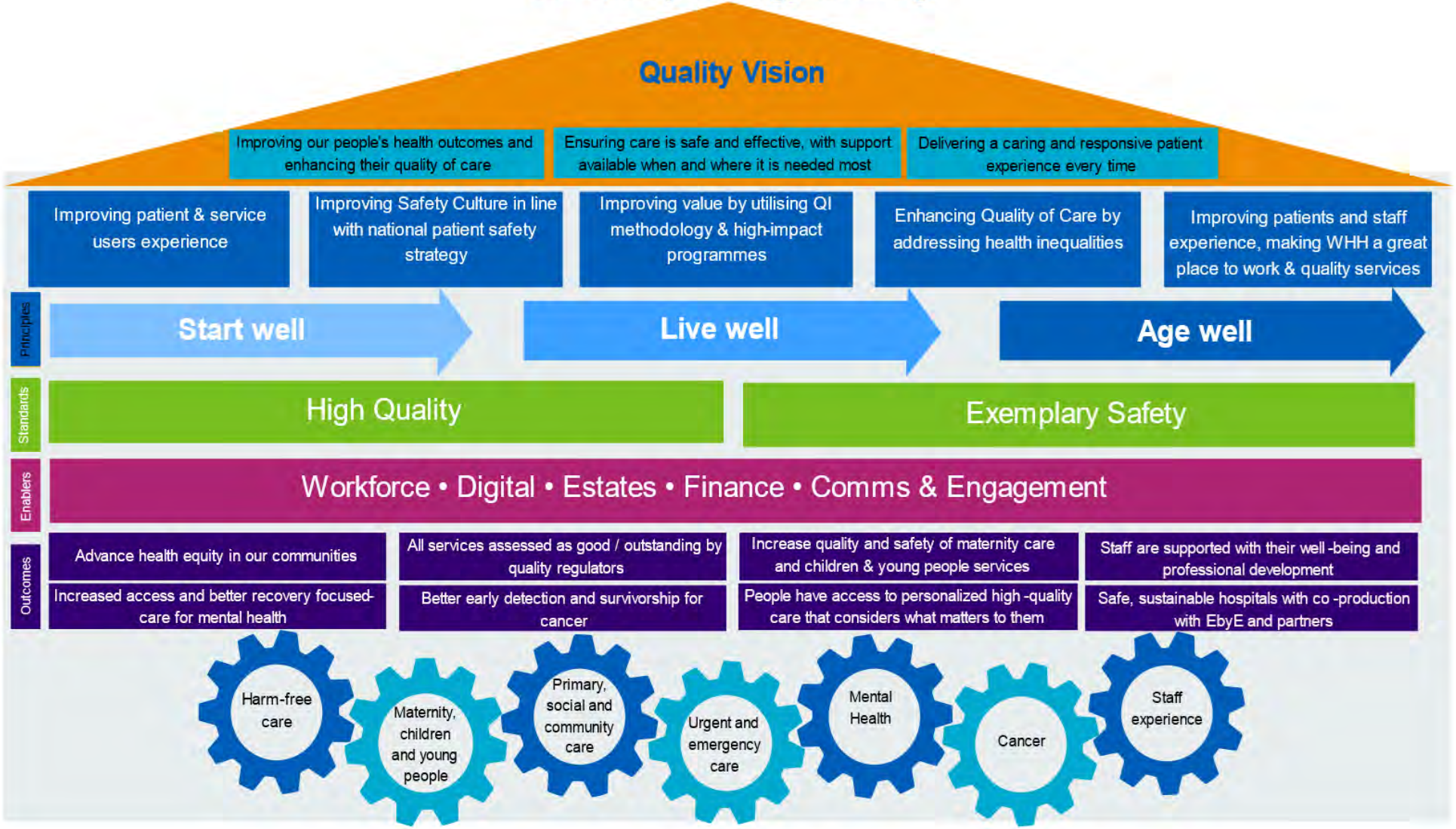
III. Next steps and readiness for annual business planning process-

A high level plan is developed to monitor and evaluate the key deliverables and next steps of implementing the Quality Strategy, which will be reviewed at the monthly meeting of the Quality Priorities. There will also be collaborative team (e.g., Strategy, Governance, Quality Academy and Care Groups) to represent at the annual business planning process to review and assess the progress of Quality Priorities in preparation for next financial year.

3. RECOMMENDATIONS

The Board of Directors are asked to note the informationcontained in this paper about the progress updates of the Quality Strategy 2025-2027.

Our Quality Strategy on a Page



Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/10/104**			
SUBJECT:	**Maternity & Neonatal Update July-September 2025**			
DATE OF MEETING:	**1 October 2025**			
AUTHOR(S):	Laura James – Clinical Business Unit Manager			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah - Chief Nurse			
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)***	**#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. **#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: The paper relates to care of pregnant people/those on the pregnancy continuum and improving safety and outcomes for this cohort.			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
		✓		
	Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum and improving safety and outcomes for this cohort.			
	3. Foster good relations between people who share a protected	**Yes**	**No**	**N/A**
		✓		

	characteristic and those who do not			
	Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum and improving safety and outcomes for this cohort.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This paper provides an overview of activity, performance and quality within the maternity and neonatal services for the period July – September 2025. The paper provides Board with oversight of the WHH position in relation to key national safety and quality issues, compliance with the Maternity Incentive Scheme Year 7, and local improvement actions. This report provides a summary of the following: • ATAIN Q1 2025/26 • Maternity Incentive Scheme Year 7 position • September Maternity Quality & Safety update • Transitional Care Q1 2025/26			
PURPOSE: *(please select as appropriate)*	For approval	To note ✓	Decision	
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/25/09/143i QAC/25/09/143ii QAC/25/09/143iii QAC/25/09/143iv		
	Date of meeting	9 September 2025		
	Summary of Outcome	Noted and approved		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity & Neonatal Update July-September 2025	AGENDA REF:	BM/25/10/104

1. BACKGROUND/CONTEXT

This paper provides an overview of activity, performance, and quality within the Maternity and Neonatal Services for the period July - September 2025.

The paper provides Board with oversight of the WHH position in relation to key national safety and quality issues, compliance with the Maternity Incentive Scheme Year 7, and local improvement actions.

This paper provides a summary in relation to the following reports which have been presented and discussed to Quality Assurance Committee oversight:

- ATAIN Q1 2025/26
- Maternity Incentive Scheme Year 7 position
- September Maternity Quality & Safety update
- Transitional Care Q1 2025/26

All papers have been shared and discussed at the appropriate committee meeting.

2. ATAIN Q1 2025/26

The ATAIN objective is to reduce the number of avoidable admissions of infants ≥37+0 weeks gestation to the Neonatal Unit (NNU). The national ambition is to ensure that term admission rates are below 6% of live births. Northwest Neonatal Operational Delivery Network (NWNODN) has set a separate target of 5.6% for term admissions to neonatal units. This initiative aims to keep parents and babies together as much as possible and to avoid separating them at the crucial time after birth.

The WHH Q1 2025/26 ATAIN rate is 7.88%, which does not meet the national target of 6% or the NWNODN target of 5.6%. The service remains an outlier in the NWODN for term admissions, despite a reduction in the service's ATAIN rate in the previous quarter.

This is also despite the innovative 'PEEP for 30' project (up to 30 minutes of respiratory support at delivery prior to considering NNU admission) which has been shown by audit to have avoided at least 35 admissions in 2024. This project includes a pathway for rapid normalisation and discharge from the NNU and a significant number of babies are discharged within 6 or 12 hours of admission. The' PEEP for 30' project showed a high proportion of babies with initial respiratory distress (62%) were infants of diabetic mothers. This highlights the importance of ensuring a robust pathway of care for those with diabetes in pregnancy which QAC will be aware is a significant workstream within the service.

Term admissions deemed avoidable in Q1 2025/26 were primarily attributed to cases where care could have been safely delivered on the Transitional Care (TC) pathway, preventable hypothermia in two infants, and non-clinical factors such as maternal illness or social concerns. Good practice was evident in several short admissions with prompt return to

mothers, effective ward reviews preventing readmission, and strong intrapartum documentation that upheld patient preferences.

Key learning themes included the need for accurate APGAR score recording on BadgerNet, strategies to prevent late neonatal deterioration, such as parent education on thermal care and use of biliblankets, and renewed focus on acute management of deteriorating babies.

The MDT CTG workshops have resumed, and a TC development project is underway to expand capacity and reduce admissions. However, social care-related admissions remain unavoidable due to lack of funded alternatives. Individualised reflection and supervision-supported learning have been embedded to reinforce these insights.

The ATAIN action plan is monitored at the monthly Women's & Children's (WCH) Governance Meeting.

3. MATERNITY INCENTIVE SCHEME (MIS)

3.1 Background

NHS Resolution has now commenced year seven of the Clinical Negligence Scheme for Trusts (CNST) MIS to continue to support the delivery of safer maternity care by implementing 10 safety standards. Specifications and timelines were released on 2 April 2025. Trusts are required to complete their Board declaration form and submit to NHS Resolution by 12 noon on 3 March 2026.

Trusts that can demonstrate all 10 safety standards will recover 10% of their CNST contribution and receive a share of unallocated funds.

3.2 Current position

To date, WHH continues to make steady progress toward compliance with MIS Year 7, with quarterly meetings held with the LMNS to review performance against Saving Babies' Lives and MIS standards.

Safety Actions 1 and 2 are fully compliant, with PMRT reviews meeting national standards and consistent data submissions to the MSDS.

A QI project has been launched to address transitional care (Safety Action 3), led by the Neonatal Matron and focused on improving staffing pathways.

Safety Action 4 is compliant, with consultant presence monitored monthly and locum audits scheduled for completion in September.

Safety Action 5 presents a risk due to a 4.87 WTE midwifery shortfall identified in the Birthrate Plus assessment, which has been escalated to the Strategic People Committee, Executive Team, and added to the CBU risk register. Despite this, safe staffing has been maintained, with no breaches in one-to-one care or supernumerary coordinator presence during the reporting period.

The Trust remains on track with Safety Action 6, having submitted Q2 evidence for SBLCBv3 and awaiting LMNS review.

Safety Action 7 is currently non-compliant due to the MNVP's inability to attend PMRT reviews, as required under revised national guidance. This has been escalated to the Board and LMNS, with infrastructure development underway to support future compliance. Safety

Safety actions 8 and 9 are compliant, with robust training plans in place and ongoing engagement between the quadrumvirate, MNVP leads, and the non-executive Maternity Safety Champion. The Director of Midwifery continues to provide quarterly updates to the Trust Board, ensuring visibility of risks and progress.

3.3 Monitoring/reporting

Progress with SBLCBv3 and MIS Year 7 is shared and discussed at CBU Governance meetings.

4. QUALITY & SAFETY MEASURES & METRICS

A review of quality and safety within the maternity and neonatal services is shared with Quality Assurance Committee (QAC) each month across a range of key themes and areas of national and local focus.

Patient Safety Events

In July 2025, themes from patient safety events were as follows:

- Admission of term babies admitted to Neonatal Unit (NNU)
- Postpartum Haemorrhage (PPH) 1000ml-1500ml
- Postpartum Haemorrhage (PPH) >1500ml

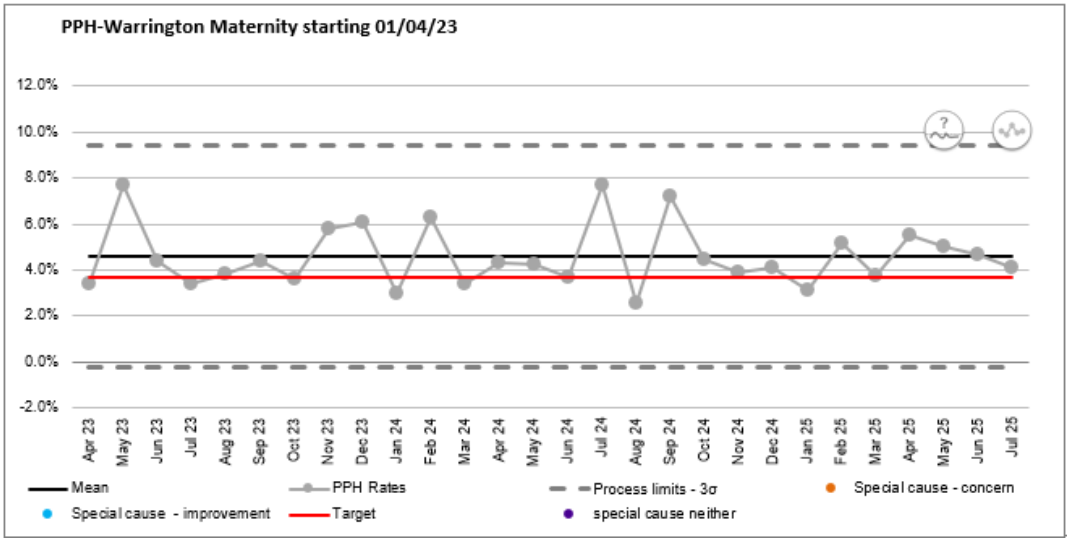
All patient safety events have received an internal review to identify urgent learning. Further details of the cases, learning identified and plans to improve are included in the detailed reports shared to Quality Assurance Committee. However, a summary of key matters relating to themes identified from patient safety events are detailed below:

4.1 Term Admissions to NNU

All term admissions are reviewed via the ATAIN process, which reports quarterly to the Quality Assurance Committee (QAC).

4.2 Postpartum Haemorrhage (PPH)

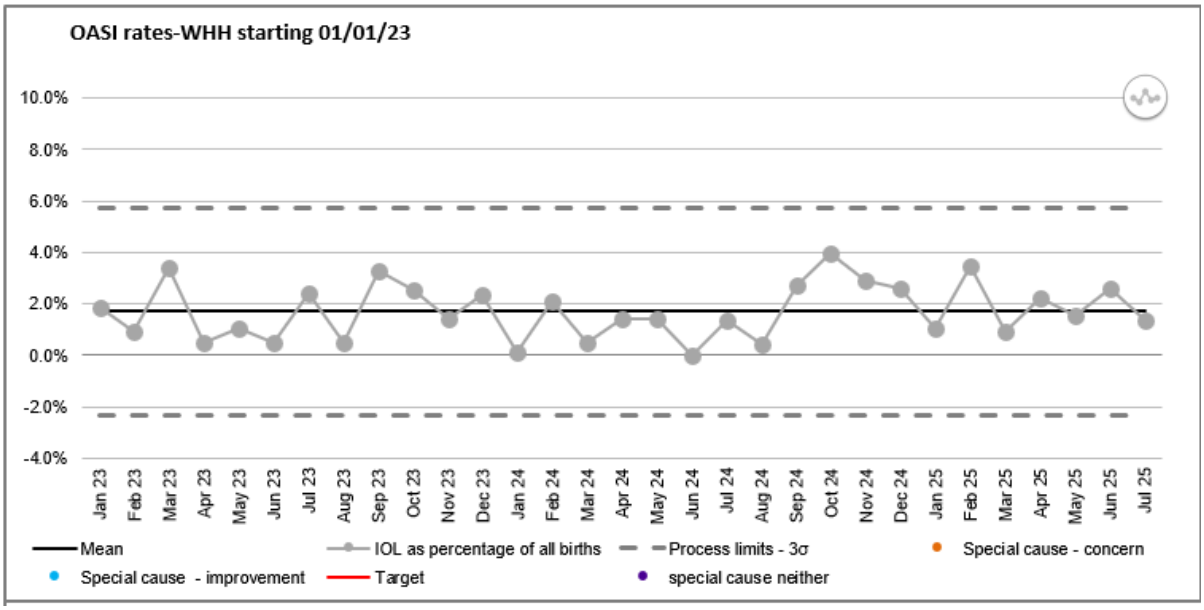
There were 23 cases of PPH 1000ml-1500ml. This is an increase in cases from June 2025. All cases of PPH 1000ml-1500ml are reviewed and learning shared. There were 8 cases of PPH ≥1500mls in July. The SPC chart for PPH ≥1500mls to end of July continues to show common cause variation but with a sustained reduction since April 2025.



4.3 Harm Events

There were no fatal or severe harm events in July 2025 in the maternity or neonatal services. There were three moderate harm events, all cases of 3rd/4th degree tear (OASI). These cases were reviewed by the maternity MDT through Intrapartum Review Group (IRG).

Work continues to reduce rates of OASI (3rd and 4th degree tears) following an increase in cases in February 2025.



4.4 Workforce metrics

Work remains ongoing across the Maternity and Neonatal teams to sustain compliance with mandatory training and completion of staff appraisals.

At the end of July compliance for mandatory training across maternity and child health colleagues is 91.21% for Trust mandatory training (including safeguarding training) and

90.69% for role specific training (both above the Trust target). This excludes staff who are currently absent from work on a long-term basis.

Compliance with PDR completion is a challenge with a position of 78.41%. This is an improvement from June 2025, a trajectory is in place to achieve full compliance by end of September 2025. This is being monitored weekly.

Good compliance with maternity specific training standards is largely being sustained with further improvement noted following a slight deterioration in position reported to QAC in June 2025. Escalation processes have been enacted for those obstetric colleagues not compliant with K2 (fetal surveillance competencies).

Current position – Training compliance - maternity specific

	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)	Newborn Life Support Level 2
Midwives	96.9%	98.4%	97.6%	95.3%
Obstetric Consultants	91.6%	100%	100%	n/a
Other Obstetric	100%	92.3%	84.6%*	n/a
Obs Anaesthetic	96.6%	n/a		n/a
Maternity Support Workers	100%	n/a		n/a
Neonatal medical and ANNP	n/a	n/a	n/a	Awaiting Data

Turnover for maternity and child health staff (permanent staff) in July 2025 is 11.47%, below the Trust target. This is illustrated in the graph below:

The vacancy rate for maternity and child health staff remains positive and is significantly below the Trust target at 2.21%. This is illustrated in the graph below:

4.5 Service user and staff feedback

The service continues to share good practice and compliments with the team. A 'Thank You Thursday' initiative has been established where positive feedback and achievements are celebrated and shared across the team via a bimonthly newsletter.

Thank you Thursdays for the months of May and July 2025 are included in appendices one and two for information.

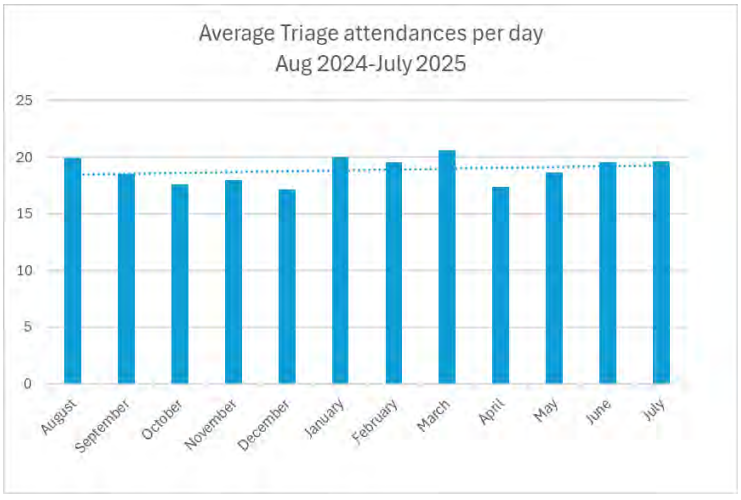
4.6 Maternity Triage

The Maternity Triage service is included within this paper in light of significant regional and national scrutiny of triage services.

Current performance

In July 2025, 608 triage attendances were recorded on the BadgerNet patient record system maintaining the average number of attendances per day of 19 seen since the beginning of 2025.

Triage attendances August 2024-July 2025	
Month	**Attendances**
August	618
September	556
October	545
November	539
December	531
January	621
February	547
March	638
April	521
May	577
June	587
July	602

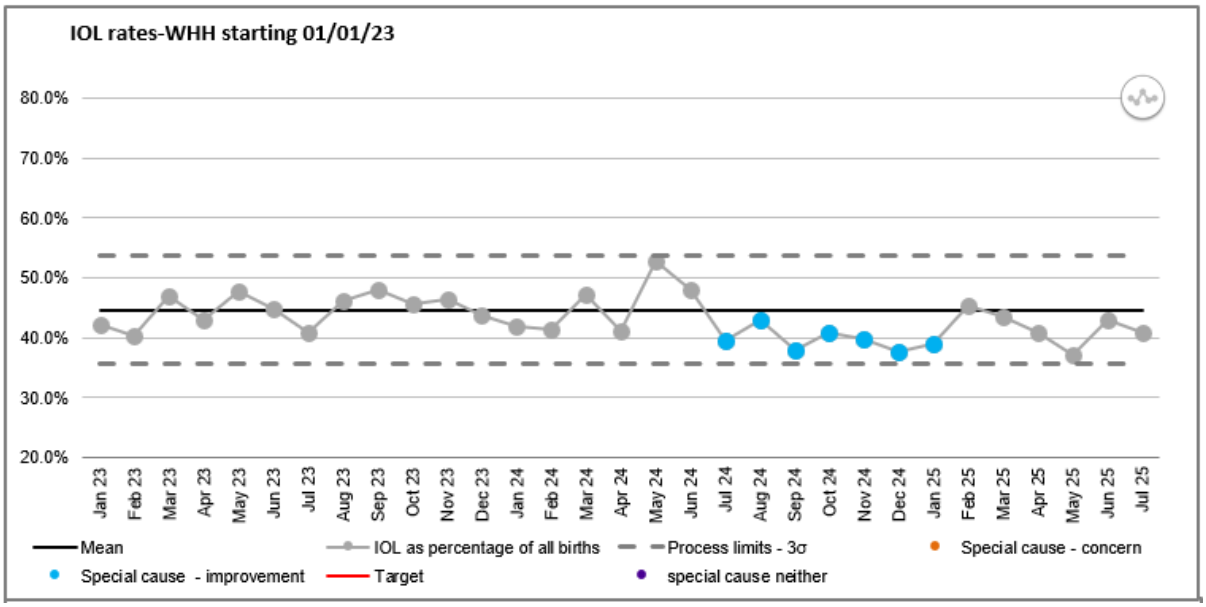


- 25.4% of attendees in July were seen immediately on arrival.
- The longest wait recorded for initial review was 46 minutes.
- 96.2% of attenders were seen within 15 minutes of arrival (best practice guidance). This is beyond the KPI of 90% review within 15 minutes.
- 99.34% of attenders were seen within less than 30 minutes of arrival (NICE guidance). Again, this is beyond the KPI which stipulates 95% review within 30 minutes.
- 0.3% of attendees (two women) were categorised as red on arrival. All were seen within 15 minutes of arrival for initial triage.
- 20.2% of attendees were categorised orange on arrival. This is a slightly smaller proportion compared to May and June 2025 but maintains the increase seen when compared to April 2025 when the proportion was 18.2%.

4.7 Induction of Labour (IOL)

Trust Board will be aware the service was identified as an outlier during 2024 within the LMNS with regard to the timeliness of induction of labour processes. As a result, a significant IOL workstream is underway.

As part of this, the service monitors overarching rates of IOL as high rates will contribute to capacity and flow. The SPC chart below shows monthly IOL rates at WHH from January 2023 to July 2025, presented as a percentage of all births. The service's aim is to reduce this rate.



In July, the WHH IOL rate was 40.74%, a reduction from June's rate of 43%.

Inappropriate inductions (IOL) were initially recorded at 6.9%, however following patient discussions three IOL were rebooked at an appropriate gestation, this reduced the inappropriate IOL rate to 2.7%. This reflects continued progress, in June 2025 inappropriate IOLs were 4.1%, in May 6.5%, and in April 14%.

The monthly audit will continue to monitor appropriateness of bookings and to ensure that improvements are sustained. The IOL Bleepholder role, introduced on 7th July, has received positive informal feedback from both midwives and obstetric teams. Having a central point of

oversight is supporting clearer planning, better communication, and a more consistent approach to managing the pathway.

From 1st September, dedicated outpatient IOL slots will be available on Badger Notes. This change will ensure those birthing at WHH are aware of their outpatient pathway from the point of booking, supporting improved planning and communication.

Work is also continuing with the communications team to develop patient information videos. These resources will reflect current evidence and include tailored content for women who decline IOL at 41/40, and for those who request IOL prior to 39/40.

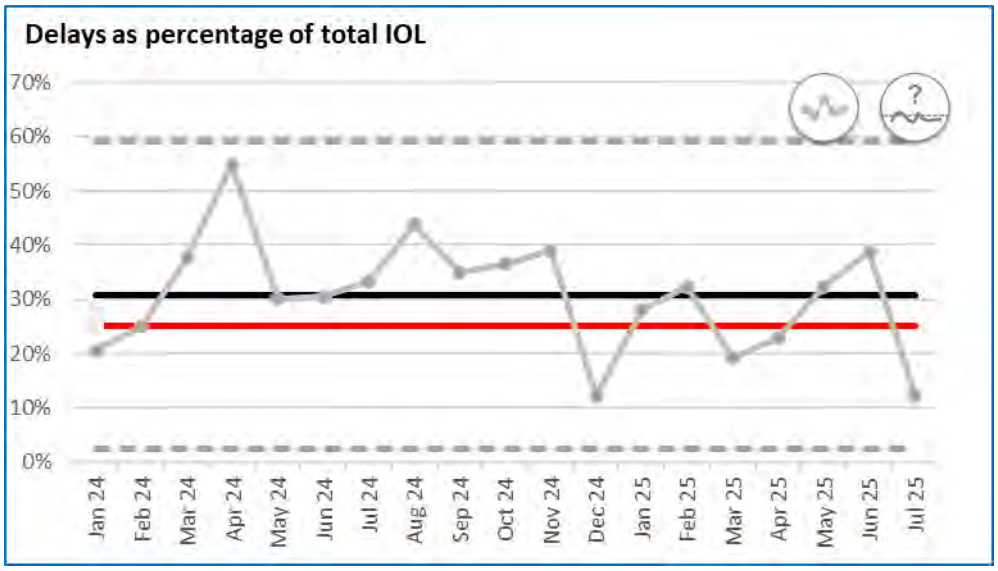
Multilingual staff are being identified to support delivery of video content in a range of languages, improving accessibility for all service users.

Work to reduce delays in IOL is ongoing. The service has a target to achieve sustained reduction in delays to around 25%. July 2025 saw a significant improvement in delays with only 12.28% of IOLs experiencing a delay. In June 2025 this figure was 38.71%. furthermore, there were no delays >24 hours in July 2025.

The data below reports the **total number undergoing IOL** and the **total number and percentage delayed by Provider** from **1st to 31st July 2025.**

	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total
Total number undergoing Induction of Labour	23	98	88	55	125	57	83	529
Total Delayed	4	5	17	1	23	7	53	110
% of Total	17.39%	5.10%	19.32%	1.82%	18.40%	12.28%	63.86%	20.79%

The position with regard to delay in IOL is being monitored via a SPC chart.



Delays in induction are included on the CBU risk register with a current rating of 16.

4.8 Maternity and Newborn Safety Investigation (MNSI) position

Background
To ensure Trust Board has oversight of the sevice's position with regard to cases being investigated by MNSI an update is provided each month.

Current position
For the period September 2024 – August 2025, MNSI have accepted four maternity related cases for investigation. One case relates to a patient safety events which occurred in 2024.

Position as at 31/7/2025 is as follows:

Incident Date	MNSI No.	Criteria	Status	Draft Report Received	Final Report Received	SOM Sign-off	QAC
25/11/2024	MI-039124	HIE/Cooling	Complete	08/04/2025	01/05/2025	02/06/2025	10/06/2025
28/04/2025	MI-041711	HIE/Cooling	In progress	Awaiting	Awaiting		
6/4/2025	MI-041411	Maternal death	In progress	Awaiting	Awaiting		
2/8/2025	MI-045085	HIE/Cooling	In progress	Awaiting	Awaiting		

The case referred in August 2025 relates to birth impacted by shoulder dystocia. In this case the baby was born in poor condition and transferred to a tertiary unit for cooling. An initial safety review did not identify any immediate learning. The investigation via MNSI is underway.

5. Quarter 1 2025/26 TRANSITIONAL CARE (TC) REPORT

5.1 Background

Transitional Care (TC) is embedded in the Maternity Incentive Scheme, Year 7, Safety Action 3. Transitional Care is not always a physical location but a pathway involving more frequent observations and coordinated care between the Neonatal and Midwifery Team. TC is for babies who need a little more nursing care and monitoring and is provided by the team on the Neonatal Unit (NNU), Birth Suite and maternity ward.

5.2 Q1 2025/26 Transitional Care activity summary

- A total of **57 babies** met the criteria for Transitional Care (TC) in Q1.
- Of these:
    - **One baby**, repatriated from Bangor, received TC care continuously from admission for 3 days.
    - **One baby** received TC care from birth.
    - **Five babies** were potential candidates for TC at birth; however, due to high patient acuity and staff sickness on the Neonatal Unit (NNU), TC staffing was not possible.
    - **Three babies** were suitable for step-down to TC, but their mothers were discharged home within 24 hours, limiting TC provision.
    - **Three babies** who stepped down from the NNU to TC were cared for under midwifery-led TC. These infants were late preterms requiring feeding support only. This arrangement helped reduce acuity on the NNU and prevented unit closure.

The other babies who met the broad TC criteria in Q1 required some level of respiratory support and were initially provided with care via NNU. Of these:

- None of these babies were stepped down to TC when clinically indicated due to staffing challenges on the NNU.
- Two babies did not meet the TC criteria once medically fit for discharge from NNU.
- Two babies followed the PEEP for 30 pathway. One of these babies was cared for by the maternity team. One was discharged to TC however was readmitted to NNU due to poor feeding, this baby should have remained on TC.

Reasons for admission to the NNU are highlighted in the table below.

	Reason baby admitted to NNU	Actions to reduce occurrence
1	Babies requiring respiratory support	• Repeat audit to be undertaken to review length of time baby required respiratory support
3	Staffing	• Review staffing

5.3 TC staffing model

To provide a TC service a designated staffing model is required. A benchmarking exercise has been completed with neonatal services within the Cheshire and Mersey locality. Of these, two units do not currently provide TC due to lack of staff. Two units allocate a band 5 staff nurse each shift to provide TC on their postnatal ward. Creation of a similar model at WHH has been costed and would require recurrent financial investment of £270,302 per annum.

There is a QI project registered to review the staffing model and there may be an option to utilise some staff from the existing establishment to meet the TC staffing requirement. This will be reviewed as part of the QI project.

Implementation of Transitional Care Shift on Neonatal Unit Roster

Starting **7th July 2025**, a dedicated **Transitional Care shift** has been incorporated into the NNU's staffing roster. This new shift allows for the consistent allocation of a specialised TC nurse during each shift.

The introduction of the TC shift will also facilitate ongoing auditing of staffing compliance by tracking instances when the shift is either cancelled or covered by external staff from the NHS Professionals (NHSP) bank. This monitoring aims to identify staffing gaps and evaluate the impact on transitional care quality and patient outcomes.

5.4 Good Practice from the Q1 2025/26 audit:

- Excellent neonatal care for babies, thus ensuring safety of babies who have been separated from their mothers.
- Excellent communication between neonatal and maternity teams on the postnatal ward, which allowed for babies to return to TC under midwifery care.
- Sharing of audit outcomes across the MDT with both Midwifery and Neonatal Teams to ensure learning is communicated.
- Significant improvements in relation to the timely step down of these babies to TC
- Unavailability of TC reviewed at operational Review Group to ensure senior oversight and review

5.5 Recommendations:

- Risk assessment to be implemented when unable to facilitate TC.
- Utilise TC to reduce term admissions.
- Staffing – Continue to ensure neonatal staff are allocated to TC babies. TC shift added to roster to allow allocation and audit when shift sent to NHSP or staff member required on NNU.

- To continue TC education with Neonatal and maternity teams following ratification of updated guideline.
- TC review group to continue to review and discuss cases and monitor actions/progress against the action plan.

5.6 Outstanding actions from action plan

- Ongoing TC audit which will be reported through this committee.
- Review of IV policy required to enable midwifery staff to undertake IV antibiotics on babies, pharmacy input required.
- TC/enhanced care bay to be created on C23

11. MONITORING/REPORTING ROUTES

The contents of this report are reported via Specialty Governance meetings. Items for escalation are monitored at Women's & Children's CBU Governance meeting monthly.

12. ASSURANCE COMMITTEE

The contents of this report have previously been noted and discussed at Quality Assurance Committee on 9 September 2025.

13. RECOMMENDATIONS

The Trust Board is requested to note the content of this paper and its associated appendices for information.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/10/104i**	
SUBJECT:	**2025-2026 Quarter 1 Avoiding Term Admission into Neonatal Unit (ATAIN) Report**	
DATE OF MEETING:	1 October 2025	
AUTHOR(S):	Ailsa Gaskill-Jones - Director of Midwifery Annabel Grossmith – Consultant Obstetrician & Gynaecology Emma Bentham – CBU Personal Assistant	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse	
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	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):		

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: The paper relates to care of pregnant people/those on the pregnancy continuum. Achieving the principles within ATAIN will have a positive impact on this group.

2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
	✓		

Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum. Achieving the principles within ATAIN will have a positive impact on this group.

3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
			✓

Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum. Achieving the

	principles within ATAIN will have a positive impact on this group.		
EXECUTIVE SUMMARY ***(KEY ISSUES):***	• Q1 2025/26 ATAIN rate (Avoiding Term Admission into Neonatal Unit) is 7.88%, which does not meet the national target (6%) or the NWNODN target (5.6%). • All admissions including those <6 hours have been included as this is the national and regional expectation. • All term admissions in Q1 were reviewed and learning from these cases informs the ATAIN action plan. • An ATAIN action plan is in place to improve the service position against ATAIN standards. • The ATAIN action plan is monitored at the monthly Women's & Children's (WCH) Governance Meeting. • A quality improvement project is currently underway to put in place a further enhanced transitional care offering, which will reduce term admissions and separation of mothers and babies.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the content of this paper.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/25/09/143i**	
	Date of meeting	9 September 2025	
	Summary of Outcome	noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	2025-2026 Quarter 1 Avoiding Term Admission into Neonatal Unit (ATAIN) Report	AGENDA REF:	BM/25/10/104i

1. BACKGROUND/CONTEXT

The ATAIN objective is to reduce the number of avoidable admissions of infants ≥37+0 weeks gestation to the Neonatal Unit (NNU). The national ambition is to ensure that term admission rates are below 6% of live births. Northwest Neonatal Operational Delivery Network (NWNODN) has set a separate target of 5.6% for term admissions to neonatal units. This initiative is to keep parents and babies together as much as possible and avoids separating them at the crucial time after birth by reducing the incidence of admissions for breathing issues, hypoglycaemia, jaundice and poor condition at birth.

NHS England » Reducing admission of full term babies to neonatal units

This paper describes the current position of Warrington and Halton Teaching Hospital (WHH) against ATAIN standards.

2. KEY ELEMENTS

2.1 WHH ATAIN position

The findings of this report have been collated from the review of all cases of term babies that were admitted to the Neonatal Unit (NNU) during the Q1 reporting period from 1 April 2025 to 30 June 2025.

Each case is reviewed by a Multidisciplinary Team (MDT) of Obstetrician, Neonatologist, Midwives, Neonatal Nurse and Operational Management. The ATAIN Group meet fortnightly to ensure any learning is captured in a timely manner but with capacity to increase frequency where indicated.

Maternity Incentive Scheme (MIS) specification directs providers to report the ATAIN data to the Trust Board of Directors on a quarterly basis. However, when reviewing the quarterly data, it is important to review the data over a longer time period due to the small number of babies involved.

2.2 Summary of unexpected term admissions to NNU

The Q1 ATAIN rate was 7.88% which does not meet the national target of 6% or the NWNODN target of 5.6%. The service remains an outlier in the NWODN for term admissions, despite a reduction in the service's ATAIN rate in the previous quarter.

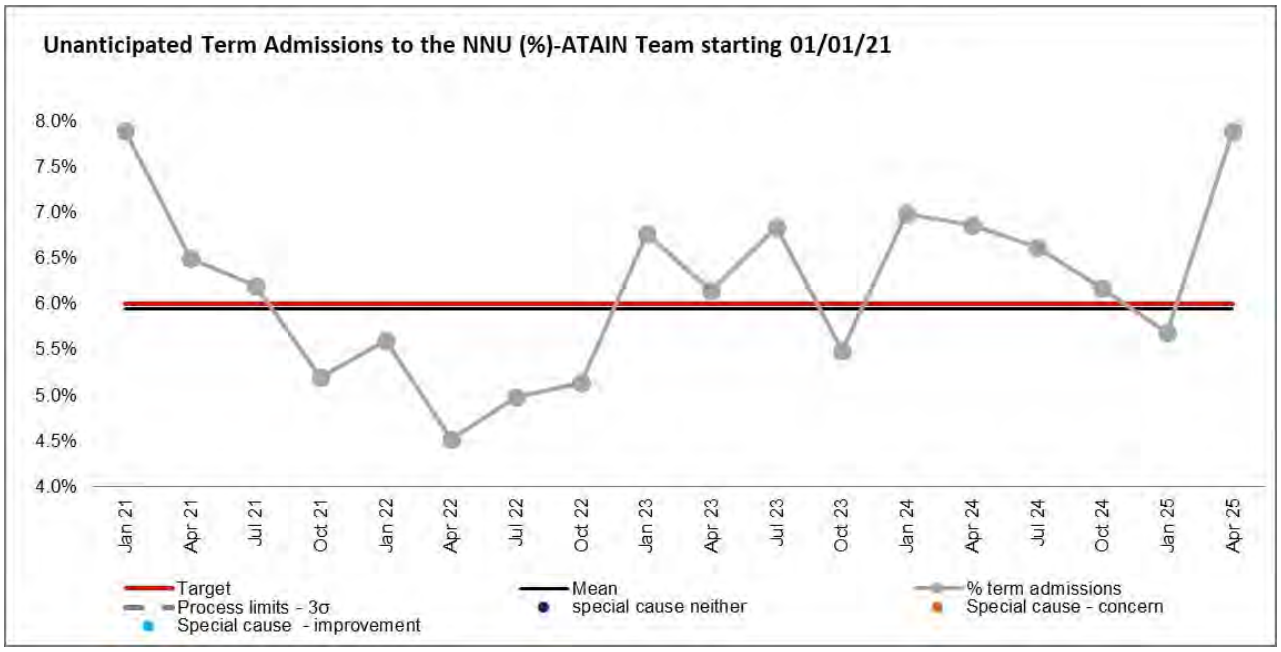
This is also despite the innovative 'PEEP for 30' project (up to 30 minutes of respiratory support at delivery prior to considering NNU admission) which has been shown by audit to have avoided at least 35 admissions in 2024. This project includes a pathway for rapid normalisation and

discharge from the NNU and a significant number of babies are discharged within 6 or 12 hours of admission. The' PEEP for 30' project showed a high proportion of babies with initial respiratory distress (62%) were infants of diabetic mothers. This highlights the importance of ensuring a robust pathway of care for those with diabetes in pregnancy which QAC will be aware is a significant workstream within the service.

Of the 45 term admissions, one was reviewed as part of the ATAIN process but no decision regarding avoidability was determined as this case is subject to MNSI and coronial investigation. Another was excluded from clinical review due to planned social admission.

WHH Reporting Period	Total Number of Live Births	Total Number of term admissions	Total Number of term admissions as a % of live births	Total Number of term admissions as a % of live births (excluding babies with <6 hrs admission)	National target 6%	NWNODN Target 5.6%
Q1 Apr – Jun 2024	612	42	6.86%	5.8%		
Q2 Jul – Sept 2024	680	45	6.62%	5.6%		
Q3 Oct – Dec 2024	600	37	6.17%	6.0%		
Q4 Jan – Mar 2025	580	33	5.69%			
Q1 Apr – Jun 2025	571	45	7.88%			

Below is a summary of unanticipated term admissions to Neonatal Unit from July 2022 – June 2025.



As part of the ATAIN review, the team will consider whether an admission to NNU was avoidable if care had been optimal. Even if learning points can still be identified, some admissions are not

preventable. Isolated and recurring causes of avoidable admissions are where actions are focussed. The percentage of avoidable admissions has remained fairly steady, despite this quarter's spike in overall admission rate.

WHH Oct 2022 - Mar 2024	Number of Term Admissions	Outcome of ATAIN review		% avoidable
		Avoidable Admissions	Unavoidable Admissions	
Q4 Jan – Mar 2024	41	13	28	31.7%
Q1 Apr – Jun 2024	42	15	27	35.7%
Q2 Jul – Sept 2024	45	16	38	35.5%
Q3 Oct – Dec 2024	37	8	27	21.6%
Q4 Jan – Mar 2025	33	9	24	27.3%
Q1 Apr – Jun 2025	45	16	28	35.6%

1.3 Reasons for term admissions (recorded on BadgerNet by ATAIN admission criteria)

60% (27) of term admissions were for management of a respiratory problem requiring observation. This may include signs of respiratory distress (including grunting) and low oxygen saturation (SATs or oxygen requirement). Only seven of these cases were deemed avoidable even if care had been optimal.

WHH Number Live Births 2022-2023		Term Admissions		Respiratory Symptoms		Sepsis/ Suspected Infection		Hypoglycaemia		Jaundice		Hypothermia	
		Number	% Live births	No of babies	% Term admissions	No of babies	% Term admission	No of babies	% Term admissions	No of babies	% Term admission	No of babies	% Term admissions
Q1 Apr-June 2024	612	42	6.86%	29	69%	2	4.7 %	2	4.7%	1	2.4%	0	0%
Q2 Jul-Sept 2024	680	45	6.62%	26	58%	1	2.2 %	2	4.4%	3	6.7%	2	4.4%
Q3 Oct-Dec 2024	600	37	6.17%	27	73%	2	5.4 %	1	2.7%	0	0%	0	0%
Q4 Jan – Mar 2025	580	33	5.69%	19	58%	3	9.1 %	3	9.1%	1	3%	2	6.1%
Q1 Apr – Jun 2025	571	45	7.88%	27	60%	1	2.2 %	0	0%	3	6.7%	1	2.2%

9 babies were admitted for reasons other than those categories listed in the table above. These include: 2 babies in poor condition at birth with low cord pH – one of these was deemed unavoidable, and the other case is subject to ongoing external investigation. 6 babies were admissions for additional monitoring (poor feeding/ neonatal abstinence syndrome, other), 5 of which could have been managed on transitional care if this had been available. 2 babies did not require admission for clinical reasons but were admitted either because the mother was unwell and father felt unable to care for it or due to anticipated social reasons (baby to be adopted).

2.4 Themes and Learning: Outcomes of ATAIN review

Reasons for categorising term admissions as avoidable included:

- Care could have been provided on Transitional Care
- Two babies deteriorated due to preventable hypothermia
- Non-clinical admissions (social/mother unwell)

2.4.1 Good Practice:

- Several examples of very short admissions with quick return to mum and effective ward review preventing readmission
- Examples of excellent intrapartum documentation
- Patient wishes respected and supported

2.4.2 Learning Points/Themes

- Learning around the importance of recording accurate APGAR scores on BadgerNet.
- Ongoing actions to reduce the risk of late deterioration of baby including education posters to advise parents on the importance of keeping babies warm and providing biliblankets for babies with jaundice to support continued phototherapy during breastfeeding.
- MDT CTG learning workshops have restarted
- Ongoing Transitional Care development project to fund an enhanced offering to avoid more admissions to the neonatal unit.
- Learning around acute initial management of the deteriorating baby.
- Still unable to avoid social care admissions, or admissions of babies where mother is unwell due to no funding for alternative provision.

Individualised learning and facilitated reflection have taken place as appropriate with the support of colleagues/supervisors.

2.4.3 Recommendations:

(Those in bold are likely to make the most significant impact on the service's ATAIN rates)

- Continue to facilitate reflective discussions with staff as required from cases requiring individualised learning
- Continue regular ATAIN Meetings with Core MDT but also ideally involving rotation of obstetric trainees and midwifery colleagues to participate in the meetings where staffing allows
- Consider including attendance at ATAIN meetings within band 5 midwifery preceptorship package
- Shared learning from ATAIN to continue to be disseminated to all Midwifery, Paediatric, Neonatal and Obstetric staff, to include presentation at joint audit meetings
- Continue MDT CTG teaching workshops for Obstetric and midwifery staff
- Continue regular review of ATAIN action tracker at the start of each meeting to ensure timely completion.
- Senior midwifery review of all babies to be facilitated on Birth Suite and C23 to support early identification of deteriorating babies to allow actions to prevent admission.
- **Exploration of a pathway to accommodate social admissions of babies on Birth Suite with maternity support worker or neonatal nursery nurse care to avoid term admission to NNU e.g. whilst awaiting birth planning meeting/safeguarding concerns/mother admitted to ICU etc.**
- **Ongoing work to ensure consistent and sustainable transitional care offer**
- Ensure learning from ATAIN feeds into wider service workstream to improve pathways for those with diabetes in pregnancy
- Investigation into whether there are any other specific factors related to the service's local population which might explain the service's status as an outlier in ATAIN rates
- **New project to introduce CPAP in theatre recovery and in delivery rooms to reduce number of very short admissions to NNU**
- Awaiting introduction of NEWTT2 which includes routine oxygen saturation monitoring on neonates

3. MONITORING/REPORTING ROUTES

The ATAIN action plan is monitored at the Women's and Children's Clinical Business Unit Governance Meeting monthly, prior to reporting to the Quality Assurance Committee. This report will be shared at the September 2025 Women's and Children's Clinical Business Unit Governance Meeting.

4. RECOMMENDATIONS

Members of the Trust Board are requested to note the findings of this paper as part of the quarterly maternity and neonatal overview.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/10/104ii**	
SUBJECT:	**Maternity Incentive Scheme Year 7 Update**	
DATE OF MEETING:	1 October 2025	
AUTHOR(S):	Ailsa Gaskill-Jones - Director of Midwifery Tina Moors – Deputy Director of Midwifery Helen Wall – Assurance & Improvement Manager	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse	
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	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):		

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: The paper relates to care of pregnant people/those on the pregnancy continuum. The principles of CNST and the Maternity Incentive Scheme (MIS) is to ensure safer care for this cohort. Achieving the principles of MIS will have a positive impact on this group.

	Yes	No	*N/A*
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	✓		

Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum. The principles of CNST and the Maternity Incentive Scheme (MIS) is to ensure safer care for this cohort. Achieving the principles of MIS will have a positive impact on this group.

	Yes	No	N/A
3. Foster good relations between people who share a protected characteristic and those who do not			✓

Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum. The principles of CNST and the Maternity Incentive Scheme (MIS) is to

	ensure safer care for this cohort. Achieving the principles of MIS will have a positive impact on this group.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	NHS Resolution's (NHSR) Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025. This paper includes a summary of progress so far and feedback from the Local Maternity and Neonatal System (LMNS). Following the first quarterly meeting with the LMNS, regarding MIS year 7, the service has received positive feedback regarding the evidence submitted. Position against each safety action is as follows: **Safety Action 1: Use of PMRT** • Q1 2025/26 PMRT review noted the Trust compliant with safety action 1 **Safety Action 2: MSDS Data Submission** • The maternity service consistently meets the required data submission standards. **Safety Action 3: Transitional Care** • The necessary work is underway to ensure the service meets all requirements of the standard. **Safety Action 4: Obstetric Medical Staffing** • Locum staffing audits are scheduled for September 2025. • Consultant presence is reviewed monthly; Trust maintains 80% compliance. **Safety Action 5: Midwifery Workforce Planning** • The 2025 Birthrate Plus® assessment of midwifery establishment highlighted a shortfall of 4.87 WTE midwives. • This creates a risk to achieving MIS year 7. This has been added to CBU risk register • A plan is underway to address shortfall. • Safe midwifery staffing is monitored via Safe Care. • For Q1 2025/26 (April–June 2025): o No shifts began without a supernumerary Birth Suite Coordinator. o 3 shifts had Coordinator lose supernumerary status during shift.

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All women in active labour received 1:1 midwifery care.

A workforce action plan remains in place to ensure safe staffing and compliance with these standards. Accordingly, the service is achieving this aspect of Safety Action 5.

Safety Action 6: Saving Babies' Lives Care Bundle v3

The LMNS have confirmed the Trust as 99% compliant with the care bundle for Q1 25/26
Evidence for Q2 2025/26 has been submitted.
External oversight of compliance against the care bundle is provided by the LMNS; next review on 17 September 2025.

Safety Action 7: Listening to Women, Parents & Families

The MNVP is fully engaged in Trust meetings as per the MIS guidance with the exception of PMRT reviews.
Due to lack of infrastructure in relation to PMRT , the WHH MNVP is deemed as not functioning per national guidance.
NHS Resolution have confirmed escalation to QAC, Trust Board and the LMNS of this will ensure compliance with MIS year 7.
A plan underway to support MNVP attendance at PMRT.
Positive collaboration with MNVP continues despite current limitations.

Safety Action 8: Local Training Plans

The Trust consistently meets training requirements, including multi-professional sessions.

Safety Action 9: Board Oversight

The service is meeting the requirements to ensure appropriate Board oversight of the maternity and neonatal services.

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<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">The Trust Board is asked to note the content of this paper.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Quality Assurance Committee</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="2">QAC/25/09/143ii</td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="2">9 September 2025</td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="2"></td></tr>
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FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

REPORT TO TRUST BOARD

SUBJECT	Maternity Incentive Scheme Year 7 Update	AGENDA REF:	BM/25/10/104ii

1. BACKGROUND/CONTEXT

NHS Resolution has now commenced year seven of the Clinical Negligence Scheme for Trusts (CNST) MIS to continue to support the delivery of safer maternity care by implementing 10 safety standards. Specifications and timelines were released on 2 April 2025. Trusts are required to complete their Board declaration form and submit to NHS Resolution by 12 noon on 3 March 2026.

Trusts that can demonstrate all 10 safety standards will recover 10% of their CNST contribution and receive a share of unallocated funds.

2. CURRENT POSITION

1.3 Current position against MIS Year 7

Trust Board will be aware that the first quarterly meeting was held with the LMNS to discuss the Trust's progress against Saving Babies' Lives and MIS in June. The next quarterly meeting is scheduled for 17 September 2025.

1.4 Safety Action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?

Trust Board will be aware that the Q1 PMRT paper, which was presented in August 2025, identified our compliance with the all the requirements of safety action 1.

1.5 Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard

The maternity service consistently achieves this standard.

1.6 Safety Action 3: Transitional Care

In line with the requirements of MIS, a QI project has been registered with the Trust. The QI project will be led by the Neonatal Matron and will focus on improving staffing for transitional care pathways.

1.7 Safety Action 4: Obstetric medical staffing

The required audits of our locum staffing will be completed by the Associate Clinical Director (Women's Health) in September 2025. Consultant presence continues to be

reviewed on a monthly basis. We are consistently compliant with the required 80% compliance rate.

1.8 Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

The outcome of the 2025 Birthrate Plus® assessment was reported to Strategic People Committee in July 2025 when the results and the total establishment shortfall of 4.87wte midwifery posts was noted. Strategic People Committee were asked to note the risk this shortfall creates to the Trust achieving year 7 of the Maternity Incentive Scheme.

The risk of not being able to demonstrate a safe model of midwifery staffing and the associated risk of not achieving MIS year 7 have been added to the CBU risk register.

The position has also been shared with the Executive team who have noted this and are aware of the associated risk to the organisation.

Work is underway to complete a risk benefit analysis of service provision/delivery across the maternity service to identify potential opportunities to achieve the necessary financial savings required to meet the cost of increasing midwifery establishment in line with the Birthrate Plus® assessment.

Monitoring of safe staffing levels is a further requirement of MIS Safety Action 5. Within the maternity service, staffing red flags across the maternity service are recorded within the Safe Care module of the health roster. As part of Safety Action 5 there is a requirement to closely monitor two key measures:

- Evidence that the midwifery coordinator in charge of labour ward must have supernumerary status to ensure there is oversight of all birth activity within the service.
- The provision of all women receiving one to one midwifery care in active labour

In the period 1st April 2025 – 30th June 2025 there were no occasions where the Birth Suite Coordinator was not supernumerary at the beginning of the shift. There were three occasions where Birth Suite Coordinator was not supernumerary. In the period 1st April 2025 – 30th June 2025 there was no episodes flagged where a woman in active labour did not receive one-to-one care.

2.7 Safety Action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Trust Board will be aware regular updates are provided via this paper in relation to the service position regarding the Saving Babies Lives Care Bundle v3 (SBLCBv3) with external oversight provided by the LMNS.

The service has submitted evidence for Q2 2025/26. The next review meeting with the LMNS is scheduled for 17 September 2025 and the outcome will be shared at QAC in October 2025.

2.8 Safety Action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

Trust Board will be aware the maternity service works closely with the Maternity and Neonatal Voices Partnership (MNVP). The MNVP has a workplan in place which includes engagement with women and families and attendance at Trust meetings.

For MIS Year 7, changes have been made to the guidance regarding what is required of an MNVP with a shift to ensuring there is the correct infrastructure to enable the MNVP to have strategic influence and be involved in decision-making.

MIS year 7 has outlined that the MNVP are required to be quorate members of several meetings. These meetings include safety champion meetings, maternity quality and safety meetings, neonatal quality and safety meetings, Perinatal Mortality Review Tool (PMRT) reviews, patient safety meetings and guideline committees. WHH MNVP currently attend all these meetings with the exception of PMRT reviews.

The change in the requirement for MNVP to be a quorate member at PMRT reviews has raised some concerns and challenges to Trusts nationally. In response to the concerns raised, NHS Resolution (NHSR) held a webinar to clarify the MIS year 7 position with Trusts. During the webinar, NHSR were explicit that a functioning MNVP would have a strategic lead in post who would be trained and supported to attend PMRT. Trusts were advised if this was not possible with the current MNVP then Trusts must deem their MNVP as not functioning in line with national guidance. To achieve compliance with MIS, Trusts who deem their MNVP to not be operating within national guidance are expected to escalate this to Trust Board and the LMNS.

At WHH the infrastructure is currently not in place to provide the MNVP with training and other support to facilitate attendance at PMRT meetings. Accordingly, and in line with the guidance provided by NHSR, the service will be deeming the WHH MNVP as not currently functioning in line with national guidance. This will be shared to Board as part of the next quarterly overview. The position will also be shared with the LMNS. WHH are not alone in facing this challenge, it has been confirmed by NHSR, for the purposes of

MIS compliance, the process of escalating to Board will ensure the service meets the standard for safety action 7.

Work is underway to develop the necessary infrastructure to facilitate MNVP attendance at PMRT reviews. This is an agenda item for the Q2 LMNS meeting in September where the service will work with the MNVP to explore ways to implement the training and support required.

Despite not meeting the specific requirement regarding PMRT meetings, it should be noted this does not detract from the positive collaboration work the service has in progress with the MNVP.

2.9 Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi-professional training?

The maternity service consistently achieves this standard.

2.10 Safety Action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Engagement regarding quality and safety issues has continued throughout August 2025. In line with the requirements of MIS, the quadrumvirate have met with the non-executive director Maternity Safety Champion and MNVP leads to discuss the service. Further meetings are scheduled for the remainder of the year.

The Director of Midwifery also attends quarterly to Trust Board to provide an overview of the maternity service and to highlight areas of risk.

3. MONITORING/REPORTING ROUTES

Progress with SBLCBv3 and MIS Year 7 is shared and discussed at CBU Governance meetings.

The content of this report will be shared at Women's Health Governance in September 2025.

4. RECOMMENDATIONS

Trust Board is requested to note the report as part of the MIS recommendations.

Particular note should be made of the position with regard to Safety Action 7 and involvement of the MNVP in PMRT reviews.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/10/104iv**	
SUBJECT:	**Maternity & Neonatal Quality Review – July 2025**	
DATE OF MEETING:	1 October 2025	
AUTHOR(S):	Ailsa Gaskill-Jones - Director of Midwifery	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse	
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	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):		

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: The paper relates to care of pregnant people/those on the pregnancy continuum and provides oversight of matters related to Maternity and Neonatal Care focussing attention on improving outcomes for this protected group.

2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	Yes	No	N/A
	✓		

Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum and provides oversight of matters related to Maternity and Neonatal Care focussing attention on improving outcomes for this protected group.

3. Foster good relations between people who share a protected characteristic and those who do not	Yes	No	N/A
			✓

Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum and provides oversight of matters related to Maternity and Neonatal Care

	focussing attention on improving outcomes for this protected group.
EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper provides an update in relation to Maternity and Neonatal quality and provides Trust Board with oversight of key matters to provide assurance to the Board of Directors on Maternity and Neonatal safety and quality issues. This information will be reported monthly to Quality Assurance Committee and then to the Trust Board of Directors on a quarterly basis. In particular: • Harm Incidents • Workforce Metrics including training compliance • Service user feedback • Staff feedback • Maternity & Neonatal Safety Investigations (MNSI) update • Complaints • Coroner Regulation 28 position In July 2025 there were no fatal or severe harm events in the maternity or neonatal services. There were three moderate harm events, all cases of 3rd/4th degree tear (OASI). Themes from Maternity/Neonatology patient safety events in July 2025 are as follows: • Admission of term babies admitted to Neonatal Unit (NNU) • Postpartum Haemorrhage (PPH) 1000ml-1500ml • Postpartum Haemorrhage (PPH) >1500ml At the end of July mandatory training compliance and role specific training across maternity and child health colleagues is above 85%. Compliance with PDR completion is a challenge with a position of 78.41%. This is however an improvement from June 2025, a trajectory is in place to achieve full compliance by end of September 2025.This is being monitored weekly. Good compliance with maternity specific training standards can be noted with an improvement following a slight deterioration in position reported to Trust Board in June 2025.

	Turnover for maternity and child health staff is below the Trust target. The vacancy rate for maternity and child health staff remains positive and is significantly below the Trust target. The service continues to share good practice and compliments with the team. Examples of how this is celebrated and shared across the team are included in appendices one and two for information. The service continues to achieve its KPIs for Maternity Triage. Work is ongoing with regard to induction of labour (IOL) pathways with some progress now being seen particularly with regard to delays in IOL and inappropriate IOL. An overview of the sevice's position with regard to cases being investigated by MNSI is provided for oversight. An update regarding three ongoing workstreams commissioned following learning from patient safety events is included for information. Specifically: • Hypertension Working Group • Q1 2025/26 Cluster review of postnatal readmissions • Cluster review of patient safety events relating to infant feeding Four complaints were received in the Maternity and Neonatal Services in July 2025. No Regulation 28 enquiries have been received.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the content of this paper.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/25/09/143iii**	
	Date of meeting	9 September 2025	
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	Maternity & Neonatal Quality Review – July 2025	AGENDA REF:	BM/25/10/104iv

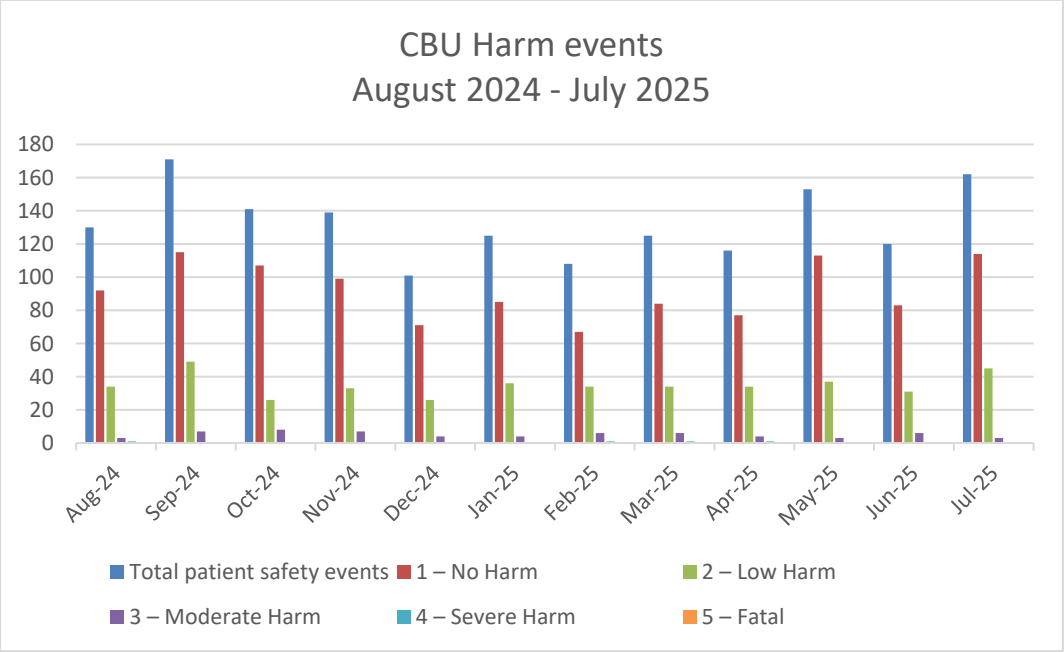
1. BACKGROUND/CONTEXT

This paper provides an update in relation to Maternity and Neonatal quality including relevant data and metrics for the month July 2025.

The paper provides Trust Boardf with oversight of the WHH position in relation to key national safety and quality issues and in line with the requirements of Safety Action 9 within the Maternity Incentive Scheme Year 7 *(Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?)* alongside emerging local and regional matters.

2. HARM EVENTS

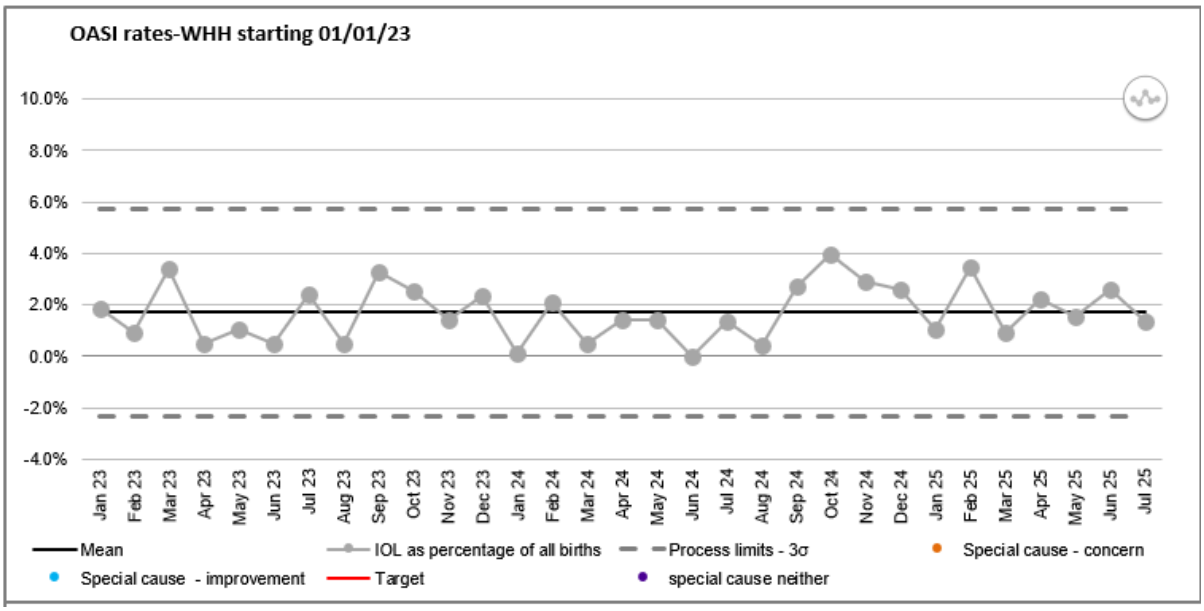
Below shows a breakdown of events reported and investigations declared across the Women's & Children's CBU for the period August 2024 - July 2025:



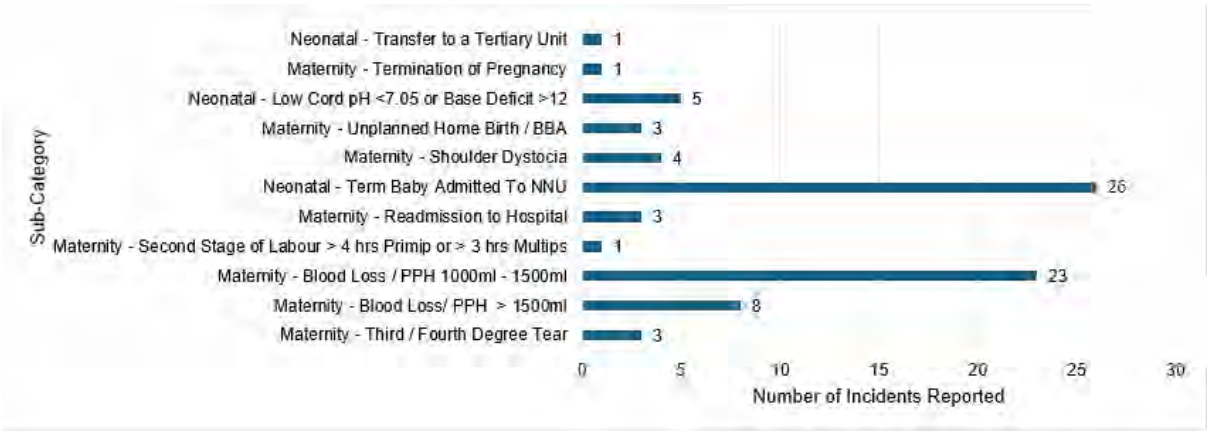
There were 162 patient safety events reported across the CBU in July 2025.

There were no fatal or severe harm events in July 2025 in the maternity or neonatal services. There were three moderate harm events, all cases of 3rd/4th degree tear (OASI). These cases were reviewed by the maternity MDT through Intrapartum Review Group (IRG).

Work continues to reduce rates of OASI (3rd and 4th degree tears) following an increase in cases in February 2025.



Themes from Maternity/Neonatology patient safety events in July 2025 are detailed below:

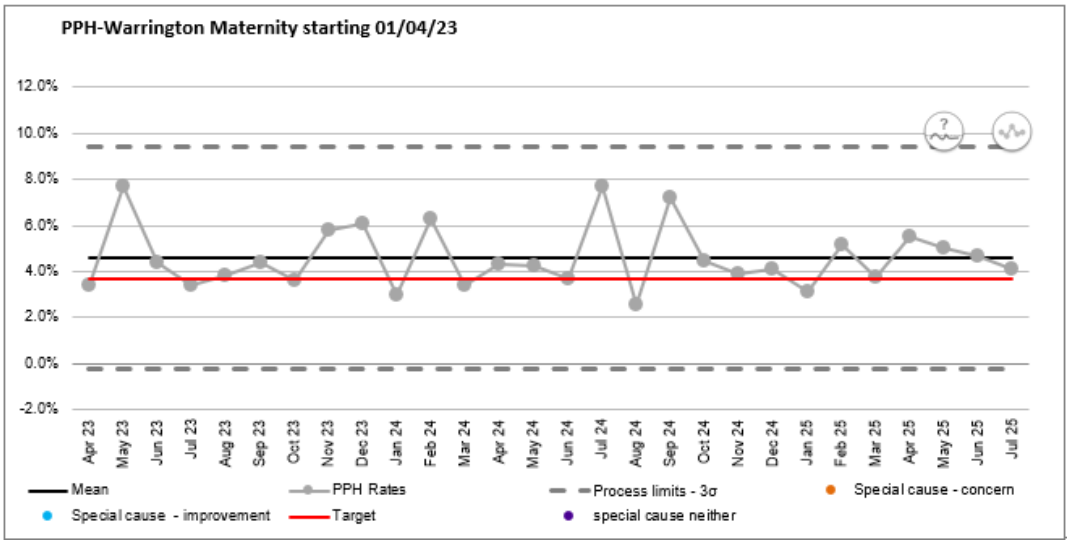


Top three themes from Maternity/Neonatology patient safety events in July 2025 were:

- Admission of term babies admitted to Neonatal Unit (NNU)
- Postpartum Haemorrhage (PPH) 1000ml-1500ml
- Postpartum Haemorrhage (PPH) >1500ml

26 term babies were admitted to the Neonatal Unit (NNU) in July 2025. All cases of term admission are reviewed via ATAIN which reports quarterly to QAC and Trust Board.

There were 23 cases of PPH 1000ml-1500ml. This is an increase in cases from June 2025. All cases of PPH 1000ml-1500ml are reviewed and learning shared. There were 8 cases of PPH ≥1500mls in July. The SPC chart for PPH ≥1500mls to end of July continues to show common cause variation but with a sustained reduction since April 2025.



3. WORKFORCE METRICS & MEASURES

Work remains ongoing across the Maternity and Neonatal teams to sustain compliance with mandatory training and completion of staff appraisals.

At the end of July compliance for mandatory training across maternity and child health colleagues is 91.21% for Trust mandatory training (including safeguarding training) and 90.69% for role specific training (both above the Trust target). This excludes staff who are currently absent from work on a long-term basis.

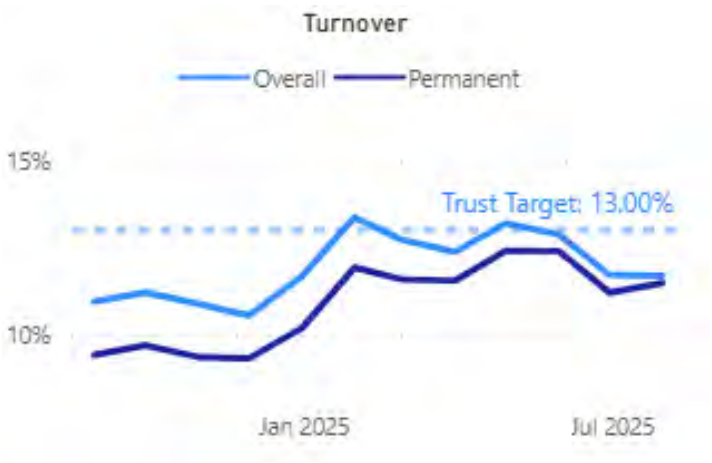
Compliance with PDR completion is a challenge with a position of 78.41%. This is an improvement from June 2025, a trajectory is in place to achieve full compliance by end of September 2025. This is being monitored weekly.

Good compliance with maternity specific training standards is largely being sustained with further improvement noted following a slight deterioration in position reported to QAC in June 2025. Escalation processes have been enacted for those obstetric colleagues not compliant with K2 (fetal surveillance competencies).

Current position – Training compliance - maternity specific

	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)	Newborn Life Support Level 2
Midwives	96.9%	98.4%	97.6%	95.3%
Obstetric Consultants	91.6%	100%	100%	n/a
Other Obstetric	100%	92.3%	84.6%*	n/a
Obs Anaesthetic	96.6%	n/a		n/a
Maternity Support Workers	100%	n/a		n/a
Neonatal medical and ANNP	n/a	n/a	n/a	Awaiting Data

Turnover for maternity and child health staff (permanent staff) in July 2025 is 11.47%, below the Trust target. This is illustrated in the graph below:



The vacancy rate for maternity and child health staff remains positive and is significantly below the Trust target at 2.21%. This is illustrated in the graph below:

4. SERVICE USER AND STAFF FEEDBACK

The service continues to share good practice and compliments with the team. A 'Thank You Thursday' initiative has been established where positive feedback and achievements are celebrated and shared across the team via a bimonthly newsletter.

Thank you Thursdays for the months of May and July 2025 are included in appendices one and two for information.

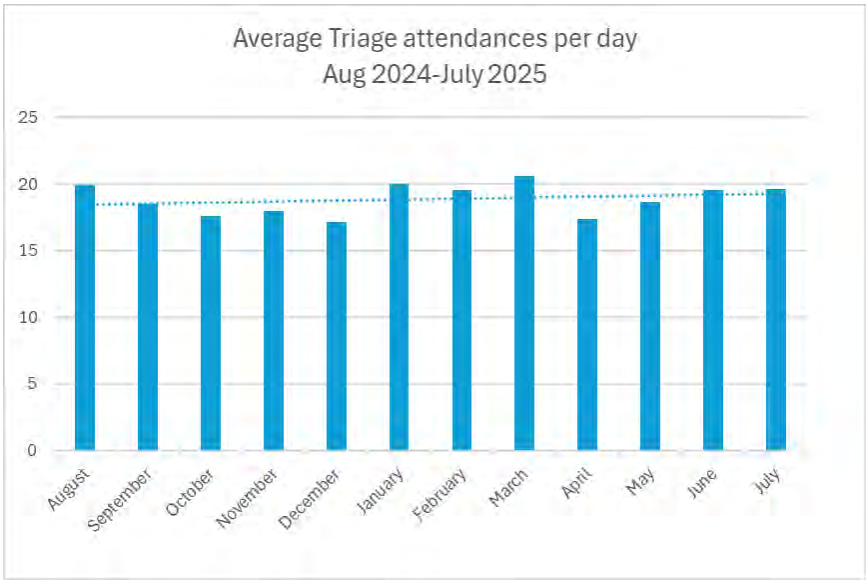
5. MATERNITY TRIAGE

The Maternity Triage service is included within this paper in light of significant regional and national scrutiny of triage services.

Current performance

In July 2025 608 triage attendances were recorded on the BadgerNet patient record system maintaining the average number of attendances per day of 19 seen since the beginning of 2025.

Triage attendances August 2024-July 2025	
Month	**Attendances**
August	618
September	556
October	545
November	539
December	531
January	621
February	547
March	638
April	521
May	577
June	587
July	602



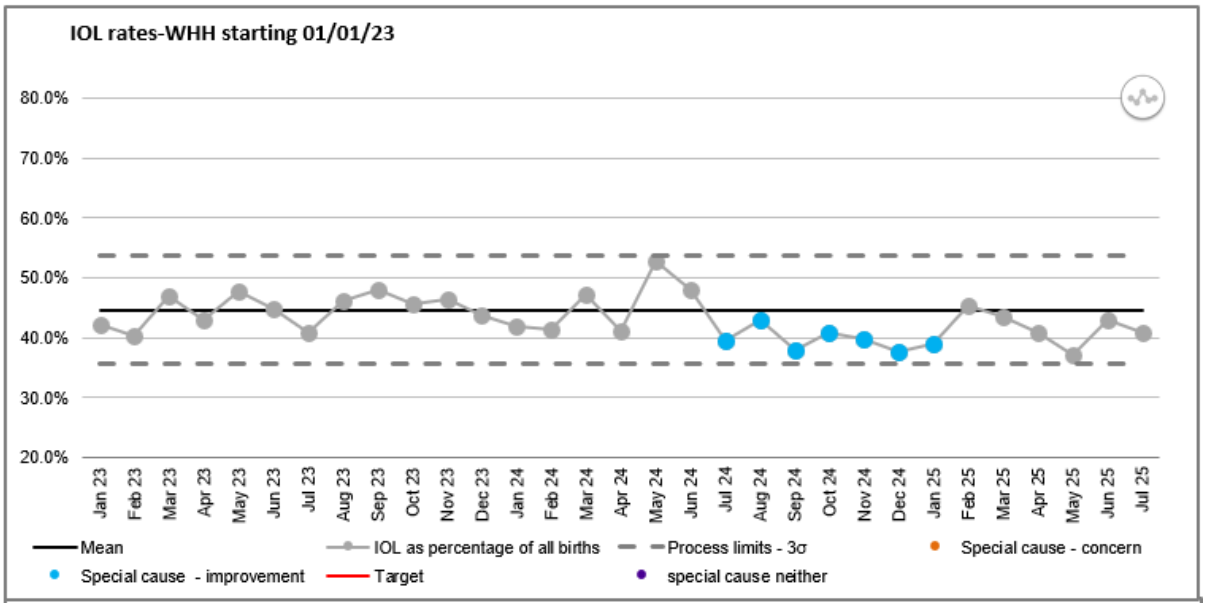
- 25.4% of attendees in July were seen immediately on arrival.
- The longest wait recorded for initial review was 46 minutes.
- 96.2% of attenders were seen within 15 minutes of arrival (best practice guidance). This is beyond the KPI of 90% review within 15 minutes.
- 99.34% of attenders were seen within less than 30 minutes of arrival (NICE guidance). Again, this is beyond the KPI which stipulates 95% review within 30 minutes.
- 0.3% of attendees (two women) were categorised as red on arrival. All were seen within 15 minutes of arrival for initial triage.

- 20.2% of attendees were categorised orange on arrival. This is a slightly smaller proportion compared to May and June 2025 but maintains the increase seen when compared to April 2025 when the proportion was 18.2%.

6. INDUCTION OF LABOUR (IOL)

Quality Assurance Committee will be aware the service was identified as an outlier during 2024 within the LMNS with regard to the timeliness of induction of labour processes. As a result, a significant IOL workstream is underway.

As part of this, the service monitors overarching rates of IOL as high rates will contribute to capacity and flow. The SPC chart below shows monthly IOL rates at WHH from January 2023 to July 2025, presented as a percentage of all births. The service's aim is to reduce this rate.



In July, the WHH IOL rate was 40.74%, a reduction from June's rate of 43%.

Inappropriate inductions (IOL) were initially recorded at 6.9%, however following patient discussions three IOL were rebooked at an appropriate gestation, this reduced the inappropriate IOL rate to 2.7%. This reflects continued progress, in June 2025 inappropriate IOLs were 4.1%, in May 6.5%, and in April 14%.

The monthly audit will continue to monitor appropriateness of bookings and to ensure that improvements are sustained. The IOL Bleepholder role, introduced on 7th July, has received positive informal feedback from both midwives and obstetric teams. Having a central point of oversight is supporting clearer planning, better communication, and a more consistent approach to managing the pathway.

From 1st September, dedicated outpatient IOL slots will be available on Badger Notes. This change will ensure those birthing at WHH are aware of their outpatient pathway from the point of booking, supporting improved planning and communication.

Work is also continuing with the communications team to develop patient information videos. These resources will reflect current evidence and include tailored content for women who decline IOL at 41/40, and for those who request IOL prior to 39/40.

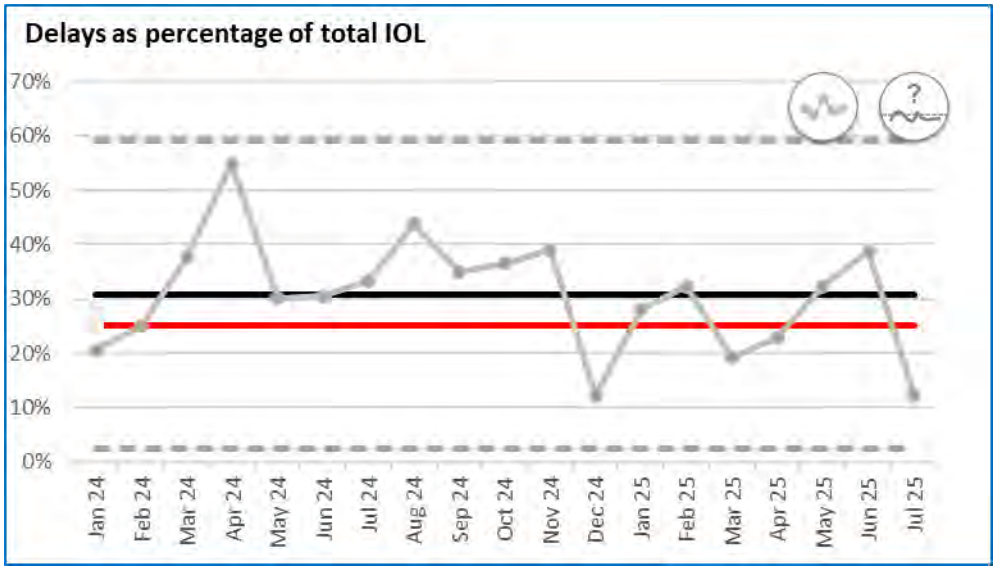
Multilingual staff are being identified to support delivery of video content in a range of languages, improving accessibility for all service users.

Work to reduce delays in IOL is ongoing. The service has a target to achieve sustained reduction in delays to around 25%. July 2025 saw a significant improvement in delays with only 12.28% of IOLs experiencing a delay. In June 2025 this figure was 38.71%. furthermore, there were no delays >24 hours in July 2025.

The data below reports the **total number undergoing IOL** and the **total number and percentage delayed by Provider** from **1st to 31st July 2025.**

	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total
Total number undergoing Induction of Labour	23	98	88	55	125	57	83	529
Total Delayed	4	5	17	1	23	7	53	110
% of Total	17.39%	5.10%	19.32%	1.82%	18.40%	12.28%	63.86%	20.79%

The position with regard to delay in IOL is being monitored via a SPC chart.



Delays in induction are included on the CBU risk register with a current rating of 16.

7. MNSI POSITION AND REPORTS RECEIVED

7.1 Background

To ensure Trust Board has oversight of the sevice's position with regard to cases being investigated by MNSI an update is provided each month.

7.2 Current position

For the period September 2024 – August 2025, MNSI have accepted four maternity related cases for investigation. One case relates to a patient safety events which occurred in 2024.

Position as at 31/7/2025 is as follows:

Incident Date	MNSI No.	Criteria	Status	Draft Report Received	Final Report Received	SOM Sign-off	QAC
25/11/2024	MI-039124	HIE/Cooling	Complete	08/04/2025	01/05/2025	02/06/2025	10/06/2025
28/04/2025	MI-041711	HIE/Cooling	In progress	Awaiting	Awaiting		
6/4/2025	MI-041411	Maternal death	In progress	Awaiting	Awaiting		
2/8/2025	MI-045085	HIE/Cooling	In progress	Awaiting	Awaiting		

The case referred in August 2025 relates to birth impacted by shoulder dystocia. In this case the baby was born in poor condition and transferred to a tertiary unit for cooling. An initial safety review did not identify any immediate learning. The investigation via MNSI is underway.

8. UPDATE RE OTHER WORKSTREAMS

8.1 Hypertension Working Group

The Hypertension Working Group has been reestablished following a number of avoidable postnatal readmissions due to hypertension. The next meeting will take place in early September.

The Q1 2025/26 postnatal readmissions audit noted three of the ten readmissions were due to hypertension of which two were deemed avoidable as care had not been provided as per the Trust guideline. Learning from the Q1 audit will feed into the action plan for the working group.

Current activity includes:

- Confirmation of regional guideline for pre-eclampsia and gestational hypertension
- Plan to develop discharge checklist with labour ward lead for women with known hypertension antenatally or in labour

- Education around the importance of regular BP monitoring shared with maternity ward team (minimum of 4 hourly monitoring throughout inpatient stay)
- Review of BadgerNet system and early warning score undertaken by digital midwife and maternity ward manager.
- Education shared with maternity ward team in relation to ‘red/yellow’ scoring and appropriate escalation and monitoring
- Awaiting roll out of national MEWS2 tool (was planned March 2025)
- Deep dive to be completed to ascertain how many of those the service provides care for have a hypertensive disorder. This will help to identify if the majority of patients are being managed appropriately.
- Review information provided to both internal and external providers e.g. discharge paperwork.

8.2 Q1 2025/26 Cluster review of postnatal readmissions

The Q1 cluster review of postnatal readmissions has been completed. For the period 1 April 2025 to the 30th June 2025, 10 patients were readmitted to the maternity unit following 571 births. This provides a readmission rate of 1.75%. This is a decrease of 0.9% from Q4.

Of the 10 patients readmitted, 8 were deemed unavoidable (80%) and 2 were deemed avoidable (20%). This is a 6.7% decrease in avoidable admissions from Q4.

There was one readmission for a wound related reason which was unavoidable, this equates to 10% of the re-admissions relating to wounds which is a decrease of 1.76% in Q4.

There were no consistent unavoidable themes within the cluster review, reasons for re-admission included Hypertension 10% (N=1), Bleeding 20% (N=2), Generally Unwell 20% (N=2) and Mastitis 20% (N=2).

Hypertension was marginally the main theme for Q1 with 30% (N=3) due to hypertension.

Overall postnatal readmissions continue to decline. The Q2 cluster review will report to QAC in December 2025.

8.3 Cluster review of patient safety events relating to infant feeding

Trust Board will be aware a patient safety theme related to infant feeding was reported to July QAC and Trust Board. Patient safety data for May 2025 noted six patient safety cases categorised as “Neonatal – infant feeding concern”. This appeared to be a new theme but was the result of changes within the Datix system to better capture patient safety events relating to infant feeding.

Of the six cases, four related to babies who had experienced >10% weight loss whilst under the care of community midwifery services. As a result, a cluster review of the cases was completed to identify themes and to ensure all learning was captured. No new themes were identified from this review albeit a new process has been introduced where all women not scheduled a community visit on day 3 of the post-natal period are contacted by the community midwifery team by telephone to discuss infant feeding. This ensures early identification of feeding issues and thus prevent excessive weight losses at the day 5 weight review.

9. COMPLAINTS

Four complaints were received relating to care in the maternity and neonatal services in July 2025.

ID	Specialty	Description	Complaint Received in the Trust
24663	Maternity	Concerns relate to the care provided by the Midwifery team and the conflicting advice given	04/07/2025
24673	Maternity	Patient has multiple concerns relating to the coordination of care, alleged delay in diagnosis of preeclampsia, poor nursing care, and poor staff behaviour.	03/07/2025
24726	Maternity	Concerns relate to the lack of communication regarding waters being broken. Patient was allegedly not asked for consent prior to this.	14/07/2025
24871	Maternity	Patient has multiple concerns relating to the coordination of her care, mismanagement of a bacterial infection, and lack of thromboprophylaxis at 28 weeks pregnancy.	29/07/2025

10. CORONER REGULATION 28 ENQUIRIES

No Regulation 28 enquiries have been received.

11. RECOMMENDATIONS

Members of the Trust Board are requested to noter the findings of this paper for information.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/10/104iii**	
SUBJECT:	**Quarter 1 2025/26 Transitional Care (TC) Report**	
DATE OF MEETING:	1 October 2025	
AUTHOR(S):	Ailsa Gaskill-Jones - Director of Midwifery Kath Watkins – Lead Nurse Women's and Children's CBU Erica Wiles – Neonatal Matron	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse	
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	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):		

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: The paper relates to care of pregnant people/those on the pregnancy continuum. Achieving positive outcomes with regard to Transitional Care will have a positive impact on this group.

	Yes	No	*N/A*
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	✓		

Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum. Achieving positive outcomes with regard to Transitional Care will have a positive impact on this group.

	Yes	No	N/A
3. Foster good relations between people who share a protected characteristic and those who do not			✓

Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum. Achieving positive outcomes with regard to Transitional Care will have a positive impact on this group.

<table>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td colspan="4">The paper provides an overview of babies who required Transitional Care (TC) in the period April – June 2025. An audit of babies who received TC within Q1 2025-26 has been undertaken and results of this will be described within this paper along with any identified learning.

Following the CQC inspection of Maternity Services at WHH in September 2023, a full review of the current Transitional Care (TC) Model has taken place. A multidisciplinary (MDT) Working Group was created with representatives from both Maternity and Neonatal Services.

The Q1 Transitional Care audit has identified the following:
57 babies who met the broad admission criteria for TC in Q1.
One baby received TC from birth, one baby received TC from admission.
The majority of babies required some level of respiratory support and were initially provided with care via NNU.
The audit has identified learning, action to resolve have been added to the TC action plan. This is included in appendix one for information.
The action plan is monitored via Women’s & Children’s Governance (WCH) and the Neonatal Oversight Meeting.</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td></td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="4">The Trust Board is asked to note the content of this paper.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="3">Quality Assurance Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="3">QAC/25/09/143iv</td></tr>
<tr><td>Date of meeting</td><td colspan="3">9 September 2025</td></tr>
<tr><td>Summary of Outcome</td><td colspan="3"></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="4">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="4">None</td></tr>
</table>

REPORT TO TRUST BOARD

SUBJECT	Quarter 1 2025/26 Transitional Care (TC) Report	AGENDA REF:	BM/25/10/104iii

1. BACKGROUND/CONTEXT

"Neonatal transitional care (NTC) is additional to normal care, provided in a postnatal clinical environment by the mother or an alternative resident carer, supported by appropriately trained healthcare professionals" (BAPM 2017).

Transitional Care (TC) is embedded in the Maternity Incentive Scheme, Year 7, Safety Action 3. Transitional Care is not always a physical location but a pathway involving more frequent observations and coordinated care between the Neonatal and Midwifery Team. TC is for babies who need a little more nursing care and monitoring and is provided by the team on the Neonatal Unit (NNU), Birth Suite and maternity ward.

The aim of TC is to keep parents and babies together in a neonatal transitional care setting and to support the resident birthing parent as primary care provider for their babies more than normal newborn care. The pathway provides additional support for small and/or late preterm babies and their families to facilitate a smooth transition to discharge baby home and prevent neonatal admission.

Following the CQC inspection of Maternity Services at WHH in September 2023, a review of the current transitional care model has taken place, from this a working group was created and a robust action plan developed. Alongside this, an audit of babies who were eligible for TC in Q1 2025/26 has been undertaken and results of this are described within this paper.

2. KEY ELEMENTS

2.1 WHH Transitional Care Position

The findings of this report have been collated from a review of all babies who met the criteria for TC during the Q1 reporting period from 1st April to 30th June.

Each case has been reviewed utilising the BadgerNet and Lorenzo database system, term infants admitted to NNU are reviewed at the ATAIN review meetings and discussed whether TC availability could have avoided the admission to NNU.
Any learning is identified and shared in a timely manner.

WHH Transitional Care Criteria

- Gestational Age 34+0 to 35+6 weeks
- Birth Weight of >1.6kg to <2.0kg

Any baby requiring one or more of the following:

- Infants requiring IV antibiotics with clinical evidence/biochemical parameters of infection.
- Additional support with feeding via nasogastric tube
- Haemolytic disease requiring phototherapy and assessment of serum bilirubin 4-6 hourly.
- Infants with Neonatal Abstinence Syndrome requiring medication on a weaning regime and on regular observations (4 hourly or more frequently)
- Babies requiring observations more frequently than four hourly.
- Management of hypoglycaemia to be controlled with a minimum of two hourly feeding

2.2 Summary of Babies who met the Transitional Care Criteria

During Q1, 57 babies met the criteria for TC. An audit of these cases has identified the following:

Received Neonatal care from admission	2
Appropriately received NNU care and stepped down to TC when well enough	5
Allocated to PEEP for 30 pathway	2
Mothers discharged within 72 hours of birth	3
Did not receive TC	11
Receiving IV antibiotics on the postnatal ward	34

Quarter 1 Transitional Care (TC) Activity Summary

- A total of **57 babies** met the criteria for Transitional Care (TC) in Q1.
- Of these:
    - **One baby**, repatriated from Bangor, received TC care continuously from admission for 3 days.
    - **One baby** received TC care from birth.
    - **Five babies** were potential candidates for TC at birth; however, due to high patient acuity and staff sickness on the Neonatal Unit (NNU), TC staffing was not possible.
    - **Three babies** were suitable for step-down to TC, but their mothers were discharged home within 24 hours, limiting TC provision.
    - **Three babies** who stepped down from the NNU to TC were cared for under midwifery-led TC. These infants were late preterms requiring feeding support only. This arrangement helped reduce acuity on the NNU and prevented unit closure.

The other babies who met the broad TC criteria in Q1 required some level of respiratory support and were initially provided with care via NNU. Of these:

- None of these babies were stepped down to TC when clinically indicated due to staffing challenges on the NNU.
- Two babies did not meet the TC criteria once medically fit for discharge from NNU.
- Two babies followed the PEEP for 30 pathway. One of these babies was cared for by the maternity team. One was discharged to TC however was readmitted to NNU due to poor feeding, this baby should have remained on TC.

Reasons for admission to the NNU are highlighted in the table below.

	Reason baby admitted to NNU	Actions to reduce occurrence
1	Babies requiring respiratory support	• Repeat audit to be undertaken to review length of time baby required respiratory support
3	Staffing	• Review staffing

2.3 TC staffing model

To provide a TC service a designated staffing model is required. A benchmarking exercise has been completed with neonatal services within our locality. Of these, two units do not currently provide TC due to lack of staff. Two units allocate a band 5 staff nurse each shift to provide TC on their postnatal ward. Creation of a similar model at WHH has been costed and would require recurrent financial investment of £270,302 per annum.

There is a QI project registered to review the staffing model and there may be an option to utilise some staff from the existing establishment to meet the TC staffing requirement. This will be reviewed as part of the QI project.

Implementation of Transitional Care Shift on Neonatal Unit Roster

Starting **7th July 2025**, a dedicated **Transitional Care shift** has been incorporated into the NNU's staffing roster. This new shift allows for the consistent allocation of a specialised TC nurse during each shift.

The introduction of the TC shift will also facilitate ongoing auditing of staffing compliance by tracking instances when the shift is either cancelled or covered by external staff from the NHS Professionals (NHSP) bank. This monitoring aims to identify staffing gaps and evaluate the impact on transitional care quality and patient outcomes.

2.4 Quality improvement project

To support the ongoing improvement of the transitional care service, a Quality Improvement project titled **"Neonatal Transitional Care: Focus on Staffing and Safety"** has been formally registered with the Quality Improvement Team at **WHH**.

2.5 Good Practice from the Q1 2025/26 audit:

- Excellent neonatal care for babies, thus ensuring safety of babies who have been separated from their mothers.
- Excellent communication between neonatal and maternity teams on the postnatal ward, which allowed for babies to return to TC under midwifery care.
- Sharing of audit outcomes across the MDT with both Midwifery and Neonatal Teams to ensure learning is communicated.
- Significant improvements in relation to the timely step down of these babies to TC
- Unavailability of TC reviewed at operational Review Group to ensure senior oversight and review

2.6 Recommendations:

- Risk assessment to be implemented when unable to facilitate TC.
- Utilise TC to reduce term admissions.
- Staffing – Continue to ensure neonatal staff are allocated to TC babies. TC shift added to roster to allow allocation and audit when shift sent to NHSP or staff member required on NNU.
- To continue TC education with Neonatal and maternity teams following ratification of updated guideline.
- TC review group to continue to review and discuss cases and monitor actions/progress against the action plan.

2.7 Outstanding actions from action plan

- Ongoing TC audit which will be reported through this committee.
- Review of IV policy required to enable midwifery staff to undertake IV antibiotics on babies, pharmacy input required.
- TC/enhanced care bay to be created on C23

3. EXTERNAL ASSURANCE

Progress in relation to TC is included in Maternity Incentive Scheme, Year 7, Safety Action 3 (SA3).

Quarterly meetings are scheduled with the LMNS to discuss progress against all aspects of MIS year 7, this will include SA3. Feedback from these meetings will be shared with QAC and Trust Board.

4. MONITORING/REPORTING ROUTES

The TC action plan is monitored at both the Women's and Children's Clinical Business Unit Governance Meeting and Neonatal Oversight meeting which take place monthly, prior to reporting to the Quality Assurance Committee and Trust Board. This report will be shared at both meetings.

5. RECOMMENDATIONS

Members of the Trust Board are requested to receive and discuss the findings of this paper for information.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/10/105**			
SUBJECT:	**Communications and Engagement Update (bi monthly) July to August 2025**			
DATE OF MEETING:	1 October 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):				
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 July to August 2025. The report covers a two-month period 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. Key highlights from the report include: • **Communications Activity:** The Communications and Engagement Team managed 28 job requests, issued			

<table>
<tr><td></td><td colspan="3">multiple media releases, and published 9 stories across various Trust websites during July and August 2025
• Campaigns: Key campaigns included the 'See it. Report it. Stop it' anti-bullying initiative
• Training: The team developed online EHIA training with bi-monthly awareness sessions on public consultation planned into the schedule from September 2025 onwards
• Community engagement: WHH actively participated in Disability Awareness Day and Warrington Mela, promoting cultural inclusion and community involvement with staff and governors
• Better Care Together: BCT programme updates shared included shared values survey, organisational change framework, plus microsite updates and support for monthly staff engagement sessions
• Accessibility and inclusion: Efforts to improve accessibility resulted in improved website accessibility scores and the team is now incorporating health literacy checks on patient leaflets as business as usual

The report also includes details of engagement events which the Trust is hosting or planning to attend during 2026</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">The Trust Board is asked to note the contents of this update on Communications and Engagement activity during the quarter.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">n/a</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="2"></td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="2">To note</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="3">None</td></tr>
</table>

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Communications and engagement update

Bi-monthly report (July to August 2025)

Trust Board meeting

1 October 2025

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 (July to August 2025) the Communications and Engagement Team…

- processed and allocated **28** communications 'job requests' for design, film, photography and communications campaign support
- issued **4** Trust media releases (plus **1** WHH Charity media release)
- published **9** stories across our main Trust website, charity website and breast screening services website
- prepared / issued **4** media statements
- handled **8** enquiries from local, regional and national print and broadcast media

July / August activity and achievements overview

- Launched the ‘See it. Report it. Stop it’ campaign alongside the Culture, Inclusion and Engagement Team (see slide 10)
- Promoted new resources around anti-bullying and harassment to support staff to discuss, react and access support related to bullying and harassment in the workplace
- Developed WHH’s online EHIA training module and scheduled bi-monthly ‘Engagement, involvement and public consultation in service change’ (see slide 11)
- Attended DAD 2025 and Warrington Mela with staff teams and governors
- Supported a staff CQC information session to prepare for any CQC assessment under the Single Assessment Framework
- Continued to develop and improve accessibility of the Trust website, with our Trust site and Breast Screening Service site now both rated ‘Great’ with accessibility scores of 96% and 93% respectively on the Silktide Accessibility checker
- Promoted the launch of two charity-funded bespoke multi-faith cabinets
- Supported the launch of the new WHH Charity website (see slide 12)

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

Media

Media releases issued during July and August 2025, including:

Living Well Warrington programme shortlisted for 2025 HSJ Awards

Read the release

Warrington and Halton Teaching Hospitals appointment letters are going digital

Read the release

New dental CT scanner helps patients at Warrington and Halton Teaching Hospitals receive quicker diagnosis

Read the release

Resident doctor industrial action - 25 to 30 July

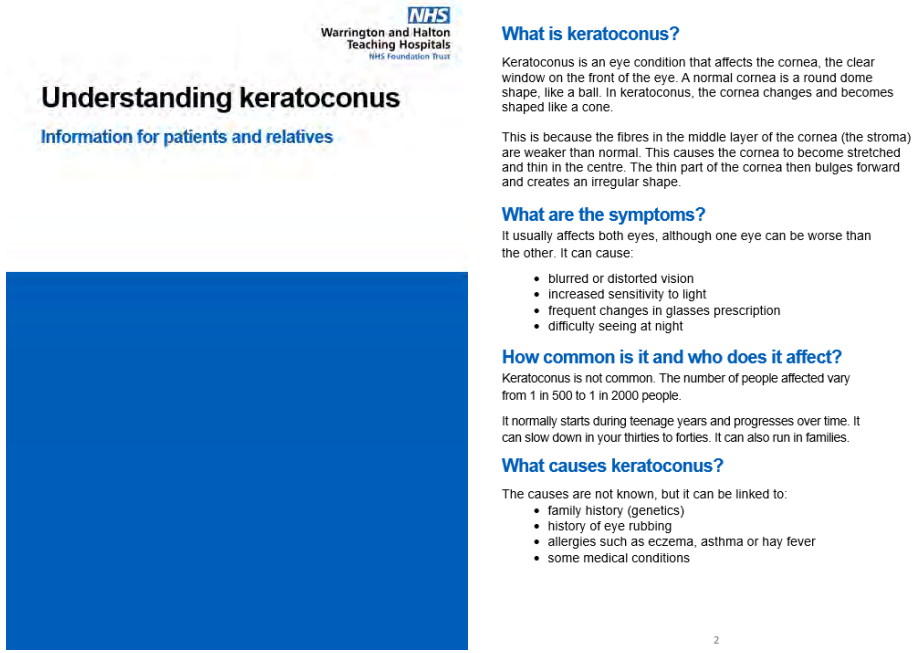
Read the release

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

Production of Patient Information (PINFO)

From July to August the Communications and Engagement Team:

- Supported clinical teams in putting **6** new leaflets through the PINFO process
- Reviewed and edited **12** existing leaflets to ensure content remains clinically appropriate and reflects WHH style guidelines
- Identified a total of **175** expired leaflets as a large number of leaflets expired in July and August
- Archived **23** leaflets no longer being required by services
- Introduced health literacy checks for reading age as part of review of new and existing leaflets



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Understanding keratoconus

Information for patients and relatives

What is keratoconus?

Keratoconus is an eye condition that affects the cornea, the clear window on the front of the eye. A normal cornea is a round dome shape, like a ball. In keratoconus, the cornea changes and becomes shaped like a cone.

This is because the fibres in the middle layer of the cornea (the stroma) are weaker than normal. This causes the cornea to become stretched and thin in the centre. The thin part of the cornea then bulges forward and creates an irregular shape.

What are the symptoms?

It usually affects both eyes, although one eye can be worse than the other. It can cause:

- blurred or distorted vision
- increased sensitivity to light
- frequent changes in glasses prescription
- difficulty seeing at night

How common is it and who does it affect?

Keratoconus is not common. The number of people affected vary from 1 in 500 to 1 in 2000 people.

It normally starts during teenage years and progresses over time. It can slow down in your thirties to forties. It can also run in families.

What causes keratoconus?

The causes are not known, but it can be linked to:

- family history (genetics)
- history of eye rubbing
- allergies such as eczema, asthma or hay fever
- some medical conditions

2

Events

Disability Awareness Day 2025

Warrington's annual pan-disability event on Sunday 13 July featured over 250 exhibitors and 18,000 visitors at Walton Hall and Gardens. WHH had representation from services including orthotics, breast screening, pulmonary rehabilitation, Warrington and Halton Maternity and Neonatal Voices Partnership (MNVP) and our public governors.

Warrington Mela 2025

Held on Sunday 31 August the event celebrated cultural inclusion across the borough with demonstrations and dances, including Bollywood performances, Indian classical dances, Ukrainian singing, Chinese lion dancing and giant puppetry.

WHH exhibited at Mela Village with support from our governors and staff from diabetes, breast screening, recruitment / apprenticeships and Macmillan Delamere Centre teams, along with Warrington and Halton MNVP.

Warrington and Halton Teaching Hospitals
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Key campaigns / highlights from July to August 2025

Better Care Together (BCT)

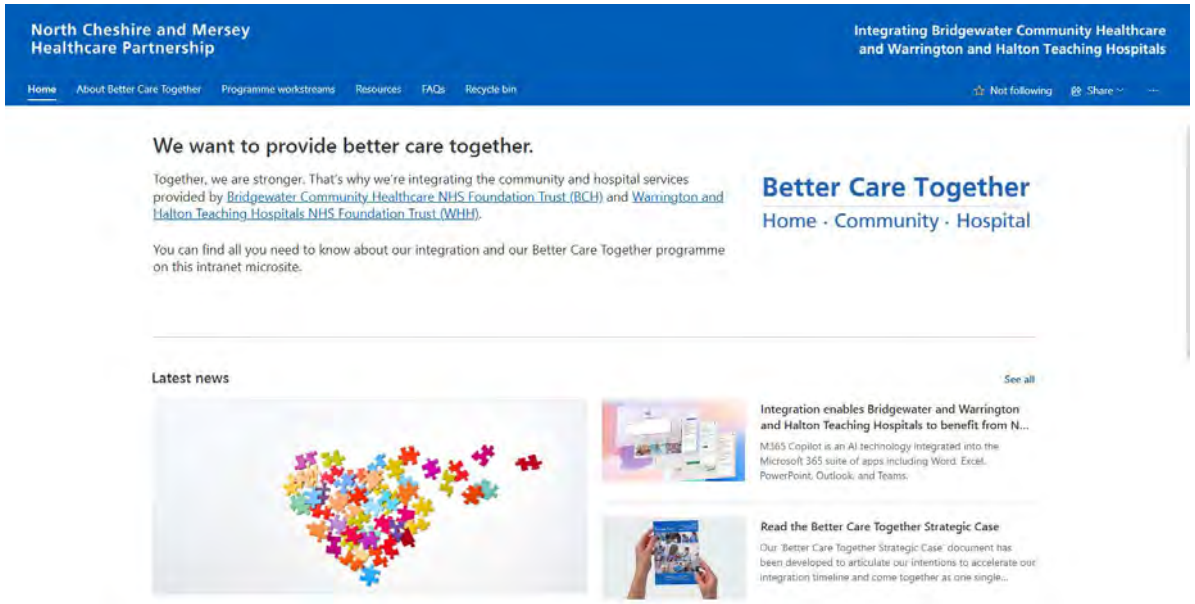
Engagement and communications updates covered during this period included the following topics:

- Developing ‘shared values’ survey
- Organisational Change framework
- Case studies – CoPilot AI and Dermatology AI service
- Accelerated timeline for integration transaction
- 10 Year Health Plan update
- Priority clinical pathways updates
- Launch of joint Culture Plan

Joint channels currently include:

- Joint good morning messages
- Monthly Team Brief continues to meet monthly
- Microsite updates (e.g. FAQs)
- Staff engagement sessions
- Stakeholder brief

We continue to develop joint channels through the Communications and Engagement Delivery Group



Better Care Together (BCT)

The BCT microsite has provided information for staff on the integration programme and proposals, including regularly updated FAQs, operational activity and engagement opportunities.

Microsite activity

- July – 1,803 visits (459 unique)
- August – 2,798 (644 unique)
- The most viewed pages were workstreams and FAQs.

August was the busiest month for microsite traffic, after the launch of the site, which is likely due to the launch of the Organisational Change Framework and sharing of the BCT Strategic Case document.

Monthly joint staff engagement sessions presented by members of our Executive Team have shared regular updates on the BCT programme, as well offering open forums for staff questions / comments.

Engagement session activity

- July – 189 staff
- August – 175 staff

See it. Report it. Stop it.

WHH is committed to a zero-tolerance approach to any form of bullying and harassment in the workplace. However, according to our 2024 Staff Survey:

- 1 in 5 experienced harassment, bullying or abuse from patients or the public (540 staff)
- 16% from other colleagues (389 staff)
- 7.6% from managers (180 staff)

Unfortunately, only **50% of those affected reported it**.

WHH's new 'See it. Report it. Stop it' campaign and **anti-bullying: resource and guide** is designed to support staff to appropriately discuss, react and access support with relation to bullying and harassment in the workplace.

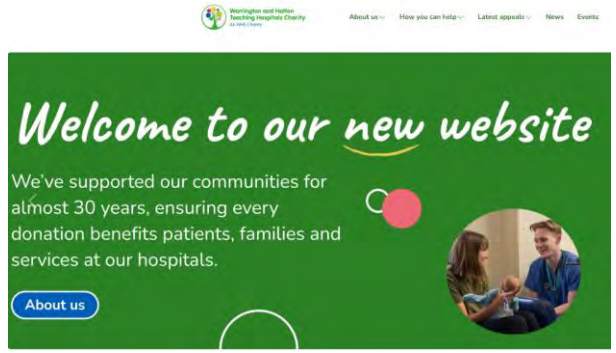
To support the campaign we have promoted new resources and shared intranet news articles, good morning messages plus an intranet banner and screensaver.

WHH Charity

Thursday 10 July saw the launch of the redeveloped WHH Charity website.

The site's redevelopment has involved patients, carers, Experts by Experience, governors and staff, to ensure site design and content was built with accessibility in mind, using lived experience insight.

The new site will enable the charity to build on the support during the past 10 years by promoting volunteering, fundraising and community support opportunities. Further promotion of the site will continue to increase traffic over the coming months.



Website activity

- July – 4,684 visits (507 unique)
- August – 1,227 visits (634 unique)
- The most viewed pages have been news, our impact, events, and volunteer with us

Newsletters

- Charity newsletter - August 2025

Training and awareness raising

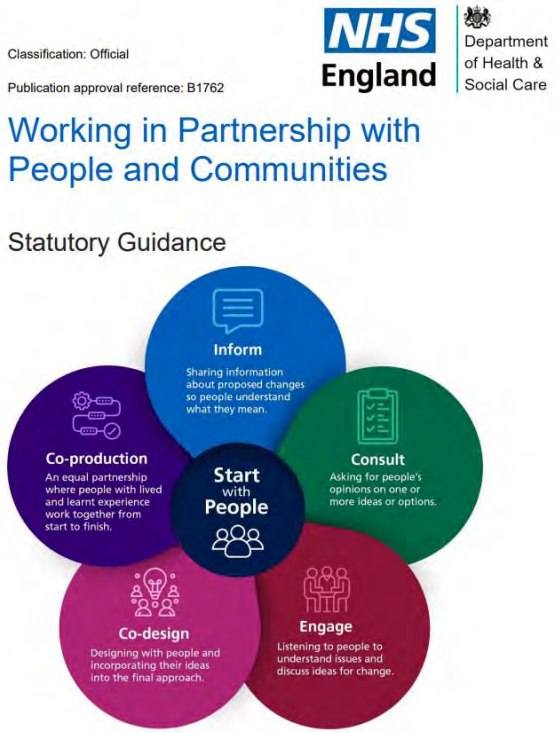
Online training

The Communications and Engagement Team have contributed to WHH's online EHIA training module to include guidance on public engagement and involvement duties and good practice.

Awareness raising sessions

The team are now delivering bi-monthly awareness sessions on 'Engagement, involvement and public consultation in service change' to build awareness of NHS duties and legal requirements for engagement and involvement in the planning and development of service change.

Each session will improve understanding of how to effectively work with people and communities as well as exploring statutory public involvement duties and other key legal considerations.



Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Working with People and Communities Strategy

July to August 2025

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	• 23 Experts by Experience recruited during 25/26 (8 from July to August). • 214 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	• 9 EbyE Projects delivered in 25/26 (plus 3 extended projects – health literacy, site map updates and Runcorn Health and Education Hub). • 2 EbyEs participating in July and August 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 20). • Ongoing involvement with Estates and Strategy teams to ensure substantial strategic, capital or service developments have EbyE involvement / representation e.g. site signage and maps (Wayfinding and First Impressions Task and Finish Group)	• 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 Q3 projects including Better Care Together engagement and workstreams for clinical and operational services integration. • Communications and Engagement support provided to Better Care Together Clinical and Operational Integration workstream and training in development	• 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. • Easy Read version of supplementary information distributed with patient letters is in development will be launched with new North Cheshire and Mersey patient letter template in April 2026	• 2025-26
2. Ensure website compliance with Web Content Accessibility Guidelines (WCAG) standards	• Trust site and Breast Screening Service site now both rated 'Great' with accessibility scores of 96% and 93% respectively on the Silktide Accessibility checker	• Ongoing
3. Accessible content creation	• Work underway to look at a joint Accessible Information and Communication (including health literacy) • WHH and Bridgewater Communications and Corporate Governance teams supported development of digitally accessible templates with more to follow.	• Ongoing
5. Patient information	• A process to check the reading age has been introduced when reviewing all new and existing patient leaflets to ensure a health literacy approach is embedded.	• 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 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. Events undertaken were: ✓ Disability Awareness Day ✓ Warrington Mela	• Ongoing
3. Support Place Based activity and other key local events	• Content upload process for Living Well Warrington website is now co-ordinated within the Communications and Engagement team	• 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	• 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.	• 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. • New WHH Charity website launched 10 July 2025.	• Ongoing

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Upcoming engagement events

Upcoming engagement events: 2026

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Date	Event	Time	Venue	Event purpose
20 May 2026	International Clinical Trials Day	10am to 2pm	Main entrance, Warrington Hospital and George Lloyd Restaurant, Halton Hospital	Trust-led, annual event promoting the accomplishments of clinical research professionals in public health/medicine and their efforts in clinical trials.
13 June 2026	Warrington Pride	TBC	Warrington town centre / Golden Square	Annual partnership event celebrating the LGBTQIA+ community.
27 June 2026	Warrington Armed Forces Day	10am to 6pm	Crosfields Rugby Club, 131 Hood Lane North, Great Sankey, Warrington, WA5 1XU	Annual partnership event comprised of Armed Forces Rugby League games, military vehicle displays, stands and activities.
13 July 2026	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.
30 August 2026	Warrington Mela	TBC	Queen's Gardens, Palmyra Square, Warrington, WA1 1JN	Annual open event supporting cultural diversity and community inclusion within the town.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/10/107 (i)**			
SUBJECT:	**2024-2025 Annual Submission to NHS England Northwest Appraisal and Revalidation and Medical Governance**			
DATE OF MEETING:	1 October 2025			
AUTHOR(S):	Dr Anne Robinson Responsible Officer Dr Hilary Furniss – AMD for appraisal and revalidation Kate Davidson – Medical Education Manager			
EXECUTIVE DIRECTOR SPONSOR:	Dr 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):	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: This report highlights the work undertaken, analysis of findings and implications for the Trust associated with the experience of staff through the lens of race with specific links to bullying and harassment disparities.			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
		✓		
	Further Information: This report includes the analysis of data to ensure that there are equitable opportunities for staff to access, irrelevant of their protected group. This data can be found in the body of this report.			
	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 assurances to the Board that the system for medical appraisal and the processes for monitoring the completion of annual appraisals to support GMC revalidation for the medical workforce are robust. Doctors who practise medicine in the UK must be registered and hold a licence to practise Both registration and licensing are delivered by the GMC. Every licensed doctor who practises medicine must revalidate. Revalidation is an evaluation of a doctor's fitness to practise. It supports professional development, drives improvements in clinical governance and gives patients confidence that the doctor is up to date. GMC revalidation is based on annual whole practice appraisals; information from systems of clinical governance and a five yearly revalidation recommendation. All doctors have a legal obligation to revalidate and failure to comply with the requirements may result in withdrawal of their licence to practise Most licensed doctors are supported with their appraisal and revalidation through connection to a 'designated body'. Within that organisation, a 'responsible officer' oversees the process of revalidation and makes a recommendation to the GMC about whether a doctor should be revalidated. The designated body is the organisation in which the doctor undertakes most, or all of their practice and their responsible officer is a senior doctor within that organisation. The relationship between a doctor, their designated body and responsible officer is known as their 'connection details'. The Trust maintains the list of doctors for whom it is the designated body. The responsible officer is Dr Anne Robinson. The responsible officer must: 1. Make sure doctors have access to appraisal systems and processes for collecting and holding information 2. Make a recommendation to the GMC every five years, indicating whether the doctor is up to date, fit to practise and should be revalidated. The GMC sets clear guidance on the requirements for annual appraisal and the supporting information that a doctor must present. Doctors at WHHFT collate their supporting information using SARD - a web-based system enabling the secure storage of documentation. Since 2012 WHHFT has had processes and systems in place to enable, track and monitor appraisal completion rates.

PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to approve the 2024-2025 Annual Submission to NHS England North West Appraisal and Revalidation and Medical Governance		
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee	
	Agenda Ref.	**SPCIC/25/09/120ii**	
	Date of meeting	17 September 2025	
	Summary of Outcome	The Strategic People Committee supported the report for approval at Trust Board on 1 October 2025.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

2024-2025 Annual Submission to NHS England Northwest: Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **31st October 2025**.

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

2024-2025 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Warrington and Halton Teaching Hospitals NHS Foundation Trust
What type of services does your organisation provide?	NHS

	Name	**Contact Information**
Responsible Officer	Dr Anne Robinson	anne.robinson9@nhs.net
Medical Director	Dr Paul Fitzsimmons	paul.fitzsimmons1@nhs.net
Medical Appraisal Lead	Dr Hilary Furniss	hilary.furniss@nhs.net
Appraisal and Revalidation Manager	Mrs Kate Davidson	kate.davidson4@nhs.net
Additional Useful Contacts		
Deputy AMD Appraisal & Revalidation	Dr Ian Kilroy	i.kilroy@nhs.net
Medical Workforce Development lead – Appraisal and Revalidation	Ms Paula Harris	Paula.Harris6 @nhs.net

Service Level Agreement
Do you have a service level agreement for Responsible Officer services?
NO

If yes, who is this with?

Organisation:
Please describe arrangements for Responsible Officer to report to the Board:
Date of last Responsible Officer Report to the Board: October 2024
Action from last year: Dr Anne Robinson to continue as Responsible Officer for WHH supported by the A&R team.

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

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

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

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

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of: WHH

can confirm that:

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

Y/N	Yes
Action from last year:	Dr Robinson to continue as RO supported by relevant CPD/attendance at quarterly NHS England NWHLRO meetings
Comments:	
Action for next year:	In view of the forthcoming acquisition with Bridgewater Trust, RO provision may change.

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

Y/N	Yes
Action from last year:	Appointing either Deputy AMD for Appraisal and Revalidation or Senior Appraiser. We hope this will eliminate any single points of failure, allow training of an experienced colleague to support with the review of appraisals and support the team with the workstream to add clarity and structure to the development opportunities for all grades of medical staff
Comments:	Deputy appointed from February 1st, 2025 – Dr Ian Kilroy
Action for next year:	- Retirement of Revalidation Lead March 2025 – Review of organisational structure and roles – Recruitment to new posts - Review capacity and resources in preparation for acquisition of Bridgewater

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

Y/N	Yes
Action from last year:	Initiation of new processes surrounding cohesive SARD accounts and GMC registrations. We have initially completed a full review of both lists to ensure this matches and appropriate people on both lists.
Comments:	This is now a monthly review completed by the relevant team members together to ensure completeness and full clarity.
Action for next year:	Continue the same processes

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

Y/N	Yes
Action from last year:	Maintain policy framework and undertaken policy consultation and reviews
Comments:	With the change to the organisational structure and roles some policies may require advanced review. ARG ToR and schedule of work will be included in this.
Action for next year	Review policies in line with structure change within the department and Trust Update ARG ToR and schedule of work to support new structure

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

Y/N	Yes
Action from last year:	Site visit for review scheduled 3/10/24. Complete by the end of 2024
Comments:	Peer review undertaken 3/10/24 by two neighbouring Trusts (RLUFT and MWLFT). Report and Action plan devised following feedback which is monitored by the ARG group and reports to OPC. Action plan comprised 8 items, 5 of which are completed and 3 ongoing. **In progress** 1. **Recruitment of new appraisers** Status- in progress and ongoing as appraisers retire – appraiser training in November 2025 (last appraiser training October 2024) 2. **Review MPIT process. Report back to ARG every two months** Status – in progress 3. **Review the use of a common platform for newly started doctors** Status - in progress, with new departmental structure facilitating this **Complete** 1. **Complete TOR for triangulation** Status- completed 2. **Check with SARD about parameters for retention of information.** Status – completed 3. **Clarification of actions of obtaining background information for locum, bank and short-term doctors.** Status – completed/happening regularly 4. **Appointment of Deputy for AMD A&R (Dr Furniss).** Status – completed 5. **Appraiser forum update is thrice a year now. (Following RO attendance at East Lancashire peer review group meeting.)** Status - Completed
Action for next year:	WHH to take part in a peer review of a neighbouring Trust, Royal Liverpool University Foundation Trust, scheduled for October 2025, alongside Mersey and West Lancashire Foundation Trust.

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

Y/N	Yes

Action from last year:	Doctors' development portfolio- The RO, AMD for A&R are working with the Trust's organisational development team to summarise the development opportunities that are available to doctors on joining the Trust. This is an ongoing workstream and will be supported further with the introduction of the Deputy AMD for Appraisal and Revalidation or Senior Appraiser Ongoing actions/workstreams of the SAS Task and Finish Group
Comments:	Focussed work with the Foundation Year 2 group prior to completion of their FY2 year regarding Appraisal and Revalidation requirements and particularly in relation to non-training programme career portfolios. Planning 1 to 1 meetings with new starter doctors in the Trust
Action for next year	- Continue focus work regarding A&R with FY2 doctors - Establish 1 to 1 meetings with newly appointed doctors

1B – Appraisal

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

Y/N	Yes
Action from last year:	GMP 2024 – Following the soft launch in April 2024 the future objective will be embedding into this SARD appraisal documentation in order to provide formality, structure and assurances and cascading the changes our to appraisees and appraisers by the end of 2024
Comments:	GMP 2024 now fully embedded into SARD, and all information cascaded to appraisees and appraisers. Sessions provided for both Warrington & Bridgewater appraisers covering all areas of educational appraisal & supporting information requirements for educational appraisal
Action for next year:	Review educational supervisor's appraisals to ensure they meet the required standards.

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

Y/N	Yes
Action from last year:	Continue with current processes
Comments:	All colleagues are treated on an individual basis with particular circumstances considered when entering into discussions. Regular reminders are sent out via the SARD electronic platform and one-to-one meetings are offered to support confidential discussions and create personal support plans to provide the best opportunity to engage with the process. The Trust prioritises shared understanding of the objectives behind appraisal ensuring the exercise is meaningful and achieves intended outcomes bringing continued professional development to the forefront. If, following the offer of support mechanisms above, engagement continues to be an ongoing concern, a face-to-face appointment is scheduled with the RO in line with the escalation process. In order to ensure triangulation of doctors having difficulty and the support being offered the RO has open discussion with GMC to provide awareness and assurance.
Action for next year:	Continue with current processes

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

Y/N	Yes
Action from last year:	Continue operational usage of policy
Comments:	Continued use of policy completed however the policy will need to be reviewed ahead of review date following organisational and departmental structure change
Action for next year:	Review policy following completion of the organisational and departmental structure change

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

Y/N	Yes

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

Action from last year:	Appraiser training day – booked 2nd October 2024
Comments:	79 current appraisers 7 scheduled to undertake training Oct 2025 Appraiser refresher training to continue annually. Recruitment of new appraisers and new appraiser training offered annually. Regular review of distribution of number of appraisees and appraisers have. Open dialogue with appraisers when making changes to distribution The acquisition of BCHT and integration of the 2 A&R departments from April 2026 may facilitate further cross appraisal.
Action for next year:	Appraiser training booked 5th November 2025

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

Y/N	Yes
Action from last year:	Aim to reduce overdue appraisals and to complete within the designated appraisal year.
Comments:	Reduction in turnaround time for completion of the appraisal summaries achieved; 50% reduction in those taking more than 35 days. In 2023-24 cycle **75** appraisal took more than 35 days to complete. In 2024-25 cycle **34** appraisals took more than 35 days to complete. QA appraisers via database, tracking training, forum attendance and their ASPAT scores and timeliness of completing appraisal summaries after meetings. Continue offer of annual refresher course
Action for next year:	Review the process for managing overdue appraisals in line with the organisational structure change to consider responsibilities of the new roles and departmental structure Offer support and training to appraisers who are lower performing on QA

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

Y/N	**Yes**
Action from last year:	Appraiser QA reports are to be included in the quarterly Chairs log report to OPC
Comments:	Complete - included OPC reporting following each ARG meeting
Action for next year:	Continue with reporting of QA appraisal

1C – Recommendations to the GMC

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

Y/N	Yes
Action from last year:	Options appraisal to decide most effective presentation of information for revalidation decision making panels
Comments:	With the retirement of the revalidation lead and restructure this will be carried over to the current year
Action for next year:	Options appraisal to decide most effective presentation of information for revalidation decision making panels

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

Y/N	Yes
Action from last year:	Continue current processes
Comments:	Upcoming recommendations are reviewed in advance as per our policy and correspondence shared with doctors advising them of the date and requirements at least 6 weeks prior. Individual emails are also sent if there is a particular outstanding requirement such as MSF. Panels are scheduled with time prior to the revalidation deadline so if outcome is not positive the Doctor has time to complete outstanding requirements, and a further review take place. Anyone still not meeting the criteria when the submission is due will be deferred and contacted with a comprehensive explanation of requirements and timeframe for completion.
Action for next year:	Continue current processes

1D – Medical governance

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

Y/N	Yes
Action from last year:	Continue with current processes
Comments:	Regular contact is maintained between the appraisal and revalidation group and the Governance department. The governance department supply information on request. • Three reports for annual appraisal documentation relating to any serious events in which the doctor has been named in the appraisal review period. Ongoing claims are reported and any complaints which remain unresolved. Reflection on each area is expected in appraisal documentation and should be covered in appraisal discussion. • Reports to inform the Revalidation Panels in supporting revalidation recommendations, which contain all serious incidents and ongoing claims • Ad-hoc reports to inform governance requests on individual doctors.
Action for next year:	Continue with current processes

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

Y/N	**Yes**
Action from last year:	Use of SARD for documentation to support triangulation Consider use of NCIS data as part of governance reports relevant surgeon's appraisals
Comments:	SARD information is utilised for ongoing monthly triangulation meetings
Action for next year:	Use of NCIS data and other relevant benchmarking data to be incorporated into individual appraisals

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

Y/N	**Yes**
Action from last year:	Continue current processes
Comments:	SARD - governance reports, Appraiser training dates, previous appraisals, PDPs, MSFs all uploaded
Action for next year:	Continue current processes

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

Y/N	**Yes**
Action from last year:	The Trust's MHPS policy outlines the process for dealing with concerns in relation to a doctor's fitness to practice. This policy is due for review in December 2024 (extended to 1st March 2026). Commence policy review as planned.
Comments:	This policy is currently going through ratification and will be reviewed at JLNC the deadline for review has been extended to March 2026.
Action for next year:	MHPS policy review and ratification.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	**Yes**
Action from last year:	Ongoing scheduled reporting.
Comments:	The Trust values include kindness, and senior leaders are trained in compassionate leadership. Principles of just and learning culture are embedded into the formal process documents. Training which is inclusive of just and learning culture awareness is provided to those with a formal role within Trust employee relations and specifically MHPS processes. Compassionate leadership training is available to all Trust management staff. The training included a recent lecture on compassionate leadership at the Trust Quality Academy meeting by Professor West. All concerns are taken seriously and, following investigation, results fed back to those who have raised concerns. The Trust has an ongoing compassionate leadership program externally facilitated and available across the working including for all levels of medical staff. All those nominated for undertaking a role within formal employee relations processes are trained to undertake the role for which they are appointed. The Trust employee relations policies include measures in support of just and learning culture including minimum use of suspension, regular suspension reviews, timeline requirements for review to ensure case delays are minimised and managed. Clear responsibilities for communication. Options for welfare referrals to occupational health where required by any stakeholder within employee relations processes. Support for all case roles including hearing chairs, case managements and investigation officers by qualified HR professionals, Medical Triangulation meetings are conducted on a monthly basis chaired by the Medical Director and attended by the Trust RO, these are supported by HR Business Partners. Case oversight meetings are conducted on a monthly basis by the Trust Chief People Officer. Lesson learned processes are conducted on a regular basis for employee relations case management processes, including case management for medical staff groups. Formal reporting that is inclusive of quality measures such as timeline to resolution, case patterns/ themes and outcome are presented to the strategic people committee on a bi-annual basis. A process of regular case debriefs, and lesson learn processes are undertaken for review of formal case management.

	An annual HR Dashboard report is produced for the Operational People Committee which feeds into the Trust's Strategic People Committee which includes case themes and protected characteristics.
Action for next year:	Continue current processes

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

Y/N	**Yes**
Action from last year:	Continue completion in a timely fashion
Comments:	There is a recognised process for sharing information between Responsible Officers (RO) via a Medical Practice Information Transfer form (MPIT) which is provided by NHS England. This is the way in which we request information for new starters to WHH from their previous employer's RO and is also the way in which we respond to requests we receive to provide information regarding doctors who have previously worked at WHH. However, the MPIT process is not restricted to when doctors change employers, and we use this process to share information of note about a doctor as and when the need arises. An example of this would be when a doctor works at WHH as well as an independent healthcare provider and there is information of note which our RO needs to share.
Action for next year:	MPIT process review to be undertaken as part of the organisational restructure

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

Y/N	Yes
Action from last year:	Continue with current processes
Comments:	The Trust has a robust process for undertaking equality impact assessments for all policy developments these are subject to scrutiny by the ratification committee and reviewed on a cycle of at least every three years.

	This process includes a review of protected characteristics, socioeconomic factors, health inequalities and the Armed Forces and Military Veterans community. This ensures that there is no negative / adverse impact on the grounds of a protected characteristic. In addition, this highlights opportunities for positive impact to ensure processes are free from bias and discrimination. A quality assurance process is completed by the Workforce Equality, Diversity and Inclusion Team.
Action for next year:	Continue with current process

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

Y/N	**Yes**
Action from last year:	MHPS process of being reviewed in line with the Trusts new Disciplinary Policy.
Comments:	This policy is currently going through ratification and will be reviewed at JLNC the deadline for review has been extended to March 2026. Sexual Safety at work – the Trust has led sessions on this, including planning a GM- led session and part of the implementation of Internal Professional Standards.
Action for next year:	MHPS policy review and ratification.

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

Action from last year:	Complete inclusion of GMP 2024 into appraisal documentation on SARD in order to provide formality, structure and assurances.
Comments:	GMP 2024 now fully embedded into SARD, and all information cascaded to appraisees and appraisers. WHH Internal Professional standards implemented and disseminated in Trust.

	Sexual Safety work in WHH including the planned GMC session in April
Action for next year:	Continue with current processes Implementation of Sexual Safety at work in WHH

1E – Employment Checks

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

Y/N	**Yes**
Action from last year:	Ongoing operational vetting processes.
Comments:	The Trust's Recruitment Team ensure that the 6 Employment Checks as per the NHS Employers are carried out for all Doctors recruited into the organisation as follows, with governance processes in place to ensure any risks identified are reviewed in conjunction with the HR Business Partnering Team:- • Identity • Right to Work • Professional Registration & Qualifications • Employment History & Reference Standards • Criminal Record Work Health Assessment Standards
Action for next year:	Continue with current processes. Agency - For all agency workers we are required to check BLS/ALS/APLS and advise department which level the doctor currently has. For ST3+ O&G short term locums in maternity care we have been asked to check if they have a Certificate of Eligibility (as per RCOG requirements) and MRCOG.

1F – Organisational Culture

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

Y/N	Yes
Action from last year:	Continue operational use of values framework, disciplinary rule standards and internal professional standards documents. Continue publication of and communication of the Trust professional standards.
Comments:	The Trust has an established values framework which underpins the Trust disciplinary standards and rules
Action for next year:	Continue with current processes

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

Y/N	Yes
Action from last year:	Continue current process
Comments:	Staff Networks are a core part of the review of policies and processes and are aligned to the equality impact assessment process. Additionally, the Trust has launched a Culture Plan which emphasizes the importance of equality, diversity, compassion and inclusivity. Additional to the protected characteristics, the FREDA (fairness, respect, equality, dignity and autonomy) principles of the Human Rights Act 1998 are aligned to the impact assessment process. The Trust Workforce Inclusion and Culture Sub-Committee additionally monitors risks related to equality, diversity and inclusion as well as culture, by which the Deputy Medical Director is a core member of the group. The Trust produces an annual report on equality, diversity and inclusion – this can be found here: https://whh.nhs.uk/strategy/equality-diversity-and-human-rights A review of the Medical Internal Professional Standards was completed in 2024/25 which included alignment to the GMP2024 and Trust values. Sessions in 2024 and 2025 have focused on alignment with Staff Survey results and key themes.

Action for next year:	To continue to embed the principles of compassionate and inclusive leadership, as well as alignment to the Staff Survey results and targeted training. For example, reasonable adjustments and inclusive leadership. Implement in full the active bystander programme.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	**Yes**
Action from last year:	Continue to develop the role of the FTSU champions and the links to the culture work at WHH. Build further on the worker wellbeing offer to staff who speak up and ensuring their wellbeing and safety.
Comments:	Since 2024 there has been more dedicated time allocated for the FTSU Guardian. This has enabled further engagement work with colleagues within the People Directorate namely HR BP team and Culture and inclusion team to develop and deliver sexual safety in the workplace training and to have more time to manage FTSU cases. The disclosures from FTSU are triangulated with staff survey results and other workforce data to provide more support to areas in the Trust highlighted as requiring this.
Action for next year:	Continue with current processes

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

Y/N	Yes
Action from last year:	Actions for next year include further engagement with Medical and Dental staff to increase representation for the staff survey and therefore the utilisation of the data to inform staff voice.
Comments:	Engagement sessions with Medical and Dental have taken place and these have been supported by the Culture and Inclusion / FTSU function, including sessions on GMP 2024 with the GMC, sexual safety in the workplace and engagement on the NHS Staff Survey results for Medical and Dental workforce. A review of the Medical Internal Professional Standards was completed in 2024/25 which included alignment to the GMP2024 and Trust values. Sessions in 2024 and 2025 have focused on alignment with Staff Survey results and key themes.
Action for next year:	Targeted work on sexual safety and active bystander, including alignment with refreshed results from the NHS Staff Survey.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	**Yes**
Action from last year:	Benchmark reporting data against similar Trusts
Comments:	All Medical and Dental staff are managed where applicable under the MHPS framework. Where there is necessity to invoke the disciplinary policy there has been a new process implemented where a review of the situation is conducted, and a decision is made as to what is the appropriate next steps. This falls under the Trust Disciplinary Policy which is for all staff and is due to be reviewed to ensure EDI equality.
Action for next year:	Review the Policy and ensure that when the acquisition takes place that this is smooth and does not lend itself to any misunderstanding of use of the Policy.

1G – Calibration and networking

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

Y/N	**Yes**
Action from last year:	Include outcome of peer review in next year's report
Comments:	**Peer review Action Plan Oct 2024** **In progress** 1. **Recruitment of new appraisers** Status- in progress and on-going – appraiser training in November 2025 (last appraiser training October 2024) 2. **Review MPIT process. Report back to ARG every two months** Status – in progress 3. **Review the use of a common platform for newly started doctors** Status - in progress, with new departmental structure facilitating this **Complete** 1. **Complete TOR for triangulation** Status- completed

	2. **Check with SARD about parameters for retention of information.** Status – completed 3. **Clarification of actions of obtaining background information for locum, bank and short-term doctors.** Status – completed/happening regularly 4. **Appointment of Deputy for Dr Furniss.** Status – completed 5. **Appraiser forum update is thrice a year now. (Following RO attendance at East Lancashire peer review group meeting.)** Status - Completed Attendance and networking at regional RO meetings and Revalidation Lead meetings, by the A&R team.
Action for next year:	Complete outstanding actions as listed above. Continue with meeting attendances and networking.

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025.

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

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	359
Total number of appraisals completed	319
Total number of appraisals approved missed	34
Total number of unapproved missed	6
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	76
Total number of late recommendations	0
Total number of positive recommendations	73
Total number of deferrals made	3
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	8
Total number of trained case managers	8

Total number of concerns received by the Responsible Officer[2]	1
Total number of concerns processes completed	10
Longest duration of concerns process of those open on 31 March (working days)	428
Median duration of concerns processes closed (working days)[3]	177
Total number of doctors excluded/suspended during the period	2
Total number of doctors referred to GMC	1
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	0
Total number of new employment checks completed before commencement of employment	6
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

Section 3 – Summary and overall commentary

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

Actions for the Appraisal and revalidation team have progressed well and been triangulated with the actions identified in the peer review to ensure we are responsive to all available information and feedback.

- Dr Robinson to continue as RO supported by relevant CPD/attendance at quarterly NHS England NWHLRO meetings.
- Appointment of Deputy AMD for Appraisal and Revalidation.
- Initiation of new processes surrounding cohesive SARD accounts and GMC registrations.
- Maintenance of policy framework and undertaken policy consultation and reviews.
- Peer review scheduled 3/10/24, was completed and subsequent action plan completion in progress.

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

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

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

- Doctors' development portfolio- The RO, AMD for A&R are working with the Trust's organisational development team to summarise the development opportunities that are available to doctors on joining the Trust. This is an ongoing workstream and will be supported further with the introduction of the Deputy AMD for Appraisal and Revalidation.
- Ongoing actions/workstreams of the SAS Task and Finish Group
- GMP 2024 – Following the soft launch in April 2024 this is now embedded into SARD appraisal documentation in order to provide formality, structure and assurances and the changes were cascaded to appraisees and appraisers before the end of 2024
- Continue operational usage of policy.
- Appraiser training day – took place 2nd October 2024, next booked for 5th November 2025.
- Reduction overdue appraisals and to complete within the designated appraisal year.
- Appraiser QA reports are included in the quarterly Chairs log report to OPC.
- Options appraisal to decide most effective presentation of information for revalidation decision making panels, with change in departmental structure.
- Use of SARD for documentation to support triangulation. Consider use of NCIS data as part of governance reports relevant surgeons' appraisals.
- The Trust's MHPS policy outlines the process for dealing with concerns in relation to a Doctors' fitness to practice. This policy deadline has been extended to 1st March 2026. Commence policy review as planned.
- Ongoing operational vetting processes
- Continue operational use of values framework, disciplinary rule standards and internal professional standards documents. Continue publication of and communication of the Trust professional standards.
- Continue to develop the role of the FTSU champions and the links to the culture work at WHH. Build further on the worker wellbeing offer to staff who speak up and ensuring their wellbeing and safety.
- Actions for next year include further engagement with Medical and Dental staff to increase representation for the staff survey and therefore the utilisation of the data to inform staff voice.
- Benchmark reporting data against similar Trusts

Actions still outstanding

- Complete organisational restructure and realign responsibilities and workstreams.
- Review current resources in preparation for the acquisition of Bridgewater
- Options appraisal to decide most effective presentation of information for revalidation decision making panels.
- Use of NCIS data as part of governance reports relevant surgeon's appraisals.
- MHPS policy review and ratification deadline has been extended to March 2026

Current issues
Acquisition of Bridgewater and integration of WHH and BW Community Healthcare Trust A&R processes
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
• Dr Anne Robinson to continue as Responsible Officer for WHH supported by the A&R team. • Review of organisational structure and roles – Recruitment to new posts • Review capacity and resources in preparation for acquisition of Bridgewater • Review policies in line with structure change within the department and Trust • Update ARG ToR and schedule of work to support new structure • WHH to take part in a peer review of a neighbouring Trust, Royal Liverpool University Foundation Trust, scheduled for October 2025. • Continue focus work regarding A&R with FY2 doctors • Establish 1 to 1 meetings with newly appointed doctors • Review educational supervisor's appraisals to ensure they meet the required standards. • Review Medical Appraisal policy following completion of the organisational and departmental structure change. • Annual Appraiser training booked 5th November 2025 • Review the process for managing overdue appraisals in line with the organisational structure change to consider responsibilities of the new roles and departmental structure. • Continue with reporting of QA appraisal • Options appraisal to decide most effective presentation of information for revalidation decision making panels • Use of NCIS data and other relevant benchmarking data to be incorporated into individual appraisals • MHPS policy review and ratification March 2026. • MPIT process review to be undertaken as part of the organisational restructure • Implementation of Sexual Safety at work in WHH

• Implement in full the active bystander programme
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
Significant ongoing progress in Appraisal and Revalidation across the organisation which have been achieved in a context of very significant operational financial pressures in the organisation and wider ICS. This coming year's challenges and aspirations will continue to focus on maintaining high appraisal and recommendation for revalidation rates, developing workstreams in line with the new organisational structure, continuing peer review processes with neighbouring Trusts and building on the Trust's culture plan, particularly around the use of Internal Professional Standards, well-being offer and equality and diversity agendas.

Section 4 – Statement of Compliance

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

Signed on behalf of the designated body

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

Official name of the designated body:	

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/10/107 (i)**			
SUBJECT:	**Workforce Race Equality Standard (WRES) Annual Report 2024/25**			
DATE OF MEETING:	1 October 2025			
AUTHOR(S):	Adam Harrison-Moran, Associate Chief People Officer: Strategic Workforce Development & Culture			
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Chief People 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)***	None			
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: This report highlights the work undertaken, analysis of findings and implications for the Trust associated with the experience of staff through the lens of race with specific links to bullying and harassment disparities.			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
		✓		
	Further Information: This report includes the analysis of data to ensure that there are equitable opportunities for staff to access, irrelevant of their protected group. This data can be found in the body of this report.			

<table>
<tr><td rowspan="2"></td><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes
✓</td><td>No</td><td>N/A</td></tr>
<tr><td colspan="4">Further Information:
The data utilised to analyse and develop this report includes metrics from the Staff Survey. This intends to inform improvements in relations between people who share a protected characteristic and those who do not. The detail of this is in the body of the report.</td></tr>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td colspan="4">The Workforce Race Equality Standard (WRES) is a mandated report which the Trust is required to complete on an annual basis. The standard sets out agreed actions to ensure employees from Black, Asian and Minority Ethnic (BAME) backgrounds have equality of access to career opportunities and receive fair treatment in the workplace. The requirements of the Trust include:
• The data collation and reporting to the national WRES team which was completed on 31 May 2025
• Analysis of findings to be completed with an action plan for improvement developed by 31 October 2025
• Publication of the Trust action plan by 31 October 2025

High-level findings of the report highlight both improvements and areas of concern. The Trust's BAME workforce profile increased to 19.32%, with notable gains in clinical and medical groupings. Non-clinical workforce clusters one to three saw improvements, while cluster four experienced a slight reduction. The BAME clinical workforce rose to 19.2% and the Medical and Dental workforce increased to 59.66%. The likelihood of BAME staff being appointed from shortlisting improved to 0.83 and the likelihood of entering the formal disciplinary process remained below 1.0 at 0.89.

Perceptions of equal opportunities for career progression among BAME staff improved and BAME Board membership increased to 12.6% compared to the overall workforce. However, there were increases in harassment, bullying and discrimination experienced by BAME staff from colleagues and the public. Despite improvements, significant disparities remain between BAME and White staff experiences, monitored through the Board Assurance Framework.</td></tr>
</table>

	The report details an action plan for improvement, codeveloped with the Trust Staff Networks and aligned to strategic priorities.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to receive and note the paper which has been formally approved on behalf of the Trust Board by the Strategic People Committee in Common in August 2025.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee	
	Agenda Ref.	**SPCIC/25/08/096 (i)**	
	Date of meeting	20 August 2025	
	Summary of Outcome	Approved on behalf of Trust Board	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

1. Background/context

NHS England and the NHS Equality and Diversity Council introduced the Workforce Race Equality Standard (WRES)[1] in 2015. The standard sets out agreed actions to ensure employees from Black, Asian and Minority Ethnic (BAME) backgrounds have equality of access to career opportunities and receive fair treatment in the workplace. As such on an annual basis the NHS organisations are required as per the NHS standard contract to complete a data analysis against nine metrics, formulating a Trust wide action plan for improvement. Responsibility for oversight of the action plan sits with the Trust Board for sign off and approval.

The Trust is expected to show progress against 9 indicators of workforce equality, including a specific indicator to ensure that the organisation is representative across all levels, including the Trust Board. The WRES measures are important as they demonstrate the experience that our organisation is providing for our racially diverse workforce and research shows that a motivated, included and valued workforce contributes to the delivery of outcomes such as reduced health inequalities, high quality patient care, increased patient satisfaction and improved patient safety[2].

The WRES data has been provided by the Trust's Electronic Staff Record (ESR), the National Staff Survey results and via the HR Business Partnering Team. The data has been submitted to the national central government portal as per the national timescales in May 2025. A copy of this data can be found as **Appendix One**.

The Trust's WRES Action Plan for 2024/25, found as **Appendix Two**, has been produced through an analysis of the data with a comparison to the previous year's data and progress made against the Action Plan for 2023/24. Additionally, the plan has utilised elements of the Trust's action plan for the NHS North West BAME Assembly Anti-Racist Organisation Framework[3] requirements.

In addition to being monitored by NHS England, compliance with the WRES and subsequent action plans are also monitored by the Care Quality Commission (CQC), as local intelligence for the well-led domain of the new assessment framework.

For the purposes of this report, non-white ethnicities are referred to utilising the same language as the WRES, Black and Ethnic Minorities (BME), however throughout the WRES indicator descriptions and narrative within the action plan, the term Black, Asian and Minority Ethnic (BAME) is also used.

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[1] NHS England – Workforce Race Equality Standard: https://www.england.nhs.uk/about/equality/equality-hub/workforce-equality-data-standards/equality-standard/

[2] West M (2021) Compassionate Leadership: Sustaining Wisdom, Humanity and Presence in Health and Social Care

[3] NHS North West BAME Assembly – Anti-Racist Organisation Framework: https://www.england.nhs.uk/north-west/wp-content/uploads/sites/48/2023/07/The-North-West-BAME-Assembly-Anti-racist-Framework-FINAL.pdf

2. Reporting and timescales

The NHS standard contract outlines how organisations must meet the required timescales of the National Workforce Race Equality Standard (WRES) Team. This was completed in May 2025.

As part of the reporting requirements, organisations are required to develop an action plan approved by Trust Boards and uploaded to the Trust's website by 31 October 2025.

The Strategic People Committee in Common holds the delegated responsibility of the Trust Board to receive and approve the contents of the WRES, with escalation of the decision reported via the Committee Chairs Log with the paper reported as supplementary.

It is noted that the Trust implements an ethnicity pay gap and has done since 2023/24. This is reported through the EDI Annual Report as part of the workforce profile review and will be presented to the Strategic People Committee in Common from Q4 2025/26.

3. Key findings in 2024/25

The full datasets identified as part of the Workforce Race Equality Standard (WRES) for 2024/25, can be found as **Appendix One**. This section provides a high-level analysis of the key findings from the WRES reporting. A copy of the action plan to address the findings in this report can be found as **Appendix Two**.

Analysis of the Trust's WRES data has identified improvements against a number of the WRES indicators, including:

- The Trust wide profile for BME workforce increased to 19.32% from 17.45% in 2024 – with the majority across the clinical (Agenda for Change) and medical workforce.
    - For the non-clinical workforce there were improvements in clusters one to three in 2024/25 whilst a slight reduction from 7.7% to 6.3% in cluster four. Overall, the percentage of BAME non-clinical workforce increased from 5.9% to 7.4%.
    - For the clinical workforce there were improvements in all clusters with the total BAME clinical workforce increasing from 17.8% to 19.2%.
    - For the Medical and Dental workforce, again, there were improvements in all clusters with the total BAME workforce increasing from 57.49% to 59.66%.
- The relative likelihood of BME staff being appointed from shortlisting compared to White staff in 2024/25 is 0.83. Improvements are noted from previous years where reporting was above the 1.0 ratio, however it is noted that this now reflects a negative impact on White staff with the aim being to achieve a 1.0 ratio.
- The relative likelihood of BME staff entering the formal disciplinary process compared to White staff remained below 1.0 at 0.89 in 2024/25. This is an improvement closer to 1.0 than the previous year.

- For BAME staff, the percentage of those believing that the organisation provides equal opportunities for career progression or promotion increased in 2024/25.
- The percentage of BAME Board membership and the overall workforce improved with a difference of 12.6%, compared with the previous year of 11.6%.

Analysis of the Trust's WRES data has also identified areas of deterioration in comparison with the 2024/25 results. They include:

- The percentage of BAME staff who experienced harassment, bullying or abuse from other colleagues increased in 2024/25.
- The percentage of BAME staff who in the last 12 months experienced discrimination at work from staff increased in 2024/25. Although still an increase, it is noted that the WRES metrics combined 'other colleagues' and 'managers' into one metric.
- The percentage of staff who experienced harassment, bullying or abuse from patients, visitors or the public increased in 2024/25.

Overall, there remains a significant disparity in the experience of BAME staff and White staff at the Trust. Although this is an improving picture, there remains work to be done to remove the imbalance. This is monitored through the Board Assurance Framework, under risk 2103.

4. Actions required/responsible officer

The Chief People Officer is the executive lead for workforce equality, diversity and inclusion. This includes all statutory reporting requirements.

5. Measurements/evaluations

As detailed in section three.

6. Monitoring/reporting routes

Actions associated with the Workforce Race Equality Standard (WRES) will be integrated into the Workforce Equality, Diversity and Inclusion Strategy 2022-2025 delivery dashboard.

Monitoring of the Workforce Equality, Diversity and Inclusion Strategy 2022-2025 delivery dashboard is completed by the Workforce Inclusion and Culture Sub-Committee, chaired by the Chief People Officer on a bi-monthly basis. From September 2025, quarterly WRES and WDES oversight groups led by the Chief People Officer with Staff Network leads is in place for enhanced scrutiny of activity.

In addition, as part of the NHS standard contract, progress updates associated with the WRES are reported bi-annually to the Clinical Quality Focus Group (CQFG) for assurance.

7. Timelines

Data reporting of the Workforce Race Equality Standard was completed by 31 May 2025.

Following approval of the associated action plan, found as **Appendix Two**, the Trust is required to submit the plan to NHS England and publish on its website by 31 October 2025.

8. Assurance committee (if relevant)

Assurance for the Workforce Race Equality Standard is completed by the Strategic People Committee in Common as delegated responsibility on behalf of the Trust Board.

9. Appendix One: WRES Dataset (2024/25)

Metric 1: Percentage of staff in each of the Agenda for Change Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by:

- Non-Clinical staff
- Clinical staff - of which, non-medical staff and Medical and Dental staff

Non-clinical workforce	BME		White		Unknown		Total
	Num	%	Num	%	Num	%	
Cluster 1: AfC Bands <1 to 4	84	8.4%	909	91.3%	3	0.3%	996
Cluster 2: AfC bands 5 to 7	11	4.5%	231	95.1%	1	0.4%	243
Cluster 3: AfC bands 8a and 8b	2	2.8%	69	97.2%	0	0.0%	71
Cluster 4: AfC bands 8c to VSM	3	6.3%	45	93.8%	0	0.0%	48
Total non-clinical	**100**	**7.4%**	**1254**	**92.3%**	**4**	**0.3%**	**1358**

Clinical workforce	BME		White		Unknown		Total
	Num	%	Num	%	Num	%	
Cluster 1: AfC Bands <1 to 4	121	12.6%	834	86.9%	5	0.5%	960
Cluster 2: AfC bands 5 to 7	441	23.6%	1389	74.4%	38	2.0%	1868
Cluster 3: AfC bands 8a and 8b	17	9.9%	152	88.9%	2	1.2%	171
Cluster 4: AfC bands 8c to VSM	1	5.9%	16	94.1%	0	0.0%	17
Total clinical	**580**	**19.2%**	**2391**	**79.3%**	**45**	**1.5%**	**3016**

Medical and Dental	BME		White		Unknown		Total
	Num	%	Num	%	Num	%	
Medical & Dental Staff, Consultants	120	52.86%	102	44.93%	5	2.20%	227
Medical & Dental Staff, Non-Consultants career grade	54	79.41%	14	20.59%	0	0.00%	68

Medical & Dental Staff, Medical and dental trainee grades	73	58.87%	47	37.90%	4	3.23%	124
Total Medical and Dental	**244**	**59.66%**	**156**	**38.14%**	**9**	**2.20%**	**409**

Total workforce	**BME**		**White**		**Unknown**		**Total**
	Num	%	Num	%	Num	%	
Number of staff in workforce	**924**	**19.32%**	**3801**	**79.47%**	**58**	**1.21%**	**4783**

Metric 2: Relative likelihood of staff being appointed from shortlisting across all posts.

2023/24	2024/25
The relative likelihood of White staff being appointed from shortlisting compared to BME staff was **0.97**. This indicates BME candidates are more likely to be appointed compared to White candidates.	The relative likelihood of White staff being appointed from shortlisting compared to BME staff was **0.83**. This indicates BME candidates are more likely to be appointed compared to White candidates.

N.B. A value of "1.0" for the likelihood ratio means that White and BME staff are equally likely to be appointed from shortlisting, whilst a value above 1 indicates that white candidates are more likely to be appointed than BME candidates and a value below 1 indicates that White candidates are less likely to be appointed than BME candidates.

Metric 3: Relative likelihood of staff entering the formal disciplinary process as measured by entry into a formal disciplinary investigation.

2023/24	2024/25
The relative likelihood of BME staff entering the formal disciplinary process compared to White staff was **0.78**. This indicates that BME staff are less likely to enter the formal disciplinary proceeding compared to White staff.	The relative likelihood of BME staff entering the formal disciplinary process compared to White staff was **0.89**. This indicates that BME staff are less likely to enter the formal disciplinary proceeding compared to White staff.

N.B. A value of "1.0" for the likelihood ratio means that BME and White staff are equally likely to enter formal disciplinary proceedings, whilst a value above 1 indicates that BME staff are more likely to enter formal disciplinary proceedings than White staff and a value below 1 indicates that BME staff are less likely to enter formal disciplinary proceedings than White staff.

Metric 4: Relative likelihood of staff accessing non-mandatory training and CPD.

2023/24	2024/25
The relative likelihood of BME staff accessing non-mandatory training and CPD compared to White staff was **0.81**. This indicates that BME staff are more likely to access non-mandatory training or CPD in comparison to White staff.	The relative likelihood of BME staff accessing non-mandatory training and CPD compared to White staff was **0.95**. This indicates that BME staff are more likely to access non-mandatory training or CPD in comparison to White staff.

N.B. A value of "1.0" for the likelihood ratio means that white and BME staff are equally likely to access non-mandatory training or CPD, whilst a value above 1 indicates that white staff are more likely to access non-mandatory training or CPD than BME staff and a value below 1 indicates that white staff are less likely to access non-mandatory training or CPD than BME staff.

Metric 5 to 8 (linked to the Staff Survey 2023):

5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (It is noted that this question aligns other colleagues and managers together and is therefore different to the Staff Survey questions).
7. Percentage of staff believing that their organisation provides equal opportunities for career progression or promotion.
8. In the last 12 months have you personally experienced discrimination at work from any of the following? (b) Manager/team leader or other colleagues.

Question	White				Black, Asian and Minority Ethnic (BAME)			
	2022	2023	2024	Trend	2022	2023	2024	Trend
Q14a) Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	21.21%	19.69%	**19.75%**	**No change**	25.50%	28.24%	**29.51%**	**Deteriorated**
Q14c) Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	17.15%	14.54%	**13.87%**	**Improved**	25.68%	19.61%	**24.20%**	**Deteriorated**
Q15) Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	61.72%	64.90%	**63.41%**	**Deteriorated**	40.82%	50.98%	**52.54%**	**Improved**
Q16b) Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months	4.74%	5.35%	**4.75%**	**Improved**	18.92%	13.33%	**15.40%**	**Deteriorated**

Metric 9: Percentage difference between the organisation's Board voting membership and its overall workforce.

Percentage difference between:

i. the organisations' Board voting membership and its overall workforce
ii. the organisations' Board executive membership and its overall workforce

	2023/24			2024/25		
	White	BAME	Ethnicity unknown	White	BAME	Ethnicity unknown
Total Board members - % by Ethnicity	94.1%	5.9%	0%	93.3%	6.7%	0%
Voting Board members - % by Ethnicity	100%	0%	0%	91.7%	8.3%	0%
Non-Voting Board Member - % by Ethnicity	80%	20%	0%	100%	0%	0%
Executive Board Member - % by Ethnicity	100%	0%	0%	87.5%	12.5%	0%
Non-Executive Board Member - % by Ethnicity	87.5%	12.5%	0%	100%	0%	0%
Overall workforce - % by Ethnicity	81.2%	17.5%	1.4%	79.5%	19.3%	1.2%
Difference (Total Board compared to Overall Workforce)	12.8%	11.6%	-1.4%	14%	-13%	-1%

10. Appendix Two: WRES Action Plan 2024/25

The Workforce Race Equality Standard action plan has been developed in conjunction with the Multi-Ethnic Staff Network based on actions developed in 2023/24 and the NHS BAME Assembly Anti-Racist Organisation Framework action plan.

Metric Alignment / Theme	Action	Timescale / RAG	Anticipated Success Factors
Anti-Racism	**Reattainment of the 'bronze' accreditation for the Anti-Racist Organisation Framework.**	**May 2026**	Achievement of the 'bronze' accreditation by the North West Black, Asian and Minority Ethnic Assembly.
	Attainment of 'silver' accreditation for the Anti-Racist Organisation Framework.	**May 2026**	Achievement of the 'silver' accreditation by the North West Black, Asian and Minority Ethnic Assembly.
	Collaboration with the LCR Race Equality Hub to develop an Anti-Racism Strategy for the region.	**July 2026**	Engagement with the Race Equality Hub and development of an action plan following the launch of the strategy in March 2026.
	Relaunch the Anti-Racist Working Group with wider engagement and representation to ensure all communities are able to share their views.	**August 2025**	Relaunched working group to sit alongside the accreditation steering group. Annual review of membership to ensure all communities are able to access the forum.
	Develop listening and wellbeing forums for staff affected by racism in the workplace aligned with the Violence and Aggression / Bullying and Harassment programmes.	**September 2025**	First session to be launched in Q3 2025/26 and reviewed quarterly as part of the Anti-Racist Steering Group.
Training	**Implementation of a Cultural Competency programme for all line managers of internationally recruited staff to embed psychological safety principles.**	**October 2025**	Programme developed with a confirmed trajectory targeting line managers initially.

	Implement an Anti-Racist training programme working with external organisations and lived experience to support wider awareness and interventions through an anti-racist lens utilising WHH datasets.	**October 2025**	Programme developed with a confirmed trajectory to reach all line managers by 2027.
	Development of a series of board related EDI training and development programmes, including anti-racism, cultural appreciation, analysis and competency across all characteristics.	**December 2026**	Board development programme to include at least one EDI related offer annually based on refreshed data from equality reporting schedules.
	Implementation of an insourced Reciprocal Mentoring programme to commence between executive members, senior and aspiring leaders representing all characteristics.	**November 2025 (Review to be completed six-monthly)**	Reciprocal Mentoring programme launched and built into talent management plans for the following year.
Bullying and Harassment **To note: This action forms part of a wider Trust wide action plan for improvement**	**Launch a refreshed bullying, harassment and abuse campaign Trust wide with refreshed reporting routes, information targeting patients, workforce and the public and create reader friendly policy guides for managers / staff to access.**	**December 2025 (Progress to be monitored annually until March 2027)**	Launch of the refreshed campaign with materials. Reduction in reported instances via the staff survey annually with an increase in formal reports via Datix / employee relations to reduce the disparity.
	Scope the development of an anti-bullying policy and procedure which replicates national best practice for sexual misconduct, including anonymous reporting.	**August 2025**	Options appraisal completed following the scoping to align with the bullying and harassment programme.
	Launch a Culture, Inclusion and Wellbeing Steering Group focused on targeting interventions to wellbeing through a holistic approach, including	**October 2025**	Steering Group terms of reference approved by the Workforce Inclusion and Culture Sub-Committee with assurance reported through the bullying and harassment programme.

	bullying and harassment, violence and aggression, presenteeism etc.		
Accountability	**Complete a review of Trust wide EDI objectives to realign 2026/27 objectives with updated intelligence from equality reporting, e.g. anti-racism.**	**January 2026**	Updated objectives for all staff, with targeted leadership objectives.
International Recruitment	**Launch the 'Supporting Staff Who Become Patients' standard operating procedure, codeveloped with the Multi-Ethnic Staff Network.**	**July 2025**	Launch of the SOP with an engagement plan to ensure familiarity, particularly for internationally recruited staff.
	Finalise the review of the International Recruitment pack, aligning resources and pastoral support for staff across the Trust and professions.	**August 2025**	Refreshed pack completed and shared Trust wide and on the intranet.
Staff Network	**Support the Multi-Ethnic Staff Network in increasing its representation to ensure all communities are represented and their voice is amplified.**	**September 2025**	Network communications plan developed in line with networks 'in common' formal launch.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/10/107 (ii)**			
SUBJECT:	**Workforce Disability Equality Standard (WDES) Annual Report 2024/25**			
DATE OF MEETING:	1 October 2025			
AUTHOR(S):	Adam Harrison-Moran, Associate Chief People Officer: Strategic Workforce Development & Culture			
EXECUTIVE DIRECTOR SPONSOR:	Michelle Cloney, Chief People 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):	None			
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: This report highlights the work undertaken, analysis of findings and implications for the Trust associated with the experience of staff through the lens of disability with specific links to bullying and harassment disparities.			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
		✓		
	Further Information: This report includes the analysis of data to ensure that there are equitable opportunities for staff to access, irrelevant of their protected group. This data can be found in the body of this report.			

<table>
<tr><td rowspan="2"></td><td>3. Foster good relations between people who share a protected characteristic and those who do not</td><td>Yes
✓</td><td>No</td><td>N/A</td></tr>
<tr><td colspan="4">Further Information:
The data utilised to analyse and develop this report includes metrics from the Staff Survey. This intends to inform improvements in relations between people who share a protected characteristic and those who do not. The detail of this is in the body of the report.</td></tr>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td colspan="4">The Workforce Disability Equality Standard (WDES) is a mandated report which the Trust is required to complete on an annual basis. The standard sets out agreed metrics which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.

The requirements of the Trust include:
• The data collation and reporting to the national WDES team which was completed on 31 May 2025.
• Analysis of findings to be completed with an action plan for improvement developed by 31 October 2025.
• Publication of the Trust action plan by 31 October 2025.

High-level findings of the report highlights both improvements and areas of concern. The Trust saw an increase in disability declarations, with 5.16% of staff declaring a disability, up from 4.11% in 2023/24. Improvements were noted across clinical, non-clinical and Medical and Dental staff clusters. The likelihood of disabled staff being appointed from shortlisting improved significantly and there were positive trends in staff survey metrics related to harassment, bullying and abuse. However, areas of deterioration included a decrease in staff reporting harassment, perceived equal opportunities for career progression and satisfaction with organisational value.

The percentage difference between the Board's voting membership and the overall workforce also deteriorated. Despite these challenges, the Trust remains above the national average for Acute and Acute and Community Trusts. Gaps in the workforce profile at senior levels and disparities between disabled and non-disabled staff experiences remain areas for focus, as outlined in the action plan.</td></tr>
</table>

	The report details an action plan for improvement, codeveloped with the Trust Staff Networks and aligned to strategic priorities.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to receive and note the paper which has been formally approved on behalf of the Trust Board by the Strategic People Committee in Common in August 2025.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Strategic People Committee	
	Agenda Ref.	**SPCIC/25/08/096 (iii)**	
	Date of meeting	20 August 2025	
	Summary of Outcome	Approved on behalf of Trust Board	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

1. Background/context

The Workforce Disability Equality Standard (WDES)[1] was introduced in 2019, part modelled on the Workforce Race Equality Standard (WRES)[2]. The standard sets out agreed metrics which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. As such on an annual basis the NHS organisations are required as per the NHS standard contract to complete a data analysis against 10 metrics, formulating a Trust wide action plan for improvement. Responsibility for oversight of the action plan sits with the Trust Board for sign off and approval.

The Trust is expected to show progress against 10 indicators of workforce equality, including a specific indicator to ensure that the organisation is representative across all levels, including the Trust Board. The WDES measures are important as they support positive change for all staff by creating a more inclusive environment for disabled people working and seeking employment in the NHS. Research shows that a motivated, included and valued workforce contributes to the delivery of outcomes such as reduced health inequalities, high quality patient care, increased patient satisfaction and improved patient safety[3].

The WDES data has been collated from the Trust's Electronic Staff Record (ESR), the National Staff Survey results for 2024 and via the HR Business Partnering Team. The data has been submitted to the national central government portal as per the national timescales in May 2025. A copy of this data can be found as **Appendix One**.

The Trust's WDES Action Plan for 2024/25, found as **Appendix Two**, has been produced through an analysis of the data with a comparison to the previous year's data and progress made against the action plan for 2023/24. The production of the reporting and data has been supported by the Trust's Disability Awareness Network (DAN) as well as consultation with the wider workforce as part of an analysis of staff survey data.

In addition to being monitored by NHS England, compliance with the WDES and subsequent action plans are also monitored by the Care Quality Commission (CQC), as local intelligence for the well-led domain of the new assessment framework.

For the purposes of this report, the term 'disabled staff' and 'non-disabled staff' is used which reflects that of the WDES Technical Guidance. The term 'long-term health condition' is also used when referring to the National Staff Survey.

[1] NHS England – Workforce Disability Equality Standard: https://www.england.nhs.uk/about/equality/equality-hub/workforce-equality-data-standards/wdes/
[2] NHS England – Workforce Race Equality Standard: https://www.england.nhs.uk/about/equality/equality-hub/workforce-equality-data-standards/equality-standard/
[3] West M (2021) Compassionate Leadership: Sustaining Wisdom, Humanity and Presence in Health and Social Care

2. Reporting and timescales

The NHS standard contract outlines how organisations must meet the required timescales of the National Workforce Disability Equality Standard (WDES) Team. This was completed in May 2025.

As part of the reporting requirements, organisations are required to develop an action plan, approved by Trust Boards and uploaded to the Trust's website by 31 October 2025.

The Strategic People Committee in Common holds the delegated responsibility of the Trust Board to receive and approve the contents of the WDES, with escalation of the decision reported via the Committee Chairs Log with the paper reported as supplementary.

It is noted that the Trust implements a disability pay gap and has done since 2024/25. This is reported through the EDI Annual Report as part of the workforce profile review and will be presented to the Strategic People Committee in Common from Q4 2025/26.

3. Key findings in 2024/25

The full datasets identified as part of the Workforce Disability Equality Standard (WDES) for 2024/25, can be found as **Appendix One**. This section provides a high-level analysis of the key findings from the WDES reporting. A copy of the action plan to address the findings in this report can be found as **Appendix Two**.

Analysis of the Trust's WDES data has identified improvements against a number of the WDES indicators, including:

- Reporting of disability declarations improved year on year for clinical and non-clinical staff. This is an increase to:
    - 5.16% of staff declaring a disability in 2024/25 compared with 4.11% in 2023/24.
    - 79.97% of staff declaring they do not have a disability in 2024/25 compared with 77.65% in 2023/24.
    - 14.87% of staff not declaring their disability status (unknown declaration) in 2024/25 compared with 18.24% in 2023/24.
- For non-clinical staff, there was an improvement in clusters one, two and four compared to 2023/24 with the overall workforce who have declared a disability increasing from 6.1% to 6.6%.
- For clinical staff, there was an improvement in all clusters compared to 2023/24 with the overall workforce who have declared a disability increasing from 3.6% to 4.9%.
- For Medical and Dental staff, there was an improvement in all roles with the overall reporting increasing from 1.1% to 2.2%.
- Across all the workforce there was an improvement in every cluster apart from Medical and Dental 'trainees' for the unknown declaration rates with the largest reduction being Medical and Dental 'career grade' from 33.78% in 2023/24 to

26.47% in 2024/25. This still demonstrates further work is required but shows a significant improvement.

- The relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts decreased from 1.41 in 2023/24 to 0.95 in 2024/25. This demonstrates a significant improvement in the ratio for the first time since the WDES was published in 2019.
- For staff with a long-term health condition or illness, there were improvements across metrics reported via the staff survey, including:
    - The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
    - The percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months.
    - The percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.
    - The percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Analysis of the WDES data has also identified areas of deterioration in comparison with the 2023/24 results. This includes:

- The percentage of staff who say they reported the last time they experienced harassment, bullying or abuse at work.
- The percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion.
- The percentage of staff satisfied with the extent to which their organisation values their work.
- A slight reduction for the percentage of disabled staff who stated the Trust made reasonable adjustments to enable them to carry out their work.
- The percentage difference between the organisation's Board voting membership and its organisation's overall workforce reduced from 1.77% in 2023/24 to -5.16% in 2024/25.

It is noted that although deterioration is noted, the Trust remains above the national average for Acute and Acute and Community Trusts in these metrics in 2024. Additionally, the performance in 2024 represents an improvement compared to the 2022 results with a larger staff engagement response rate.

Although there have been improvements, data still highlights that there are gaps in the Trust workforce profile at Band 8a and above for staff living with a disability or long-term health condition. Specifically, work is required to improve the diversity of the senior leadership of the Trust, as well as support those who have not declared their disability status to feel comfortable to do so. This aims to be addressed through work embedded within the action plan noted as **Appendix Two**.

Additionally, there is still a significant disparity between disabled staff and non-disabled staff when reviewing the results in the NHS Staff Survey. This is particularly significant when looking at the percentage of staff experiencing harassment, bullying or abuse in the workplace. Overall, this remains a targeted area for focus for disabled staff and non-disabled staff as evidenced within the action plan.

4. Actions required/responsible officer

The Chief People Officer is the executive lead for workforce equality, diversity and inclusion. This includes all statutory reporting requirements.

5. Measurements/evaluations

As detailed in section three.

6. Monitoring/reporting routes

Actions associated with the Workforce Disability Equality Standard (WDES) will be integrated into the Workforce Equality, Diversity and Inclusion Strategy 2022-2025 delivery dashboard.

Monitoring of the Workforce Equality, Diversity and Inclusion Strategy 2022-2025 delivery dashboard is completed by the Workforce Inclusion and Culture Sub-Committee, chaired by the Chief People Officer on a bi-monthly basis. From September 2025, quarterly WRES and WDES oversight groups led by the Chief People Officer with Staff Network leads is in place for enhanced scrutiny of activity.

In addition, as part of the NHS standard contract, progress updates associated with the WDES are reported bi-annually to the Clinical Quality Focus Group (CQFG) for assurance.

7. Timelines

Data reporting of the Workforce Disability Equality Standard was completed by 31 May 2025.

Following approval of the associated action plan, found as **Appendix Two**, the Trust is required to submit the plan to NHS England and publish on its website by 31 October 2025.

8. Assurance committee (if relevant)

Assurance for the Workforce Disability Equality Standard is completed by the Strategic People Committee in Common as delegated responsibility on behalf of the Trust Board.

9. Appendix One: WDES Dataset (2024/25)

Metric 1: Percentage of staff in Agenda for Change (AfC) pay bands or medical and dental subgroups and very senior managers (VSM) including Executive Board members compared with the percentage of staff in the overall workforce.

Non-clinical workforce	Disabled		Non-disabled		Unknown		Total
	Num	%	Num	%	Num	%	
Cluster 1: AfC Bands <1 to 4	68	6.8%	745	74.8%	183	18.4%	996
Cluster 2: AfC bands 5 to 7	16	6.6%	192	79.0%	35	14.4%	243
Cluster 3: AfC bands 8a and 8b	3	4.2%	63	88.7%	5	7.0%	71
Cluster 4: AfC bands 8c to VSM	2	4.2%	44	91.7%	2	4.2%	48
Total non-clinical	**89**	**6.60%**	**1044**	**76.9%**	**225**	**16.6%**	**1358**

Clinical workforce	Disabled		Non-disabled		Unknown		Total
	Num	%	Num	%	Num	%	
Cluster 1: AfC Bands <1 to 4	49	5.1%	795	82.8%	116	12.1%	960
Cluster 2: AfC bands 5 to 7	95	5.1%	1524	81.6%	249	13.3%	1868
Cluster 3: AfC bands 8a and 8b	5	2.9%	143	83.6%	23	13.4%	171
Cluster 4: AfC bands 8c to VSM	0	0.0%	14	82.4%	3	17.6%	17
Total clinical	**149**	**4.90%**	**2476**	**82.1%**	**391**	**13.0%**	**3016**

Medical and Dental	Disabled		Non-disabled		Unknown		Total
	Num	%	Num	%	Num	%	
Medical & Dental Staff, Consultants	3	1.38%	159	73.27%	55	25.35%	217
Medical & Dental Staff, Non-Consultants career grade	2	2.94%	48	70.59%	18	26.47%	68
Medical & Dental Staff, Medical and dental trainee grades	4	3.23%	98	79.03%	22	17.74%	124

Total Medical and Dental	**9**	**2.20%**	**305**	**74.57%**	**95**	**23.23%**	**409**

Total workforce	**Disabled**		**Non-disabled**		**Unknown**		**Total**
	Num	%	Num	%	Num	%	
Number of staff in workforce	**247**	**5.16%**	**3825**	**79.97%**	**711**	**14.87%**	**4783**

Metric 2: Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts.

2023/24	2024/25
The relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts is **1.41**. This indicates that non-disabled staff are more likely to be appointed from shortlisting compared to disabled applicants.	The relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts is **0.95**. This indicates that non-disabled staff are less likely to be appointed from shortlisting compared to disabled applicants.

To note:

i) A relative likelihood of 1 indicates that there is no difference: i.e. non-disabled applicants are equally as likely of being appointed from shortlisting as disabled applicants.

ii) A relative likelihood **above** 1 indicates that non-disabled applicants are more likely to be appointed from shortlisting compared to disabled applicants: e.g. a likelihood ratio of 2 indicates non-disabled applicants are twice (2 times) as likely to be appointed from shortlisting as disabled applicants.

iii) A relative likelihood **below** 1 indicates that non-disabled applicants are less likely to be appointed from shortlisting compared to disabled applicants: e.g. a likelihood ratio of 0.5 indicates non-disabled applicants are half (0.5 times) as likely to be appointed from shortlisting as disabled applicants.

Metric 3: Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

2023/24	2024/25
There is no difference between the relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff.	There is no difference between the relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff.

To note:

i) A relative likelihood of 1 indicates that there is no difference, i.e. disabled staff are equally as likely as non-disabled staff to enter formal capability processes.

ii) A relative likelihood **above** 1 indicates that disabled staff are more likely to enter formal capability processes than non-disabled staff: e.g. a likelihood ratio of 2 indicates that disabled staff are twice (2 times) as likely to enter a formal capability process compared to non-disabled staff.

iii) A relative likelihood **below** 1 indicates that disabled staff are less likely to enter formal capability processes compared to non-disabled staff: e.g. a likelihood ratio of 0.5 indicates disabled staff are half (0.5 times) as likely to enter a formal capability process compared to non-disabled staff.

Metric 4 to 9a (linked to the Staff Survey 2024):

Question	Staff with a long-term health condition or illness				Staff without a long-term health condition or illness			
	2022	2023	2024	Trend	2022	2023	2024	Trend
Q14a) Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	26.85%	25.75%	**25.04%**	**Improved**	19.93%	18.83%	**20.05%**	**Deteriorated**
Q14b) Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months	17.91%	11.47%	**10.07%**	**Improved**	7.98%	5.68%	**6.55%**	**Deteriorated**
Q14c) Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	24.44%	22.68%	**18.86%**	**Improved**	15.68%	12.45%	**14.38%**	**Deteriorated**
Q14d) Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	42.95%	53.88%	**49.76%**	**Deteriorated**	49.52%	48.74%	**50.32%**	**Improved**
Q15) Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	53.99%	58.04%	**57.83%**	**Deteriorated**	61.03%	64.80%	**62.37%**	**Deteriorated**
Q11e) Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	26.86%	22.70%	**21.53%**	**Improved**	18.29%	15.63%	**14.82%**	**Improved**

Q4b) Percentage of staff satisfied with the extent to which their organisation values their work	34.07%	40.77%	**38.51%**	**Deteriorated**	45.64%	50.65%	**47.53%**	**Deteriorated**

Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.

Metric 10: Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

Percentage difference:

i. By voting and non-voting membership of the board.
ii. By Executive and non-exec membership of the board.

	2023/24			2024/25		
	Disabled	Non-disabled	Unknown	Disabled	Non-disabled	Unknown
Total Board Members	6%	82%	12%	0%	100%	0%
of which: Voting Board members	0%	92%	8%	0%	100%	0%
Non-voting Board members	20%	60%	20%	0%	100%	0%
Exec Board members	0%	89%	11%	0%	100%	0%
Non-exec Board members	12.5%	75%	12.5%	0%	100%	0%
Number of staff in workforce	4%	78%	18%	5.16%	79.97%	14.87%
Difference (Total board - Overall workforce)	1.77%	4.7%	-6.48%	-5.16%	20.03%	-14.87%

10. Appendix Two: WDES Action Plan 2024/25

The Workforce Disability Equality Standard action plan has been developed in conjunction with the Disability Awareness Network based on actions developed in 2023/24.

Metric Alignment / Theme	Action	Timescale / RAG	Anticipated Success Factors
Disclosure and Reporting	**Increase the disability disclosure rate through education, targeting self-declaration and interventions whereby disclosure rates can change.**	**October 2026**	Refreshed campaign aligned with the organisational strategy. Improvement in unknown declaration rate of 2% annually.
	Decrease the unknown disability disclosure rate of the medical and dental workforce through targeted interventions, including medical appraisal.	**October 2026 (Annual progress updates)**	Targeted engagement in conjunction with the Medical Director and Deputy Medical Director. Improvement of declaration rate of 2% annually.
	Work with Medical Education to identify opportunities for training and improved induction measures on reasonable adjustments, aiming to increase the confidence in reporting of disability declaration across the medical profession.	**May 2026**	Improved medical and dental EDI inductions and training sessions. Improvement in GMC and NETS Survey results for wellbeing. Improvement in medical and dental WDES reporting.
Reasonable Adjustments	**Relaunch the Reasonable Adjustments Hub with emphasis on the updated guidance document and supported SOPs.**	**September 2025**	Reasonable Adjustments Hub relaunched with an increase in microsite hits month on month.

	Complete a review of the Trust Workplace Passport to support suitability for clinical and non-clinical roles. Following the review, make adjustments to ensure that the passport is widely accessible.	**September 2025**	Passport audit completed and review undertaken, with a relaunch of the passport across all professions.
	Implement a Neurodiversity in the Workplace easy read guide based on the Reasonable Adjustments guidance. Develop a short bitesize learning platform for managers.	**November 2025**	Guide to be developed to support managers access and microsite hits to be monitored for the new training platform quarterly.
	Develop a resource for pre-application and employment checks to support new applicants in disclosing their disability status and/or required reasonable adjustments.	**September 2025**	New resource developed both digitally and by print for recruitment and Occupational Health resources.
Access to Work / Maximus	**Increase awareness of external reasonable adjustments organisations to support:** **1. Individual's access to adjustments** **2. Management's awareness of processes to take**	**September 2025**	Refreshed SOP to be in place for managers with targeted communications to staff through various formats, including pre-employment and normal channels.
	Scope the development of an insourced reasonable adjustments function to support improvements in access to reasonable adjustments.	**March 2026**	Best practice scoped and an options appraisal completed.
Staff Network	**Support wider engagement of the Disability Awareness**	**September 2026**	Increased network engagement, launched as part of the networks 'in common' promotion.

	Network by relaunching the network alongside networks 'in common' from July 2025.		
Bullying and Harassment **To note: This action forms part of a wider Trust wide action plan for improvement**	**Launch a refreshed bullying, harassment and abuse campaign Trust wide with refreshed reporting routes, information targeting patients, workforce and the public and create reader friendly policy guides for managers / staff to access.**	**December 2025** **(Progress to be monitored annually until March 2027)**	Launch of the refreshed campaign with materials. Reduction in reported instances via the staff survey annually with an increase in formal reports via Datix / employee relations to reduce the disparity.
	Scope the development of an anti-bullying policy and procedure which replicates national best practice for sexual misconduct, including anonymous reporting.	**August 2025**	Options appraisal completed following the scoping to align with the bullying and harassment programme.
	Launch a Culture, Inclusion and Wellbeing Steering Group focused on targeting interventions to wellbeing through a holistic approach, including bullying and harassment, violence and aggression, presenteeism etc.	**October 2025**	Steering Group terms of reference approved by the Workforce Inclusion and Culture Sub-Committee with assurance reported through the bullying and harassment programme.
Accountability	**Complete a review of Trust wide EDI objectives to realign 2026/27 objectives with updated intelligence from equality reporting, e.g. active bystander.**	**January 2026**	Updated objectives for all staff, with targeted leadership objectives.
Training	**Implement a bitesize 'disability' training package Trust wide with**	**October 2025**	Training package launched and recorded on ESR with attendance increasing quarterly.

	targeted offers. Identify areas of low compliance with reasonable adjustments and target training with an annual review completed against the Staff Survey results.	**(Progress to be monitored annually until March 2027)**	Review of staff survey results annually to refresh areas of targeted focus.
	Complete a review of current HR and OD learning offers to identify opportunities to embed reasonable adjustments, disability and neurodiversity cultural improvements within pre-existing programmes.	**September 2025**	Review of current training models to be completed with updates to training being progressed as a result.
	Launch a training programme aligned with supporting attendance on reasonable adjustments and creating a supportive culture, aimed at addressing presenteeism within the workplace.	**March 2026**	Training materials launched.
	Development of a series of board related EDI training and development programmes, including anti-racism, disability awareness, cultural appreciation, equality analysis and competency across all characteristics.	**December 2026**	Board development programme to include at least one EDI related offer annually based on refreshed data from equality reporting schedules.
	Implementation of an insourced Reciprocal Mentoring programme to commence between executive members, senior and aspiring leaders representing all characteristics.	**November 2025** **(Review to be completed six-monthly)**	Reciprocal Mentoring programme launched and built into talent management plans for the following year.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/10/108**			
SUBJECT:	Bi-monthly Strategy Highlight Report			
DATE OF MEETING:	1 October 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 continue to work towards becoming a single organisation. Trust Boards approved a proposal to accelerate the transaction to become a single organisation from April 2026. • Over 100,000 additional diagnostic tests have been undertaken in Community Diagnostic Centre (CDC) spaces since it opened in May 2023. The third phase of the CDC programme completed in May 2025 and both the new CT and MRI scanners are now fully operational. There is a potential opportunity to develop a fourth phase of the CDC with further funding from the national programme pending approval of a business case. If successful, this would enable ophthalmology assessment services to be provided at Runcorn Shopping City. • The Living Well Warrington online platform went live to the public on 26th March. The site has received over 92,000 views with the membership growing daily. The platform showcases over 680 activities that support living well across Warrington. • The Warrington Together Living Well Programme, which includes the Living Well Hub, Talking Points and Living Well Warrington online platform has been shortlisted for a HSJ Award in the Integrated Care Initiative of the Year category. Results will be announced on 20th November 25. • The full business case for development of the East Pathology Hub has been approved by the Trust Board.		
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**	Executive Management Team	
	Agenda Ref.		
	Date of meeting	23/9/2025	
	Summary of Outcome	Noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

Strategic projects update
July-August 2025

Section 1 - Key messages	
Slide 2	Summary of key developments this reporting period
Section 2 - Stakeholder engagement	
Slide 3-4	Summary of key stakeholders engaged during the reporting period
Section 3 - Key strategic projects	

Page	Project	Strategy Lead	Status
Slide 5-6	WHH/BCH Integration programme	Stephen Bennett	
Slide 7-8	Runcorn town deal	Carl Mackie/Viviane Risk	
Slide 9-10	New hospitals programme and strategic estates	Carl Mackie	
Slide 11-12	Warrington Living Well Virtual Health & Wellbeing Hub	Rachel Moran/Stephen Bennett	
Slide 13	Completed projects	Strategy team	

Section 4 - Other trust strategic updates	
Slide 14	Summary of other Trust strategy related updates
Section 5 - Cheshire and Merseyside strategic updates	
Slide 15	Summary of strategic updates from Cheshire and Merseyside

Key messages

- WHH and BCH continue to work towards becoming a single organisation. Trust Boards approved a proposal to accelerate the transaction to become a single organisation from April 2026.
- Over 100,000 additional diagnostic tests have been undertaken in Community Diagnostic Centre (CDC) spaces since it opened in May 2023. The third phase of the CDC programme completed in May 2025 and both the new CT and MRI scanners are now fully operational. There is a potential opportunity to develop a fourth phase of the CDC with further funding from the national programme pending approval of a business case. If successful, this would enable ophthalmology assessment services to be provided at Runcorn Shopping City.
- The Living Well Warrington online platform went live to the public on 26th March. The site has received over 92,000 views with the membership growing daily. The platform showcases over 680 activities that support living well across Warrington.
- The Warrington Together Living Well Programme, which includes the Living Well Hub, Talking Points and Living Well Warrington online platform has been shortlisted for a HSJ Award in the Integrated Care Initiative of the Year category. Results will be announced on 20th November 25.
- The full business case for development of the East Pathology Hub has been approved by the Trust Board.

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	Warrington neighbourhood health plan, UEC system improvement
Alex Kirkpatrick	Deputy DoF, NHSE NW	Integration
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 working group
Ian Triplow	CDC Programme Director, Cheshire & Merseyside	Community Diagnostic Centre and potential CDC expansion
Sarah Hall MP	MP	Urgent treatment centre
Linda Buckley	Managing Director, CMPC	C&M blueprint
Christina Banerji Katherine Golding	Mergers and acquisitions team, NHS England	NHS England Strategic Case review
Rob Cooper Kate Clark Mark Hogg	CEO, Mersey and West Lancashire Teaching Hospitals Director of Strategy, Mersey and West Lancashire Teaching Hospitals Finance, Mersey and West Lancashire Teaching Hospitals	Pathology Collaboration
Phil Merrifield	CEO, Made Open Software	Future developments of Living Well Warrington digital platform
Amanda Ridge	C&M ICB	Neighbourhood health plans in Warrington
Wesley Rourke	Executive Director, Environment and Regeneration	Runcorn Shopping City, Levelling up, Runcorn Town Deal
Michael Allen	Partner, KPMG	Due diligence for production of full business case for integration
Dr Laura Mount Emily Benbow	Central & West Warrington PCN	Obesity management strategy for Warrington
David Wilson	One Halton Clinical director	Clinical services integration
CEOs Cheshire, Warrington and Wirral Trusts	CEOs Cheshire, Warrington and Wirral Trusts	C&M blueprint

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
Matthew Swanborough Jon Develing	Chief Strategy and Partnerships Officer, Wirral University Teaching Hospitals Director of Strategy, Countess of Chester Hospitals	Integration, C&M strategy
Carl Marsh	Place Director, Warrington	Place development and Warrington neighbourhood health
David Cooper	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, Warrington neighbourhood health
Cathy Elliott	CEO, NHS Cheshire and Merseyside	Integration
Asia Bibi	Alder Hey Children's Hospital	Paediatric surgical hub
Steve Park	Interim CEO, Warrington Borough Council	Integration, estates development, urgent treatment centre
Dr Laura Mount Dr Ash Ahluwalia Dr Golam Choudhury Dr Mike Northey	Warrington PCN Clinical Directors	Warrington neighbourhood health, integration
Julia Rosser Julia Murray Shepard	Public Health Warrington / Public Health Halton	Sexual Health Service
Sheila Paul/Louise Lucas Paul Tyerman/Lee Matthews Laurence Pullan/Tom Kearney Rachel Cartwright	Warrington Borough Council	Living Well Warrington digital platform
Tony Bennett	Deputy Director of Strategy, Wirral University Teaching Hospitals	Warrington Living Well programme and neighbourhood health
C&M ICB Board	All board members	Support for strategic case and timeline, integration

Integration – part 1

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

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 has developed a detailed delivery plan and are working with partners to deliver objectives.

What does this mean for WHH?

The 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. 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:

- Approval of strategic case and accelerated timeline by both WHH and BCH trust boards as well as support secured from Cheshire and Merseyside ICB.
- Initial draft of Full Business Case underway
- Commission of external independent support for required due diligence

Integration – part 2

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
Provide all Due Diligence data and information	12 September
First draft of Full Business Case	12 September
Due diligence report completed	19 October
Outcome of NHS England strategic case review	October 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
Stephen.bennet@nhs.net

Runcorn town deal-part 1

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

- Concepts for the hub branding and logo in development.
- First-fix mechanical installation complete. Partition walls installed and being plastered.
- Advice on CQC application process obtained.

Runcorn town deal- part 2

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
Construction complete	Dec 2025
Services go live	Feb 2026

Contact details
Viviane Risk
Strategic Project Manager
viviane.risk@nhs.net

Carl Mackie
Halton Healthy New Town and Strategy Manager
carlmackie@nhs.net

New hospitals and strategic estates planning- part 1

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

- Principles and programme described around the Estate masterplan, including alignment to refreshed trust strategy/clinical strategy
- Tabletop review of 2015 Outline Business Case
- Continued discussion with NHS C&M around progression of case for co-located Urgent Treatment Centre

New hospitals and strategic estates planning- part 2

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
Delivery of updated strategic estates masterplan	December 2026
Notification of UTC Bid outcome	TBC

Contact details
Carl Mackie
Halton Health New Town and Strategy Manager
carlmackie@nhs.net

Living Well Virtual Hub- part 1

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 forms 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 empowers users to navigate their health and wellbeing journey more independently and is the single digital entry point for any health and wellbeing-related enquiries for the public and staff working in Warrington.
- 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 a broader shift from analogue to digital, hospital to community, and reactive care to prevention. It also supports the development of a digital blueprint for delivering the new neighbourhood health model across Warrington.
- 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

- As part of the Living Well Programme, together with the Living Well Hub and Talking Points, the platform has been shortlisted for a national HSJ Award in the Integrated Partnership of the Year Category. Results will be announced 20th November.
- 358 new members to platform, 690 live activities, 2,800 monthly active users, 92,402 page views.
- Supported new volunteering opportunities across the borough with confirmed pledges to volunteer.
- Platform sustainability plan in progress. This includes exploring options for the inclusion of for-profit businesses and the wider private sector as active contributors to the long-term success and support of the platform. The aim is to ensure ongoing viability beyond initial public funding, while maintaining the platform’s core purpose of promoting health, wellbeing, and community-led support across Warrington.
- New content published on platform in collaboration with multi-sector subject matter experts, more in the pipeline.
- Launch of pilot business subscription model 1st September to allow eligible businesses to support Living Well in Warrington via the platform.

Living Well Virtual Hub- part 2

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-Dec 25
Launch pilot business membership model	1st Sept 25
Content review and subject matter expert engagement workshops	Sept-Dec 25
Sustainability planning and evaluation	Sept 25- Jan 26

LIVING WELL IN WARRINGTON

Contact details
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Rachel Moran
Strategic Project Manager
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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.

Warrington Living Well Hub

- Attendances at the Living Well Hub have passed 30,000 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:
    - CGL – Young People's Substance Drop-In – launching Friday afternoons, complementing the existing youth offer (Youth Service and Back on Track) to strengthen wraparound support for young people.
    - SEND Play Session (0–5 years) – now running on Wednesday mornings, shaped by family and professional feedback to expand the early years SEND offer.
    - Domestic Abuse – "Own My Life" Programme – now also offered in the evening, ensuring accessibility for individuals unable to attend daytime sessions.
    - PCSO Surgery – monthly opportunity for residents to connect directly with local officer, Tony Spruce, improving access to policing support.
    - Healthwatch Drop-Ins – continuing to amplify community voice through a Mental Health Survey, Domiciliary & Social Care support, and ICAS Health Advocacy.
    - Kit 4 All – taking place on the first Friday afternoon of each month, offering new and pre-loved sports kit to help reduce barriers to physical activity.
- The Warrington Living Well programme (Living Well Hub, digital platform and Talking Points projects) has been shortlisted in the 2025 HSJ awards as an exemplar programme of work demonstrating a high-quality integrated care approach and provider collaboration.

Community diagnostic centre

- Over 100,000 additional diagnostic tests have been undertaken in the new CDC spaces (Phases 1+2) since Phase 1 went live in May 2023.
- The third and final phase of the CDC programme completed in May 2025 and both the new CT and MRI scanners in the facility are now fully operational.
- Potential opportunity to expand the CDC development at the Halton Health Hub with further allocation of funding from the national programme. Business case has been developed. If successful, this would secure a further £2.5m of capital funding to progress a fourth phase of the programme and provide ophthalmology assessment services at the site in Runcorn Shopping City.

Other Trust strategic updates

Theatre 3 at Nightingale Building, Halton

- T1 & T2 handed back from contractor to Trust on 22nd April 2025
- T1 & T2 operational from May 2025
- Recovery handover planned for September 2025
- T3 handover planned for October 2025
- WHH Project Team working closely with contractors to manage early warning notices and compensation events

Cheshire and Merseyside strategic project 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 collaborating 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. The full business case was approved by Trust Board in August. The full business case details 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 where both Trusts clinicians will meet to agree the way forward.

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Organisational Strategy Development

Lucy Gardner, Chief Strategy and Partnerships Officer
Kate Henry, Director of Communications and Engagement
Adam Harrison-Moran, Head of Culture and Inclusion

Better Care Together
Home · Community · Hospital

Ask of Trust Board today

NHS
North Cheshire and Mersey Healthcare Partnership
Integrating Bridgewater Community Healthcare and Warrington and Halton Teaching Hospitals

- Approve interim mission, vision, aims and strategic objectives, April 2026 – December 2026
- Approve proposed values for enlarged organisation, from 1st April 2026

Context

- Overarching strategy needed for the integrated organisation
- Strategy development to align with accelerated transaction timeline and continue through 2026
- Current WHH and BCH strategies valid to end of 2026
- FBC needs to include vision, values, aims and objectives for our integrated organisation by mid September
- Staff feedback suggests areas for immediate prioritisation are around the TUPE and organisational change processes and the development of our values
- Phased approach to strategy development to respond to:
    - staff feedback
    - acceleration requirements
    - the need for full and extensive engagement on future strategy

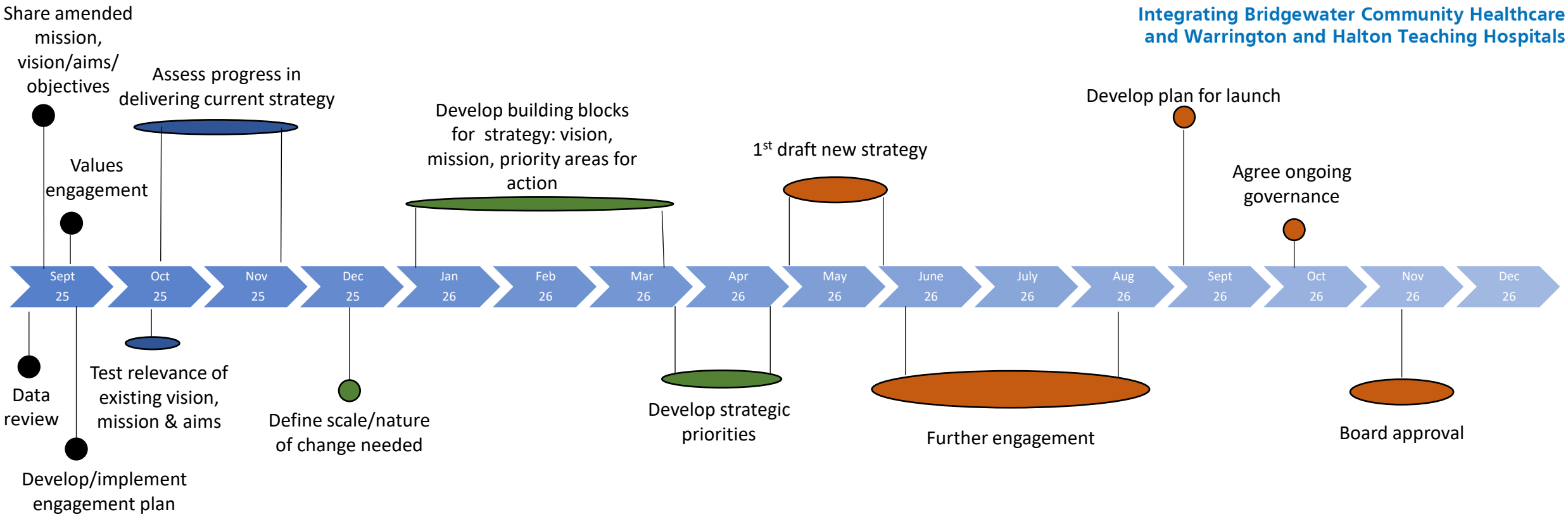
NHS

North Cheshire and Mersey Healthcare Partnership

Integrating Bridgewater Community Healthcare and Warrington and Halton Teaching Hospitals

Strategy Development Timeline

NHS
North Cheshire and Mersey Healthcare Partnership
Integrating Bridgewater Community Healthcare and Warrington and Halton Teaching Hospitals



WHH and BCH strategies remain valid

Revised interim strategy valid for North Cheshire and Mersey NHS FT

Approach to developing Organisational Strategy

Phase 1- by mid September 2025:

- Review current strategies, data, national/regional/local priorities
- Where required revise current WHH mission, vision, aims and strategic objectives in line with BCH
- Engage on values: existing forums and staff survey - to include staff, governors and NEDs
- Develop full engagement programme (internal and external) for implementation in 2026
- Share updated mission, vision, aims and objectives, new values, and wider engagement plan

Phase 2 - mid September 2025 onwards (12-15 months):

- Implementation of full engagement programme - overarching strategy and enabling strategies
- Review and rationalize enabling strategies
- Communicate new strategy internally and externally

Proposed revised Mission, Vision and Aims

NHS
North Cheshire and Mersey Healthcare Partnership
Integrating Bridgewater Community Healthcare and Warrington and Halton Teaching Hospitals

Our Mission

We will be Exceptional for our patients, our communities and each other

Our Vision

We will be a great organisation providing excellent healthcare and opportunities to work and learn

Our Aims

QUALITY

We will always put our patients first delivering safe, compassionate, inclusive and effective care and an excellent patient experience

PEOPLE

We will be the best place to work by creating an environment where every employee feels valued, supported, and inspired to develop, grow, and thrive—today and in the years ahead

SUSTAINABILITY

We will work in partnership with others to achieve social and economic wellbeing in our communities and improve equity in health outcomes.

Proposed revised Strategic Objectives

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 our organisation	Financial sustainability

Values- approach to development

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Engagement:

- A three-week staff engagement exercise has been undertaken from August 2025 through a staff survey which was shared through forums such as the Good Morning Message to additionally include Governors
- The survey highlighted the current values of both Trusts and examples of other NHS organisations and asked stakeholders what is important to them

Current WHH and BCH values										
Working together	Excellence	Inclusive	Kind	Embracing change	Person centred	Empowered	Open and honest	Professional	Local	Efficient

- Qualitative information has been obtained through discussion at internal and external forums
- Survey results and qualitative data have been triangulated to identify a future set of values which resonate with staff
- The findings of this engagement will feed into the Full Business Case for Better Care Together

Values- Results output

A total of 183 people completed the survey, representing a split of:

- WHH colleagues – 55% | BCH colleagues – 44% | External – 1%

The aggregated survey responses reveal several key initial insights:

- The values of 'working together', 'kindness' and 'person centred' are the most frequently quoted as resonating with staff, indicating a strong preference for collaboration, compassion and individualised care.
- Many respondents emphasise the importance of values being demonstrated in practice, not just stated, with recurring calls for leadership accountability, better communication and a culture where values are consistently lived by all levels of staff.
- There is a notable desire for values to be simple, memorable and actionable, with some staff expressing concern that too many or overly broad values can dilute their impact and make them harder to embed in daily work.

Values- Results output

From the analysis of feedback, several themes have been identified:

- **Clarity and Simplicity:** Values should be straightforward, memorable and actionable.
- **Culture Focus:** Emphasise a welcoming and inclusive culture, aligning with workforce aspirations and national priorities.
- **Clear Distinctions:** Define and communicate values, behaviours and objectives clearly to avoid confusion.
- **Behavioural Alignment:** Ensure a direct link between values and behaviours, supported by accountability mechanisms.

Values- Proposed new values for approval

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Following the analysis of the results and free-text comments, the following values are proposed for North Cheshire and Mersey NHS Foundation Trust, effective from 1 April 2026

- **Kind** – We are caring, supportive and respectful to everyone
- **Open** – We are honest, transparent and open to new ways of working
- **Fair** – We listen, value our differences and are inclusive to all
- **One team** – We work together to deliver the best care for patients

A refreshed behavioural framework will follow to align against the new values.

Ask of Trust Board today

NHS
North Cheshire and Mersey Healthcare Partnership
Integrating Bridgewater Community Healthcare and Warrington and Halton Teaching Hospitals

- Approve interim mission, vision, aims and strategic objectives, April 2026 – December 2026
- Approve proposed values for enlarged organisation, from 1st April 2026

Appendix 1
Strategy “Products”

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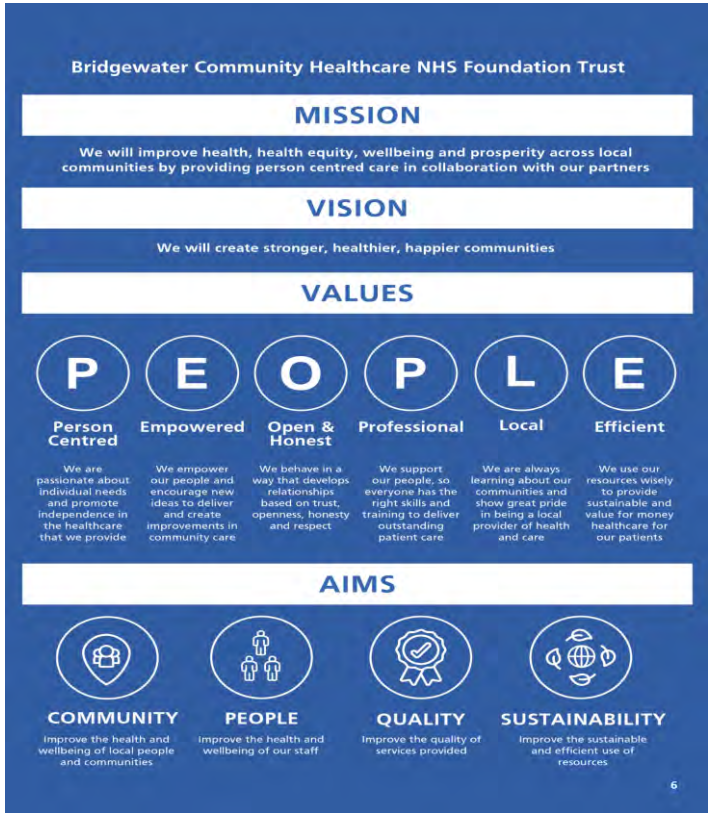
Strategy	High-level description	Timeframe
Five year organisational plan	Internal and regional use. Aligned to NHS 10-year plan, to set out the long-term objectives for the organisation. Detailed plans on annual basis, including impact measures.	December 2025
Organisational strategy	Public facing. Vision, values and objectives and priorities to deliver strategic goals.	December 2026
Clinical strategy	Public and internal facing. Including responsibilities to address health inequalities and wider determinants of health. Supported by service level clinical priorities and plans.	December 2026 (December 2025)
Financial strategy	Internal and regional use. Plan to break-even from current deficit position and maintain financial sustainability.	December 2025
Estates development plan	Internal use. To describe estate requirements to deliver clinical strategy in fit for purpose facilities. Supported by detail to inform investment cases and deliver cost improvement.	October 2026
Enabling strategies	Internal use. Approaches to provide support, resources and conditions to enable delivery of the 10-year plan and overarching strategy.	December 2026

Appendix 2
Current Strategies



Bridgewater Community Healthcare NHS Foundation Trust

MISSION

We will improve health, health equity, wellbeing and prosperity across local communities by providing person centred care in collaboration with our partners

VISION

We will create stronger, healthier, happier communities

VALUES

P	E	O	P	L	E
Person Centred	Empowered	Open & Honest	Professional	Local	Efficient
We are passionate about individual needs and promote independence in the healthcare that we provide	We empower our people and encourage new ideas to deliver and create improvements in community care	We behave in a way that develops relationships based on trust, openness, honesty and respect	We support our people, so everyone has the right skills and training to deliver outstanding patient care	We are always learning about our communities and show great pride in being a local provider of health and care	We use our resources wisely to provide sustainable and value for money healthcare for our patients

AIMS

COMMUNITY	PEOPLE	QUALITY	SUSTAINABILITY
Improve the health and wellbeing of local people and communities	Improve the health and wellbeing of our staff	Improve the quality of services provided	Improve the sustainable and efficient use of resources

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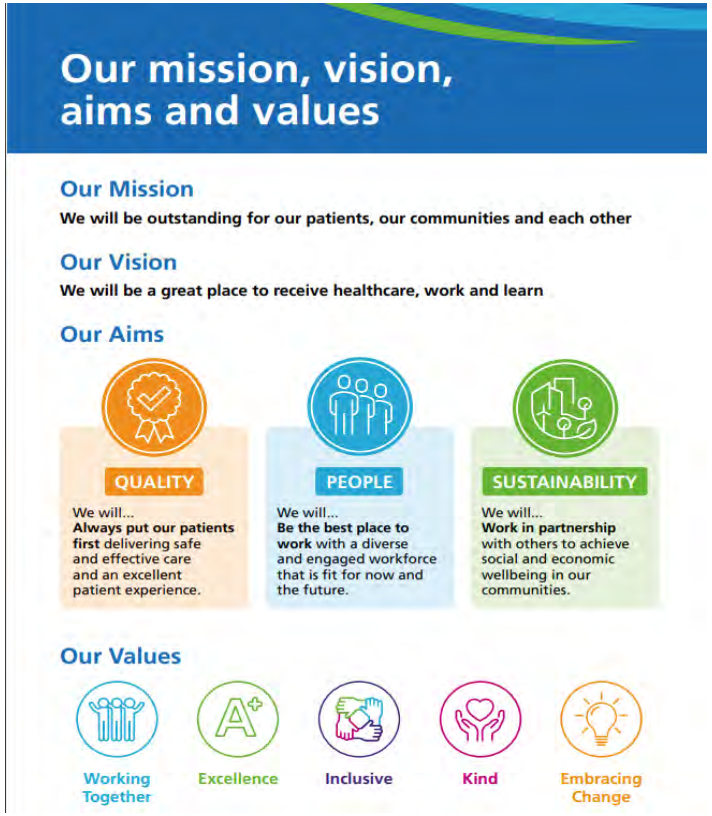


Our mission, vision, aims and values

Our Mission

We will be outstanding for our patients, our communities and each other

Our Vision

We will be a great place to receive healthcare, work and learn

Our 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.

Our Values

Working Together · Excellence · Inclusive · Kind · Embracing Change

NHS
North Cheshire and Mersey Healthcare Partnership
Integrating Bridgewater Community Healthcare and Warrington and Halton Teaching Hospitals

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/10/110**			
SUBJECT:	**Committee Chairs Annual Report – Audit Committee**			
DATE OF MEETING:	**1 October 2025**			
AUTHOR(S):	Mike O'Connor, Chair of the Audit Committee			
EXECUTIVE DIRECTOR SPONSOR:	Steve McGuirk, Chair			
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 seeks to deliver assurance to the Trust Board that the Audit Committee have met their Terms of Reference and have gained assurance throughout the reporting period of the Trust's performance.			
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**	
RECOMMENDATION:	The Trust Board is asked to review and note the reports to providing assurance that each of the Committees are meeting their purpose and ensure it meets its purpose.			

PREVIOUSLY CONSIDERED BY:	**Committee**	Audit Committee
	Agenda Ref.	**AC/25/08/43**
	Date of meeting	28/08/2025
	Summary of Outcome	Approved for reporting to Trust Board
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO TRUST BOARD

SUBJECT	Audit Committee Chair Annual Report 2024-25	AGENDA REF	BM/25/10/110

1. Background/Context

The Audit Committee is required to provide an annual report to both the Board and the Council of Governors, summarising its activities over the reporting period and highlighting any areas of concern where appropriate.

Acting on behalf of the Board, the Audit Committee is responsible for the independent review of the Trust's systems of integrated governance, risk management, assurance, and internal control. Its remit spans the entirety of the Trust's governance agenda, supporting the delivery of organisational objectives.

This report outlines the Committee's membership, its role, and the work undertaken during the year.

2. Key Elements

The Work of the Audit Committee

In year the significant issues that the committee considered in relation to financial statements, operations and compliance were as below. They were addressed through inclusion in the Internal Audit work plan and assurance sought for each element:

1. High assurance was provided in the following: EPRR, risk management core controls, general ledger, accounts payable, accounts receivable, treasury management.

2. Substantial assurance was provided in the following: Fit and proper persons, fractured neck of femur, patient activity data capture (six-week diagnostics) and IT service continuity.

3. Moderate assurance was provided in the following: Consultant job planning.

4. Limited assurance was provided for the following: Medical devices and WHO checklist/ NatSSIPs 2

There were no areas reported as providing no assurance.

Committee Membership and Attendance

Throughout the reporting period, the committee comprised a minimum of three Non-Executive Directors, with meetings quorate at two members. The Committee convened five times during the year. Non-Executive Director Michael O'Connor served as Chair of the Audit Committee.

All Committee members possess the relevant and recent financial expertise required for effective oversight. In accordance with best practice, the Chair of the Trust is not a member of the Audit Committee.

The summary of member attendance is provided below:

Member	Attendance (Actual v Max)
Michael O'Connor, Non-Executive Director	5/5
Cliff Richards, Non-Executive Director	4/5
Julie Jarman, Non-Executive Director	5/5
Jayne Downey, Non-Executive Director	5/5
John Somers, Non-Executive Director	5/5
Jan O'Driscoll, Non-Executive Director	0/5

Regular attendees at committee meetings included representatives from the Trust's external auditors, **Grant Thornton, Mersey Internal Audit Agency (MIAA)**—providing internal audit and counter-fraud services—as well as the **Chief Finance Officer** and the **Company Secretary**.

Terms of Reference

The Committee's Terms of Reference were reviewed and agreed in April 2025 to ensure they continue to remain fit-for-purpose for the 2025/26 financial year.

Governance & Risk Management

During the year the Trust continued to develop and enhance its governance and risk management systems and processes. It also fully appraised its key strategic risks and refreshed its Board Assurance Framework. Each strategic risk is allocated to a committee or the Executive Management Team Meeting for focused oversight and scrutiny, the BAF is reviewed in full by the Board at each of its bi-monthly meetings and at committee meetings in year.

The Audit Committee monitored and tracked all material governance activity during the reporting period to ensure that the system of internal control, risk management and governance is fit for purpose and compliant with regulatory requirements, aligned to best practice where appropriate and provides a solid foundation to support a **Substantial Assurance** rating from the Head of Internal Audit (HOIA).

Internal Audit Activities

MIAA acted as internal auditors for the Trust during the year. Internal audit is an independent and objective appraisal service which has no executive responsibilities within the line management structure. It pays particular attention to any aspects of risk management, control or governance affected by material changes to the Trust's risk environment, subject to Audit Committee approval. A detailed programme of work is discussed with the Executive Team and set out for each year in advance and then carried out along with any additional activity that may be required during the year.

In approving the internal audit work programme, the committee uses a three-cycle planning and mapping framework to ensure all areas are reviewed at the appropriate frequency. Detailed

reports, including follow-up reviews to ensure remedial actions have been completed, are presented regularly to the committee by internal audit throughout the year. All such information and reports are fully recorded in the minutes and papers prepared for each Audit Committee meeting.

Assurance Framework Review

A robust and well-functioning Assurance Framework is essential to sound governance. It serves as a strategic tool for Boards to confirm that there is adequate, ongoing, and dependable assurance in place—supporting organisational stewardship and the effective management of key risks that could impact success.

Following a comprehensive review, it was concluded that the organisation's current Assurance Framework is appropriately structured and aligned with NHS requirements.

Opinion	
Structure	The organisation's AF is structured to meet the NHS requirements of assurance best practice model.
Risk Appetite	The organisation considers risk appetite regularly and the risk appetite is used to inform the management of the AF.
Engagement	The AF is visibly used by the organisation.
Quality & Alignment	The AF clearly reflects the risks discussed by the Board.

2024/25 Head of Internal Audit Opinion,

The overall opinion for the period 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.

Counter Fraud Activity

The Trust's Anti-Fraud programme was delivered by MIAA's Anti-Fraud Service (AFS), in accordance with a plan agreed with the Audit Committee. The AFS supports the Trust in fostering an anti-fraud culture, deterring and detecting fraud, investigating allegations, and pursuing appropriate sanctions and redress.
During 2024–25:

- 16 potential fraud referrals were received.
- 4 referrals progressed to formal investigations.
- 11 referrals were closed.
- 1 referral remains open and will be carried forward into 2025–26.
- 1 investigation from 2023–24 was concluded.

The Trust achieved an overall 'green' rating in its self-assessment against the Government Functional Standard 013 for Counter Fraud.

Data Security and Protection Toolkit (DSPT)

In line with NHS England requirements, MIAA conducted an assessment to provide assurance regarding the validity of the organisation's intended final DSPT submission. This review considered not only whether the submission was reasonable based on the supporting evidence but also evaluated the extent to which information risk was effectively managed within this context.

The scope of the assessment followed the recommendations outlined in the 2023 NHS England publication, *Data Security and Protection (DSP) Toolkit Strengthening Assurance Guide*.
Outcomes of the review:

- **Assessment of the Self-Assessment**: *Substantial Assurance*
- **National Data Guardian Standards**: *Moderate Assurance*

External Audit

Grant Thornton LLP commenced its initial three-year term as Auditors to the Trust in January 2017. The company then commenced a two-year term in October 2020, following a competitive procurement exercise and recommendation by the Council of Governors. The contract contained the option to extend for additional years and following support from the Audit Committee and approval by the Council of Governors, an extension up to 30 September 2024 was agreed. In September 2024 a new three-year contract, with the option of one 12-month extension, for the provision of an external audit service by Grant Thornton LLP was approved.

Opinion on Financial Statements

During the year the auditors reported on the 2024-25 financial statements. No material or significant issues were raised in respect of these statements and accounts. Technical support has been provided on an ongoing basis to the Trust and representatives of Grant Thornton have attended each Audit Committee meeting.

In auditing the financial statements, it was concluded that the Accounting Officer's use of the **going concern basis** of accounting in the preparation of the financial statements was appropriate.

Technical support has been provided on an ongoing basis to the Trust and representatives of Grant Thornton have attended each Audit Committee meeting.

Fit and Proper Persons – Board Compliance

The Committee reviewed assurance that all directors continue to meet the requirements of the NHS England Fit and Proper Persons Test Framework and the Trust's Fit and Proper Person Policy. The annual report was submitted to the Regional Director of NHS England by the statutory deadline of 30 June 2025.

Issues Carried Forward

The Audit Committee remains committed to ensuring that the Trust's system of internal controls and assurance processes are robust and fit for purpose. No significant or material issues were escalated to the Board of Directors or the Council of Governors during the reporting period.

The Committee will continue to monitor risk areas identified in the 2024–25 Internal Audit Plan, which may be prioritised over those in the 2025–26 plan, subject to alignment with the Trust's strategic risk assessment.

Board Assurance Committees

During 2024–25, three Board assurance committees operated alongside the Audit Committee:

1. Quality Assurance Committee
2. Finance & Sustainability Committee
3. Strategic People Committee (streamlined as the Strategic People Committee in Common from 1 April 2025 to support integration)

Each committee was chaired by a non-executive director and included at least two non-executive directors. Committee chairs provided verbal updates to the Audit Committee, facilitating cross-committee assurance and enabling the identification of any gaps in oversight.

3. Conclusion

Throughout the year, the Audit Committee considered a broad range of matters relating to financial statements, operational performance, and regulatory compliance. Assurance was sought through collaboration with Internal Audit, other board committees, and key personnel across the Trust.

As the Chair of the committee, I report regularly to the Board of Directors via the Committee Assurance Reports, highlighting key assurance outcomes and any matters requiring escalation.

Committee meetings were observed by an elected governor, who reported quarterly to the Council of Governors on the conduct of meetings and the effectiveness of Non-Executive Directors in fulfilling their accountability role.

4. Recommendation

The Truste is asked to review the document and ensure it meets its purpose

Mike O'Connor
Chair of Audit Committee
August 2025

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/10/111**			
SUBJECT:	**Cheshire and Merseyside Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common**			
DATE OF MEETING:	**1 October 2025**			
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):***	Cheshire and Merseyside (C&M) providers have come together to collaborate on matters that can be best progressed and responded to, at scale, and through shared focus or action. CMPC has come about through a process borne from bringing together its two forerunners Cheshire and Merseyside Acute & Specialist Trust Alliance (CMAST) and the Mental Health, Learning Disability and Community Provider Collaborative (MHLDC) to focus on work of shared provider delivery: acute, specialist and community services. Working together has achieved real and tangible benefits since the pandemic and been consolidated since. All providers consider this next step will provide further opportunities and opportunities for at scale working where this makes sense.			

	Following a review requested by the system leaders and sponsored by Trust CEOs, Trust company secretaries have engaged in a process of seeking to build upon the established and available collaboration mechanisms within C&M that have been shown to work and support a track record of collaboration. In identifying, promoting and championing the benefits of collaboration NHS England have encouraged all providers to build on local successes through provider collaborative structures where these can be shown to work. C&M cosecs have worked together and drawn upon the expertise and advice of Hill Dickinson to support the redrafting and reframing of a CMPC Joint working agreement and Committees in Common terms of reference. This approach continues the chosen route of governing collaborative delivery and ongoing potential within the system. Following queries raised at the Trust Board meeting in August 2025, clarification sought from the regional team and legal advisers with a response provided in Appendix 1 The CMPC Leadership Board recommends the enclosed documents for adoption by Trust Boards. The updated documentation follows a review and redrafting process to reflect broadened arrangements and scope of the collaboration.		
PURPOSE: ***(please select as appropriate)***	**Approval** ✓	**To note** ✓	**Decision** ✓
RECOMMENDATION:	The Trust Board is asked to: 1. To endorse and agree the CMPC Joint Working Agreement and Committee in Common as proposed 2. To adopt and sponsor the approaches to collaborative working and decision making, as described, recognising the anticipated evolution and development of these proposals under the direction of C&M Trust leadership 3. To explore and commit to the use of delegation when required and supported by Trust Boards as a means of embedding system decision making		
PREVIOUSLY CONSIDERED BY:	**Committee**	n/a	
	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	Cheshire and Merseyside Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common	AGENDA REF:	BM/25/10/111

1. BACKGROUND/CONTEXT

All providers within C&M have some familiarity and individual experiences of differing means of the proposed way of working. This report therefore seeks to briefly orientate an approach and structure of the two documents and then goes on to highlight, at a headline level, changes and areas of development as proposed by Hill Dickinson or Trust company secretaries to aid clarity, understanding and to respond to the current and changed environment.

2. KEY ELEMENTS

Joint Working Agreement (JWA), further detail, and to be read in conjunction with CiC ToR:

- Covers: vision; function; priorities and headline areas of focus
- Establishes: rules of working; process of working together; stages of decision making and scale of involvement and decision making
- Sets: exit plan approach; termination approach; dispute resolution approach; information sharing and competition law principles; conflicts of interest approach

Committee in Common - Terms of Reference (CiC ToR), further detail, and to be read in conjunction with JWA:

- Sets out the C&M response, as proposed by Chairs and Chief Executives, to the Provider Leadership Board collaborative approach
- Committees in Common: Staged levels of Committees in Common decision making; rules based approach; will underpin clear and consistent communication supporting Board awareness and assurance
- Sets aims and objectives of CiC
- Establishes membership and signals wider engagement including minimum frequency of Chairs' engagement
- Quorum
- Annex A establishes potential activities delegated to the CiC when in scope of the CiC work as set in the JWA
- To note: NWAS is proposed as a participant of the meeting rather than as a Member

Changes and variation from previous documentation (or familiar approaches): further detail, and to be read in conjunction with JWA and draft CiC:

Terms of References:

- Updates of names and terminology – organisations, CMPC etc
- Added definitions – to reflect content of documents at request of company secretaries
- Refer to the full breadth of CMPC responsibilities – including community – but also not seek to restrict nor curtail future Trust Board choices
- Additional words without altering meaning of sentences to support clarity
- Reframing of section 2.1 (ToR) to reorder theme stated aims and objectives.
- Add to ICB reference 'and regulator or those charged with performance management'
- Specifying MS Teams or equivalent as an option for a CiC meeting

Joint working agreement:

- Provide further clarity on the route for determining any costs arising from collaborative arrangements (section 6)
- Provide further clarity on the route for calculating any exist costs or transition arrangements arising from a cessation of collaborative arrangements (section 6)
- Additional parameters on timescales for stages of any dispute resolution (section 10)

A request was also made from one Trust for definition and adoption of an information sharing agreement (something explored on numerous occasions in the past by Leadership Boards). If the will exists for this it is proposed that this is developed by Trust Company Secretaries (with legal support and input) and proposed to Leadership Board for adoption.

The documentation provides outputs that represent the culmination of a period of engagement and development with C&M Trust Board leadership and supporting officers. The approach represents the will and direction of this leadership steer and contribution and is put forward as representative of C&M's preferred way of operating.

The document delivers both a foundation and framework for CMPC development, decision making and supports its evolution. It focuses on approach and governance. Business and content scope will iterate and be defined by Boards as the scope and remit of CMPC develops and the ask of the system, for it, expands, varies or diminishes.

3. RECOMMENDATIONS

1. To endorse and agree the CMPC Joint Working Agreement and Committee in Common as proposed
2. To adopt and sponsor the approaches to collaborative working and decision making, as described, recognising the anticipated evolution and development of these proposals under the direction of C&M Trust leadership
3. To explore and commit to the use of delegation when required and supported by Trust Boards as a means of embedding system decision making

Cheshire and Merseyside Provider Collaborative (CMPC)

Joint Working Agreement and Committees in Common addendum (September 2025)

Background and clarifications

1 BACKGROUND

1.1 Cheshire and Merseyside (C&M) acute and specialist providers originally came together as CMAST to collaborate on matters that can be best progressed and responded to, at scale, and through shared focus or action. Working together achieved real and tangible benefits during the pandemic, with much of CMAST (now CMPC)'s foundations emerging from these activities but also building upon, wider and existing, local collaborative strengths such as the Cancer Alliance.

1.2 In identifying, promoting and championing the benefits of collaboration in 2022 NHS England encouraged all providers to build on local successes through provider collaborative structures and also required all providers to be part of a collaborative.

1.3 C&M Trust leaders worked together to explore collaborative potential, develop ways of working and defining priorities. This work included both Chief Executives and Chairs.

1.4 Following this work and the success of several CMAST initiatives it was agreed that CMAST's ways of working were embedded through a Joint Working Agreement as a means to document the progress made together and provide an opportunity for Boards to demonstrate a shared commitment to the vision, priorities and programmes of work that they have identified and initiated.

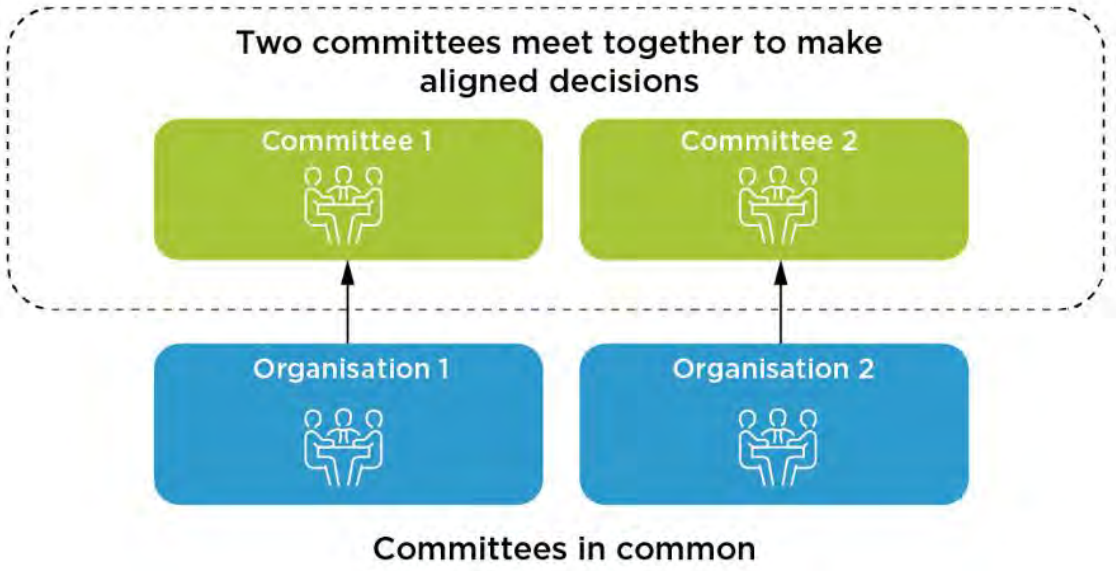
1.5 It was also proposed that there was a more formal governance structure to provide a route for shared and formalised decision making as and when required. This decision-making framework (in the committees in common) aims to underpin existing ways of working and provide a framework to build from, as necessary, to fulfil either the need, potential or ambition of Boards.

1.6 The position in the documentation represents the culmination of that period of engagement and development with Trust Board leadership and supporting officers. The approach represented the will and direction of local and national leadership and was put forward as representative of C&M's preferred way of operating. This allowed flexibility around the delegation of decisions to each Trusts committee when this was felt necessary to progress business. There has not to our knowledge been a formal delegation required yet and the JWA and CIC ToR remain a "framework for action" for CMPC not the script. Any formal delegations into your Trust committee would require Trust Board approval.

2 CLARIFICATIONS

2.1 Committees in Common approach

2.1.1 Each CMPC Trust forms a committee of its Board which then meets together with the other CMPC Trusts committees. Each committee makes its own separate decision on behalf of its 'parent' Trust, but with the aim of reaching the same decision as the other committees, therefore taking aligned decisions. The committees in common approach is summarised in the diagram below:



2.2 **Can the Trust be forced to accept a majority decision if a group of trusts or larger organisations are in favour of a particular action under the CMPC arrangements?**

2.2.1 No, the Trust Committee has its own Terms of Reference and reports back to its own Trust. It is not required to accept any other organisation's decisions and is entitled to make (or not make) any decision as it sees fit.

2.2.2 The intent for the CMPC committees in common is that the Trusts will seek to reach consensus with members and work in a collaborative and integrated way as set out in the Joint Working Agreement. Each Trust though retains its own statutory decision making as the Trust committee it creates for CMPC is the Trusts *own committee* and is not bound to follow other trusts decisions.

2.2.3 Also, it is worth noting that the scope of the delegation into to the Trust committee is to be agreed so the Trust itself will determine what decisions and authority goes into the committee that forms part of CMPC and how this reports back to the Board.

2.3 **Is the Trust committee decision binding on its Trust?**

2.3.1 The decision of a committee cannot bind its own Trust beyond the Trust's existing delegations made to that committee (which will need to be approved by the parent Trust Board). Any Board committee acting outside its delegation would be ultra vires and not valid unless and until ratified by the Board. The existing wording throughout the documents reflects this principle.

2.3.2 The committee is limited to its delegated authority and must remain within the scope of that authority – clause 5 of the ToR reinforces this by stating that any functions not delegated to the committee are retained to the Board. The committee cannot therefore lawfully make any binding decisions on anything outside of that delegation.

2.3.3 The ToR, in Appendix A, makes it clear that each Trust Board remains a sovereign entity and if a proposal is outside of delegated matters, the default procedure is that the proposal must first go to each Trust Board for discussion, and the Trust's committee would only proceed if it given a specific delegated authority, within parameters pre-agreed by its Board.

2.4 **Is there a clear and detailed scheme of delegation to the Trust's CMPC committee?**

2.4.1 Not at this stage – as stated in paragraph 1.6 above this has not been required to date.

2.4.2 Any specific subject areas and any appropriate financial limits would need to be brought forward and approved by the Trust Board for its own committee at each juncture (noted in the JWA's tiered approach at clause 4.5). Specific decisions with regard to subject areas, level of decisions and financial limits would be discussed and agreed by the Trust Board at the appropriate time (noting this is a 'framework' for those decisions to be made).

2.4.3 The CMPC committees act to function together as a forum for aligned decision-making and discussion while preserving sovereignty (each committee binds only its own Trust). It allows the CMPC Trusts to "*tackle areas of common concern and deliver a shared agenda on behalf of the collaborative and its system partners" (NHSE Guidance)*. Even where each CEO could act unilaterally on an operational decision, it was considered beneficial for a collaborative to act together with aligned delegated responsibilities so that common issues can be better addressed as part of a collaborative. The value is in creating a single forum for what would otherwise be parallel decisions made in isolation.

3 NEXT STEPS

If you would like to discuss any points raised in this note further, please contact Rob McGough (robert.mcgough@hilldickinson.com).

Hill Dickinson LLP
18 September 2025

HILL DICKINSON

Draft No: 2
Date of Draft: June 2025

Dated 2025

CHESHIRE & MERSEYSIDE PROVIDER COLLABORATIVE (CMPC) JOINT WORKING AGREEMENT

Between

(1) **BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST**

(2) **CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST**

(3) **COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST**

(4) **LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**

(5) **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST**

(6) **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST**

(7) **THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST**

(8) **LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST**

(9) **THE WALTON CENTRE NHS FOUNDATION TRUST**

(10) **LIVERPOOL WOMEN'S NHS FOUNDATION TRUST**

(11) **ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST**

(12) **MERSEY CARE NHS FOUNDATION TRUST**

(13) **EAST CHESHIRE NHS TRUST**

(14) **MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST**

(15) **MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST**

(16) **WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST**

and

(17) **NORTH WEST AMBULANCE SERVICE NHS TRUST**

CONTENTS

CLAUSE **PAGE**

1 **Introduction**

1.1 In this Agreement, the following words bear the following meanings:

Agreement	this agreement signed by each of the Trusts in relation to their joint working and the operation of the CMPC CiCs;
CMPC CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**CMPC CiC**" shall be interpreted accordingly.
CMPC Leadership Board	the CMPC CiC's meeting in common.
Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement;
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law;
Dispute	any dispute arising between two or more of the Trusts in connection with this Agreement or their respective rights and obligations under it;
Meeting Lead	the CMPC CiC Member nominated (from time to time) in accordance with paragraph 7.6 of the Terms of Reference, to preside over and run the CMPC CiC meetings when they meet in common;
Member	a person nominated as a member of a CMPC CiC in accordance with their Trust's Terms of Reference and "**Members**" shall be interpreted accordingly;
Terms of Reference	the terms of reference adopted by each Trust (in substantially the same form) more particularly set out in the Appendices 1-14 to this Agreement;
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, , Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT, Liverpool Women's NHS FT, Alder Hey

	Children's Hospital NHS FT, East Cheshire NHS Trust, Mersey and West Lancashire Teaching Hospitals NHS Trust, Mid Cheshire Hospitals NHS FT, Mersey Care NHS Foundation Trust, Bridgewater Community Healthcare NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Community Health and Care NHS Foundation Trust and "**Trust**" shall be interpreted accordingly.

1.2 Each Trust is putting in place a governance structure which will enable it to work together with the other Trusts to implement change and develop CMPC as a provider collaborative.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMPC CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a party to this Agreement as a participant in CMPC but is not forming a CMPC CiC and will be in attendance at meetings of the CMPC CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMPC CiC will be different.

1.5 The CMPC Trusts agree that, notwithstanding the good faith consideration that each Trust has afforded the terms set out in this agreement, this agreement shall not be legally binding. The CMPC Trusts enter into this agreement with the approval of their boards and intending to honour all their obligations to each other.

2 Background

Vision

2.1 Our vision did span a range of time horizons. However as we have become more confident, clear and cohesive we have summarised it to: Our vision is to work collectively for a single healthcare system to provide high quality, timely, efficient and productive services to everyone in Cheshire and Merseyside.

Key functions

2.2 The key functions of CMPC are to:

2.2.1 Deliver the CMPC vision;

2.2.2 Support the delivery of the ICS triple aim in Cheshire and Merseyside;

2.2.3 Align priorities across the member Trusts,

2.2.4 Support delivery by ICBs with the capacity to support population-based decision-making, and working with other collaboratives and partners to develop and support ICS maturity and encourage wider system working and collaboration

2.2.5 Direct operational resources across Trust members to improve service provision;

2.2.6 Prioritise key programmes for delivery on behalf of the Cheshire and Merseyside system; and

2.2.7 Create an environment of innovation, challenge and support in order to deliver improved performance and quality of service provision.

2.3 CMPC's stated priorities are to strengthen each of the Trusts by sharing collective expertise and knowledge to deliver:

2.3.1 Clinical Improvement and Transformation

2.3.2 Sustainability and Value

By achieving this we believe we will:

2.3.3 Reduce health inequalities;

2.3.4 Improve access to services and health outcomes;

2.3.5 Stabilise fragile services;

2.3.6 Improve pathways;

2.3.7 Support the wellbeing of staff and develop more robust workforce plans; and

2.3.8 Achieve financial sustainability.

2.4 The Trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the legislation, enables "group" and common decision making structures; the CMPC CiCs acting through the CMPC Leadership Board.

2.5 More specifically the CMPC CiCs and the CMPC Leadership Board will facilitate the Trusts' work in the following key work programmes at this initial stage of CMPC development*:*

2.5.1 Delivery and coordination of the C&M Elective Recovery Programme;

2.5.2 Delivery and co-ordination of the community programme to support alignment with other programmes;

2.5.3 Further development of community based alternatives to hospital admission and standardisation of the community services offer in Cheshire and Merseyside as per the Neighbourhood health guidance;

2.5.4 Cancer Alliance delivery and enablement – subject to requests of the Alliance;

2.5.5 Delivery and coordination of the C&M Diagnostics Programme including system decision making on pathology optimisation following existing C&M case for change and OBC;

2.5.6 Initiation of proposals and case for change for clinical pathway redesign - subject to discrete decision making as may be appropriate;

2.5.7 Coordinating and enabling CMPC members contribution and response to collective system wide workforce needs, pressures and the People agenda;

2.5.8 Coordinating and enabling CMPC members contribution and response to system wide financial decision making, pressures and financial governance;

2.5.9 Responding to and coordinating CMPC action in response to any national, regional or ICB initiated priorities for example TIF, system or elective capital prioritisation, reduction in long waiters; and

2.5.10 The CMPC Trusts are part of the C&M ICS. Regional and inter regional relationships should first and foremost be guided by the ICB. To support this CMPC will provide

both intelligence to the ICB and respond to ICB calls for action. Where necessary and appropriate CMPC may seek to develop relationships with peers or for trusts, across other ICS's and ICB's (for example, related to specialised commissioning). This will be notified and communicated between the CMPC Trusts in accordance with the principle outlined in clause 4.6.

The areas within scope of this Agreement may be amended though variation, by Trust Board resolutions or agreement of the annual CMPC workplan.

2.6 The Trusts will remain as separate legal entities with their own accountabilities and responsibilities. The priorities for CMPC will be complementary to (and do not revise or replace) the existing statutory duties of the Trusts (such as the delivery of NHS Constitutional Standards or equivalent). For avoidance of doubt there is no intention that the governance structure outlined in this Agreement will lead to a statutory merger or acquisition under section 56 or section 56A of the National Health Service Act 2006 (as amended).

3 **Rules of working**

3.1 The Trusts have agreed to adopt this Agreement and agree to operate the CMPC CiCs as the **CMPC Leadership Board** in line with the terms of this Agreement, including the following rules (the "**Rules of Working**"):

3.1.1 Working together in good faith;

3.1.2 Putting patients interests first;

3.1.3 Having regard to staff and considering workforce in all that we do;

3.1.4 Consider the wider system impact and perspective and discuss proposals before any unilateral Trust action which may impact other Trusts;

3.1.5 Airing challenges to collective approach / direction within CMPC openly and proactively seeking solutions;

3.1.6 Support each other to deliver shared and system objectives;

3.1.7 Recognising the relationship between acute, mental health, community and specialist providers ensuring that information is shared where this impacts on other sectors;

3.1.8 Empower and expect our professional (executive) groups to think from a system perspective and to develop proposals with this in mind;

3.1.9 Recognising and respecting the collective view and keeping to any agreements made between the CMPC CiC's;

3.1.10 Maintain CMPC collective agreed position on shared decisions in all relevant communications;

3.1.11 Be accountable. Take on, manage and account to each other for performance of our respective roles and responsibilities; and

3.1.12 Appropriately engage with the ICB and with other partners on any material service change.

4 Process of working together

4.1 The CMPC CiCs shall meet together as the CMPC Leadership Board in accordance with and discuss the matters delegated to them in accordance with their Terms of References (attached here as Appendices 1-18).

4.1.1 Meetings of the CMPC Leadership Board will be categorised under three types of business, dependent on the agenda to be discussed and whether any formal decisions are required to be taken:

A. CMPC Leadership Board – Operational business - Informal CEO discussions and representing the standard regular meeting structure; [1]

B. CMPC Leadership Board – Decisions to be made under the CMPC CiC delegations - CiC CEOs;

C. CMPC Leadership Board – CiC CEOs and Chairs discussion (or NED designate)

4.2 The CMPC CiCs shall work collaboratively with each other as the CMPC Leadership Board in relation to the committees in common model.

4.3 Each CMPC CiC is a separate committee, with functions delegated to it from its respective Trust in accordance with its Terms of Reference and is responsible and accountable to its Trust. Acknowledging this and without fettering the decision-making power of any CMPC CiC or its duty to act in the best interests of its Trust, each CMPC CiC shall seek to reach agreement with the other CMPC CiCs in the CMPC Leadership Board and take decisions in consensus, in light of its aims and Rules of Working set out in clauses 2 and 3 above.

4.4 When the CMPC CiCs meet in common, as the CMPC Leadership Board, the Meeting Lead shall preside over and run the meeting. The intention is that the lead arrangements will be reviewed periodically reflecting the will of the membership. The next review point is expected to be no later than 2026.

4.5 The Trusts agree that they will adopt a tiered approach to bringing decisions which come within the Terms of Reference to the CMPC Leadership Board which will reflect the principle of subsidiarity (that issues should be dealt with at the most immediate level that is consistent with their resolution**)** in the following approach:

Scale of involvement/impact	**Approach to decision**
Matter under discussion has no involvement or impact on other CMPC Trusts (e.g. local issue related to place)	Matter for the Trust involved and notified to the CMPC Leadership Board if appropriate.
Matter only involves or impacts a smaller group of CMPC Trusts and not all (e.g. specialised commissioning issue for specialist trusts)	The CMPC CiC's for the Trusts involved shall consider the required decision if it is within their delegation as set out in the Terms of Reference. Notify the CMPC Leadership Board.
Matter involves or impacts all CMPC Trusts and comes within the delegation under the	Matter to be dealt with through the CMPC CiCs at the CMPC Leadership Board in

[1] Chairs will be invited to CMPC Leadership Board meetings, at least quarterly.

CMPC CiCs (e.g. collaborative approach to non-clinical services or workforce)	accordance with this Agreement and the Terms of Reference.

4.6 Each CMPC Trust will report back to its own Board and the CMPC Leadership Board will be responsible for transparent information sharing in the form of common briefings and updates to each of the CMPC Trust Board meetings. The CMPC Trust chairs may (as well as their quarterly CMPC meetings - clause 4.1.1 above) meet regularly as a group to share information and for general discussions on CMPC on an informal basis. In addition, the CMPC Leadership Board will seek to ensure that each CMPC programme has the opportunity for a Chair sponsor to be appointed whose role will include updating the chairs meetings on the progress of the relevant programme.

4.7 When CMPC CiC meetings are intended to take decisions under the delegations made to those committees (in accordance with clause 4.1.1 B) then the meeting of CMPC (or if relevant, section of the meeting), may be held in public except where a resolution is agreed by the CMPC Leadership Board to exclude the public on the grounds that it is believed to not be in the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time. Papers and minutes of CMPC meetings held in public will be published.

5 Future Involvement and Addition of Parties

5.1 Subject to complying with all applicable law, and the Trusts' unanimous agreement, third parties may become parties to this Agreement on such terms as the Trusts shall unanimously agree.

5.2 Any Trust may propose to the other Trusts that a third party be added as a Party to this Agreement.

6 Exit Plan

6.1 Any exit plan, when required or proposed by a Trust, will be drafted for consideration by the Leadership Board with support by the CMPC DoFs. . it is a necessity that an agreed exit plan deals with, for example, the impact on resourcing or financial consequences of:

6.1.1 termination of this Agreement;

6.1.2 a Trust exercising its rights under clause 7.1 below; or

6.1.3 the Meeting Lead and the CMPC CiC Chairs varying the Agreement under clause 10.6.2.

6.1.4 cost apportionment, where appropriate, will be applied on a proportionate fair shares basis

6.2 An exit plan approach is drafted shall be inserted into this Agreement at Appendix 18 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement.

7 Termination

7.1 If any Trust wishes to revoke the delegation of functions to the relevant CMPC CiC committee and exit this Agreement ("**Exiting Trust**"), then the Exiting Trust shall, prior to such revocation and exit:

7.1.1 send a written notice from the Chair of the Exiting Trust to the other Trusts' Chairs and the CMPC Leadership Board of their intention to do so; and

7.1.2 if required by any of the other Trusts (by sending a written notice within ten (10) business days of receipt of such notice) meet with the other Trusts' Chairs within ten (10) business days of the notice given under clause 7.1.1 to discuss the consequences of such revocation and exit.

7.2 If:

7.2.1 no other Trust sends a notice to the Exiting Trust within the time limit referred to in clause 7.1.2; or

7.2.2 following the meeting held under clause 7.1.2 the Exiting Trust still intends to exit the Agreement,

then the Exiting Trust may (subject to the terms of the exit plan at Appendix 19) exit this Agreement.

7.3 If following the steps and meeting (if any) pursuant to clause 7.1.2 above the Exiting Trust revokes its delegation to its CMPC CiC and exits this Agreement then the remaining Trusts shall meet and consider whether to:

7.3.1 Revoke their delegations and terminate this Agreement; or

7.3.2 Amend and replace this Agreement with a revised Agreement to be executed by the remaining Trusts and to make such revisions as may be appropriate in the circumstance.

8 Information Sharing and Competition Law

8.1 For the purposes of any applicable data protection legislation the Trusts shall be the data controller of any Personal Data (as defined in the UK General Data Protection Regulation (UK GDPR)) created in connection with the conduct or performance of the principles of this Agreement.

8.2 Where appropriate the CMPC Trusts agree to use all reasonable efforts to assist each other to comply with their respective responsibilities under any applicable data protection legislation. For the avoidance of doubt, this may include providing other Trusts with reasonable assistance in complying with subject access requests and consulting with other Trusts, as appropriate, prior to the disclosure of any Personal Data (as defined in the UK GDPR) created in connection with the conduct or performance of this Agreement in relation to such requests.

8.3 All Trusts will adhere to all applicable statutory requirements regarding data protection and confidentiality. The CMPC Trusts agree to co-operate with one another with respective statutory obligations under the Freedom of Information Act 2000 and Environmental Information Regulations 2004.

8.4 Subject to compliance with all applicable law (including without limitation competition law and obligations of confidentiality (contractual or otherwise)) the Trusts agree to share all information relevant to the operation of this Agreement in an honest, open and timely manner. The Trusts, shall not, (save as permitted by this clause 8) either during or after the period of this Agreement divulge or permit to divulge to any person (including the other Trusts) any information acquired form other Trusts in connection with this Agreement which concerns:

8.4.1 any matter of commercial interest contained or referred to in this Agreement;

8.4.2 Trusts' manner of operations, staff or procedures;

8.4.3 the identity or address or medical condition or treatment of services received by any client or patient of any of the Trusts;

unless previously authorised by the Trusts concerned in writing, provided that these obligations will not extend to any information which is or shall become public information otherwise than by reason of a breach by a Trust of the provisions of this Agreement.

CMPC is committed to clear, consistent and transparent communication across the CMPC Trusts and with system partners' where appropriate. It is specifically recognised that CMPC Trusts are part of the ICS and members of Place Based Partnerships and will be working with their local partners and other collaboratives. Communication to and from Place Based Partnerships will be key for CMPC and the CMPC Trusts may be asked to represent both their own organisations and CMPC in such local place-based discussions.

8.5 For the avoidance of doubt, nothing in this Agreement shall be construed as preventing any rights or obligations that the Trusts may have under the Public Interest Disclosure Act (1998) and / or any obligations to raise concerns about any malpractice with regulatory or other appropriate statutory bodies pursuant to professional and ethical obligations including those obligations set out in the guidance issued by regulatory or other appropriate statutory bodies from time to time.

8.6 The Trusts acknowledge and agree that each may be required to disclose Confidential Information to others. For the purpose of this Agreement "Confidential Information" means all information provided in connection with this Agreement which is secret or otherwise not publicly available (in both cases in its entirely or in part) including commercial, financial, marketing or technical information, know-know or trade secrets, in all cases whether disclosed orally or in writing before or after the date of this Agreement.

8.7 The Trusts undertake for themselves and their respective Boards and employees that:

8.7.1 the disclosing Trust shall confirm whether information is to be regarded as confidential prior to its disclosure by clearly marking all such documents with 'Confidential';

8.7.2 they will use no lesser security measures and degree of care in relation to any Confidential Information received from the other Trusts than they apply to their own Confidential Information;

8.7.3 they will not disclose any Confidential Information of the other Trusts to any third party without the prior written consent of the disclosing Trust; and

8.7.4 on the termination of this Agreement, they will return any documents or other material in their possession that contains Confidential Information of the other Trusts.

8.8 The Trusts agree to provide in a timely manner and without restriction all information requested and required by the relevant designated CMPC Programme Support team (either internal team or external contractor where agreed) to carry out work including but not limited to relevant detailed financial, activity, workforce and estates related information pertaining to CMPC activities.

8.9 The Trusts will ensure they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law to the extent applicable.

8.10 The Trusts commit to agreeing a protocol to manage the sharing of information to facilitate the futher operation or development of CMPC across the Trusts as envisaged if and when required.. Once agreed by the Trusts (and their relevant information officers) , this protocol shall be

inserted into this Agreement at Appendix 19 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement[2].

9 Conflicts of Interest

9.1 Members of each of the CMPC CiCs shall make arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the CMPC Leadership Board will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of CMPC's decision-making processes.

9.2 The CMPC Leadership Board will, where relevant, agree policies and procedures for the identification and management of conflicts of interest which will be published on the CMPC website. It is proposed that such policies will either be CMPC developed or CMPC will support the adoption and application of the policy of the CMPC Chair and/or Meeting Lead.

9.3 All CMPC Leadership Board, committee and sub-committee members, and employees acting on behalf of CMPC, will comply with the CMPC policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by CMPC. Reuse / resubmission of host employer or home trust data, where applicable, will be supported

9.4 All delegation arrangements made by the Trusts will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures agreed by the CMPC Leadership Board.

9.5 Where an individual, including any individual directly involved with the business or decision-making of the CMPC Leadership Board and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the CMPC Leadership Board considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Agreement and any agreed CMPC Conflicts of interest Policy and Standards of Business Conduct Policy.

10 Dispute Resolution

10.1 The Trusts agree to adopt a systematic approach to problem resolution which recognises the Rules of Working set out in clause 3 above.

10.2 If a problem, issue, concern, or complaint comes to the attention of a Trust in relation to any matter in this Agreement, that Trust shall notify the other Trusts in writing and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

10.3 If any Trust considers an issue identified in accordance with clause 10.2 to amount to a Dispute requiring resolution and such issue has not been resolved under clause 10.2 within a reasonable period of time, the matter shall be escalated to the Meeting Lead who shall decide in conjunction with the CMPC CiCs at the CMPC Leadership Board the appropriate course of action to take.

10.4 If the Meeting Lead and the CMPC Leadership Board reach a decision that resolves, or otherwise concludes a Dispute, the Meeting Lead will advise the Trusts of the decision by written notice. Any decision of the Meeting Lead and the CMPC Leadership Board will be final and binding on the Trusts once it has been ratified by the Trusts' Boards (if applicable).

[2] To date (2022 – 2024) it has been considered unnecessary and unwarranted by virtue of ICS facilitated and governed ways of working

10.5 If the matter referred to in clause 10.3 above cannot be resolved by the Meeting Lead and the CMPC Leadership Board, within fifteen (15) Working Days, the Trusts agree that the Meeting Lead and the CMPC Leadership Board, may determine whatever action they believe necessary to resolve the Dispute which may include:

10.5.1 appointment of a panel of CMPC Leadership Board members who are not involved in the dispute to consider the issues and propose a resolution to the Dispute;

10.5.2 mediation arranged by C&M ICB for consideration and to propose a resolution to the Dispute; or

10.5.3 if considered appropriate selecting an independent facilitator and utilising the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure. Unless otherwise agreed between the CMPC Trusts, the facilitator will be nominated by CEDR to assist with resolving the Dispute;

and who shall:

- be provided with any information they request about the Dispute;
- assist the Meeting Lead and CMPC Leadership Board to work towards a consensus decision in respect of the Dispute;
- regulate their procedure and, subject to the terms of this Agreement, the procedure of the Meeting Lead and CMPC Leadership Board at such discussions;
- determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Working Days of their appointment; and
- where appropriate have their costs and disbursements met by the Trusts in dispute equally.

10.6 The above process (10.5) will seek to be addressed within one calendar month and no longer than 6 weeks unless, in such circumstances, as all parties agree to a longer time frame

10.7 If the independent facilitator proposed under clause 1.5 cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this clause 10 and only if after such further consideration the Trusts again fail to resolve the Dispute, the Meeting Lead and CMPC Leadership Board may decide to recommend their Trust's Board of Directors to:

10.7.1 terminate the Agreement;

10.7.2 vary the Agreement (which may include re-drawing the member Trusts); or

10.7.3 agree that the Dispute need not be resolved.

11 **Variation**

No variation of this Agreement shall be effective unless it is in writing and signed by the Trusts (or their authorised representatives).

12 **Counterparts**

12.1 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement.

12.2 The expression “counterpart” shall include any executed copy of this Agreement transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

12.3 No counterpart shall be effective until each Trust has executed at least one counterpart.

13 Governing law and jurisdiction

This Agreement shall be governed by and construed in accordance with English law.

This Agreement is executed on the date stated above by

……
For and on behalf of **BRIDGEWATER COMMUNITY HEALTHCARE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **CHESHIRE AND WIRRAL PARTNERSHIP NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **COUNTESS OF CHESTER HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL UNIVERSITY HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE CLATTERBRIDGE CANCER CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL HEART AND CHEST HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE WALTON CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL WOMEN'S NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **ALDER HEY CHILDREN'S HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **MERSEY CARE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **EAST CHESHIRE NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **MID CHESHIRE HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **WIRRAL COMMUNITY HEALTH AND CARE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **NORTH WEST AMBULANCE SERVICE NHS TRUST**

APPENDIX 1– TERMS OF REFERENCE FOR BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Bridgewater Community Healthcare NHS Foundation Trust CiC]

APPENDIX 2 – TERMS OF REFERENCE FOR CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Cheshire and Wirral Partnership NHS Foundation Trust CiC]

APPENDIX 3– TERMS OF REFERENCE FOR THE COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Countess of Chester Hospital NHS Foundation Trust CiC]

APPENDIX 4 – TERMS OF REFERENCE FOR THE LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool University Hospitals NHS Foundation Trust CiC]

APPENDIX 5– TERMS OF REFERENCE FOR WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC]

APPENDIX 6 – TERMS OF REFERENCE FOR THE WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Wirral University Teaching Hospital NHS Foundation Trust CiC]

APPENDIX 7 – TERMS OF REFERENCE FOR THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for The Clatterbridge Cancer Centre NHS Foundation Trust CiC]

APPENDIX 8 – TERMS OF REFERENCE FOR THE LIVERPOOL HEART AND CHEST HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool Heart and Chest Hospitals NHS Foundation Trust CiC]

APPENDIX 9 – TERMS OF REFERENCE FOR THE WALTON CENTRE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for The Walton Centre NHS Foundation Trust CiC]

APPENDIX 10 – TERMS OF REFERENCE FOR THE LIVERPOOL WOMEN'S NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool Women's NHS Foundation Trust CiC]

APPENDIX 11 – TERMS OF REFERENCE FOR THE ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Alder Hey Children's Hospital NHS Foundation Trust CiC]

APPENDIX 12– TERMS OF REFERENCE FOR MERSEY CARE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Mersey Care NHS Foundation Trust CiC]

APPENDIX 13 – TERMS OF REFERENCE FOR THE EAST CHESHIRE NHS TRUST CIC

[Insert Terms of Reference for the East Cheshire NHS Trust CiC]

APPENDIX 14 – TERMS OF REFERENCE FOR THE MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Mersey and West Lancashire Teaching Hospitals NHS Foundation Trust CiC]

APPENDIX 15 – TERMS OF REFERENCE FOR THE MID CHESHIRE HOSPITALS NHS TRUST CIC

[Insert Terms of Reference for the Mid Cheshire Hospitals NHS Trust CiC]

APPENDIX 16– TERMS OF REFERENCE FOR WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Wirral Community Health and Care NHS Foundation Trust CiC]

APPENDIX 17 – TERMS OF REFERENCE FOR THE NORTH WEST AMBULANCE SERVICE NHS TRUST CIC

[Not applicable]

APPENDIX 18 - EXIT PLAN

1 In the event of termination of this Agreement by all parties, the Trusts agree that:

1.1 each Trust will be responsible for its own costs and expenses incurred because of the termination of the Agreement up to the date of termination UNLESS it is agreed between the Trusts that the costs and expenses are to be borne equally between the Trusts;

1.2 upon reasonable written notice, each Trust will be liable for one seventeenth of any professional advisers' fees incurred by and on behalf of CMPC in relation to the termination of this Agreement (if any) up to and including the date of termination of this Agreement;

1.3 each Trust will revoke its delegation to its CMPC Committee in Common (CiC) on termination of this Agreement;

1.4 termination of this Agreement shall not affect any rights, obligations or liabilities that the Trusts have accrued under this Agreement prior to the termination of this Agreement; and

1.5 there are no joint assets and resources but should these be identified in the future, Trusts will need to confirm agreement at termination of this Agreement how any joint assets or resources will need to be dealt with on termination of the Agreement.

2 In the event of an Exiting Trust leaving this Agreement in accordance with clause 7, the Trusts agree that:

2.1 a minimum of six months' notice will be given by the Exiting Trust and they shall pay to the other Trusts all reasonable costs and expenses incurred by the other Trusts as a consequence of the Exiting Trust's exit from CMPC and this Agreement up to and including the Exiting Trust's date of exit from this Agreement. Notwithstanding this, the Exiting Trust's total aggregate liability, in respect of such reasonable costs and the expenses, shall be capped at the value of their annual contribution of resources that are agreed to remain for the financial year or term of any agreement being overseen by the CMPC CiC;

2.2 upon reasonable written notice from the other Trusts, the Exiting Trust shall be liable to pay [one thirteenth of] any professional advisers' fees incurrent by and on behalf of CMPC as a consequence of the Exiting Trust's exit from the Working Together Partnership and this Agreement up to and including the date of exit of the Exiting Trust from this Agreement;

2.3 the Exiting Trusts will revoke its delegation to its CMPC CiC on its exit from this Agreement;

2.4 the remaining Trusts shall use reasonable endeavours to procure that the Agreement is amended or replaced as appropriate in accordance with clause 7.3.2;

2.5 subject to any variation to or replacement of this Agreement in accordance with paragraph 2.4 above, and clause 7.3.2, this Agreement shall remain in full force and effect following the exit of the Exiting Trust from this Agreement

APPENDIX 19 - INFORMATION SHARING PROTOCOL

[to be inserted once deemed necessary and agreed]

V4-refresh August 2025

CMPC LEADERSHIP BOARD
TERMS OF REFERENCE FOR A COMMITTEE OF THE BOARD TO MEET IN COMMON WITH COMMITTEES OF OTHER CMPC TRUSTS

TERMS OF REFERENCE

1 Introduction

1.1 In these terms of reference, the following words bear the following meanings:

Cheshire & Merseyside Provider Collaborative or CMPC	the partnership formed by the Trusts to work together to improve quality, safety and the patient experience; deliver safe and sustainable new models of care; and make collective efficiencies. This operates within the NHS Cheshire & Merseyside Integrated Care System.
CMPC Agreement	the Joint Working Agreement signed by each of the Trusts in relation to their provider collaborative working and the operation of the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC together with the other CMPC CiCs;
CMPC CiCs	the Trust CIC and the other respective committees established by each of the Trusts to work alongside each other and "**CMPC CiC**" shall be interpreted accordingly;
CMPC Leadership Board	The Leadership Board is a regular meeting of Trust CEOs across C&M which can (when business demands, and responsibility is delegated) be called as a CMPC CiC Leadership Board can also be used as the CMPC CiCs meeting at the same time and place to consider matters of shared interest in line with these Terms of Reference.
CMPC Programme Steering Group	the Group, to provide programme support and oversight of the delivery of agreed collaborative activities;
CMPC Programme Lead	Named Lead Officer or any of subsequent person holding such title in relation to CMPC;
CMPC Programme Support	Administrative infrastructure supporting CMPC;
Meeting Lead	the CiC Member nominated (from time to time) in accordance with paragraph 7.6 of these Terms of Reference, to preside over and run the CMPC CiC meetings when they meet in common;
Member	a person nominated as a member of an CMPC CiC in accordance with their Trust's Terms of

	Reference, and Members shall be interpreted accordingly;
NHS Cheshire & Merseyside Integrated Care System or "C&M ICS"	the Integrated Care System (ICS) for Cheshire and Merseyside bringing together NHS organisations, councils, and wider partners in a defined geographical area to deliver more joined up care for the population.
NHS Cheshire & Merseyside Integrated Care Board or "C&M ICB"	the Integrated Care Board (ICB) for Cheshire and Merseyside. An NHS organisation established on July 1, 2022, that leads an Integrated Care System (ICS). ICBs are responsible for planning and funding most NHS services in their area, managing the NHS budget, and ensuring services are in place to meet the health needs of the local population.
Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC	the committee established by Warrington and Halton Teaching Hospitals NHS Foundation Trust, pursuant to these Terms of Reference, to work alongside the other CMPC CiCs in accordance with these Terms of Reference;
Warrington and Halton Teaching Hospitals NHS Foundation Trust	Warrington and Halton Teaching Hospitals NHS Foundation Trust of Lovely Lane, Warrington, Cheshire, WA5 1QG.
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT, Liverpool Women's NHS FT, Alder Hey Children's Hospital NHS FT, East Cheshire NHS Trust, Mersey and West Lancashire Teaching Hospitals NHS Trust and Mid Cheshire Hospitals NHS FT, Mersey Care NHS Foundation Trust, Bridgewater Community Healthcare NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Community Health and Care NHS Foundation Trust and "**Trust**" shall be interpreted accordingly;
Working Day	a day other than a Saturday, Sunday or public holiday in England;

1.2 The Warrington and Halton Teaching Hospitals NHS Foundation Trust is putting in place a governance structure, which will enable it to work together with the other Trusts in CMPC to implement change.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMPC CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a participant in CMPC but is not forming its own CMPC CiC and will be in attendance at meetings of the CMPC CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each respective individual CMPC CiC will be different.

1.5 Each Trust has entered into the CMPC Agreement on **[DATE]** and agrees to operate its CMPC CiC in accordance with the CMPC Agreement.

2 Aims and Objectives of the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC

2.1 The aims and objectives of the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC are to work with the other CMPC CiCs on system work or matters of significance as delegated to the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC under Appendix A to these Terms of Reference to:

2.1.1 Leadership

Provide strategic leadership, oversight and delivery of new models of care through the development of CMPC and its workstreams.

Set the strategic goals for CMPC, defining its ongoing role and scope ensuring recommendations are provided to Trusts' Boards for any changes which have a material impact on the Trusts;

2.1.2 Delivery

Consider different employment models for service line specialities including contractual outcomes and governance arrangements;

Review the key deliverables and hold the Trusts to account for progress against agreed decisions;

Ensure all Clinical Networks or other collaborative forums, by working in partnership with the ICB, have clarity of responsibility and accountability and drive progress;

Establish monitoring arrangements to identify the impact on services and review associated risks to ensure identification, appropriate management and mitigation;

Improve the quality of care, safety and the patient experience delivered by the Trusts;

Deliver equality of access to the Trusts service users; and

Ensure the Trusts deliver services which are clinically and financially sustainable.

2.1.3 Collaborate

Receive and seek advice from the relevant Professional (reference) Groups, including Medical, Nursing, Finance, Strategy, Human Resources, Operational and governance;

Receive and seek advice from the NHS Cheshire and Merseyside Integrated Care Board and regulator or those charged with performance management;

Review and approve any proposals for additional Trusts to join the founding Trusts of CMPC;

Ensure compliance and due process with regulating authorities regarding service changes;

Oversee the creation of joint ventures or new corporate vehicles where appropriate;

2.2 Review the CMPC Agreement and Terms of Reference for CMPC CiCs on at least a biennial basis

3 Establishment

3.1 The Warrington and Halton Teaching Hospitals NHS Foundation Trust's board of directors has agreed to establish and constitute a committee with these terms of reference, to be known as the Warrington and Halton Teaching Hospitals NHS Foundation Trust **CMAP** CiC. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC.

3.2 The Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC shall work cooperatively with the other CMPC CiCs and in accordance with the terms of the CMPC Agreement.

3.3 The Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC is a committee of Warrington and Halton Teaching Hospitals NHS Foundation Trust's board of directors and therefore can only make decisions binding Warrington and Halton Teaching Hospitals NHS Foundation Trust. None of the Trusts other than Warrington and Halton Teaching Hospitals NHS Foundation Trust can be bound by a decision taken by Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC.

3.4 The Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC will have regard in their decision-

making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.

4 Functions of the Committee

4.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in Warrington and Halton Teaching Hospitals NHS Foundation Trust's Constitution.

4.2 Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC shall have the following function: decision making in accordance with Appendix A to these Terms of Reference.

5 Functions reserved to the Board of the Foundation Trust

Any functions not delegated to the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC in paragraph 4 of these Terms of Reference shall be retained by Warrington and Halton Teaching Hospitals NHS Foundation Trust's Board or Governors, as applicable. For the avoidance of doubt, nothing in this paragraph 5 shall fetter the ability of Warrington and Halton Teaching Hospitals NHS Foundation Trust to delegate functions to another committee or person.

6 Reporting requirements

6.1 On receipt of the papers detailed in paragraph 13.1.2, the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC Members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to Warrington and Halton Teaching Hospitals NHS Foundation Trust's Board for inclusion on the private agenda of Warrington and Halton Teaching Hospitals NHS Foundation Trust's next Board meeting in order that Warrington and Halton Teaching Hospitals NHS Foundation Trust's Board may consider any additional delegations necessary in accordance with Appendix A.

6.2 The Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC shall send the minutes of Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC meetings to Warrington and Halton Teaching Hospitals NHS Foundation Trust's Board, on a monthly basis, for inclusion on the agenda of Warrington and Halton Teaching Hospitals NHS Foundation Trust's Board meeting.

6.3 Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC shall provide such reports and communications briefings as requested by Warrington and Halton Teaching Hospitals NHS Foundation Trust's Board for inclusion on the agenda of Warrington and Halton Teaching Hospitals NHS Foundation Trust's Board meeting.

7 Membership

7.1 The Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC shall be constituted of directors of Warrington and Halton Teaching Hospitals NHS Foundation Trust. Namely the Warrington and Halton Teaching Hospitals NHS Foundation Trust's Chief Executive who shall be referred to as a "Member".

7.2 Each Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC Member shall nominate a deputy to attend Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC meetings on their behalf when necessary ("**Nominated Deputy"**).

7.3 The Nominated Deputy for Warrington and Halton Teaching Hospitals NHS Foundation Trust's Chief Executive shall be an Executive Director of Warrington and Halton Teaching Hospitals NHS Foundation Trust.

7.4 In the absence of the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:

7.4.1 attend Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC's meetings;

7.4.2 be counted towards the quorum of a meeting of Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC's; and

7.4.3 exercise Member voting rights,

and when a Nominated Deputy is attending a Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC meeting, for the purposes of these Terms of Reference, the Nominated Deputy shall be included in the references to "Members".

7.5 The chair of the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC shall be nominated by the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC.

7.6 When the CMPC CiCs meet in common, one person nominated from the Members of the CMPC CiCs shall be designated the Meeting Lead and preside over and run the meetings on a rotational basis for an agreed period.

8 Non-voting attendees

8.1 The Members of the other CMPC CiCs and the chief executive (or designated deputy) of the North West Ambulance Service NHS Trust shall have the right to attend the meetings of Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC. The Warrington and Halton Teaching Hospitals NHS Foundation Trust's Chair shall be invited to meetings of the CMPC CiCs on at least a quarterly basis (or where the CiC feels it is appropriate – see CMPC JWA) as a non-voting attendee.

8.2 The Meeting Lead's Trust Corporate Secretary shall have the right to attend the meetings of Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC to

support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the CMPC CiCs.

8.3 The CMPC Programme Lead shall have the right to attend the meetings of Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC.

8.4 Without prejudice to paragraphs 8.1 to 8.3**Error! Reference source not found.** inclusive, the Meeting Lead may at his or her discretion invite and permit other persons relevant to any agenda item to attend any of the CMPC CiCs' meetings, but for the avoidance of doubt, any such persons in attendance at any meeting of the CMPC CiCs shall not count towards the quorum or have the right to vote at such meetings.

8.5 The attendees detailed in paragraphs 8.1 to 8.4 (inclusive) above, may make contributions, through the Meeting Lead, but shall not have any voting rights, nor shall they be counted towards the quorum for the meetings of Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC.

9 Meetings

9.1 Subject to paragraph 9.3 below, Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC meetings shall take place monthly.

9.2 The Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC shall meet with the other CMPC CiCs as the CMPC Leadership Board in accordance with the CMPC Agreement (as set out in clause 4 of the CMPC Agreement) and discuss the matters delegated to them in accordance with their respective Terms of References.

9.3 Any Trust CiC Member may request an extraordinary meeting of the CMPC CiCs (working in common) on the basis of urgency etc. by informing the Meeting Lead. In the event it is identified that an extraordinary meeting is required the CMPC Programme Lead shall give five (5) Working Days' notice to the Trusts.

9.4 Meetings of the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC shall generally be held in public save where items are agreed to be private and confidential and otherwise in accordance with clause 4.6 of the CMPC Agreement.

9.5 Matters not discussed in public in accordance with paragraph 9.4 above and dealt with at the meetings of the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC shall be confidential to the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC Members and their Nominated Deputies, others in attendance at the meeting and the members of Warrington and Halton Teaching Hospitals NHS Foundation Trust Board.

10 Quorum and Voting

10.1 Members of the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC have a responsibility for the operation of the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC. They will participate in discussion, review evidence and

provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

10.2 Each Member of the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC shall have one vote. The Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC shall reach decisions by consensus of the Members present.

10.3 The quorum shall be one (1) Member.

10.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

11 Conflicts of Interest

11.1 Members of the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC shall comply with the provisions on conflicts of interest contained in Warrington and Halton Teaching Hospitals NHS Foundation Trust Constitution/Standing Orders, the CMPC Agreement and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in Warrington and Halton Teaching Hospitals NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC.

11.2 All Members of the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC shall declare any new interest at the beginning of any Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC meeting and at any point during a Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC meeting if relevant.

12 Attendance at meetings

12.1 Warrington and Halton Teaching Hospitals NHS Foundation Trust shall ensure that, except for urgent or unavoidable reasons, Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC Members (or their Nominated Deputy) shall attend Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC meetings (in person) and fully participate in all Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC meetings.

12.2 Subject to paragraph 12.1 above, meetings of the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC may consist of a conference between Members who are not all in one place, but each of whom is able directly or by secure telephonic or video communication (the Members having due regard to considerations of confidentiality) i.e. MS Teams or equivalent to speak to the other or others, and be heard by the other or others simultaneously.

13 Administrative

13.1 Administrative support for the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC will be provided by CMPC Programme Support (or such other route as the Trusts may agree in writing). The CMPC Programme Support will:

13.1.1 draw up an annual schedule of CMPC CiC meeting dates and circulate it to the CMPC CiCs;

13.1.2 circulate the agenda and papers three (3) Working Days prior to CMPC CiC meetings; and

13.1.3 take minutes of each Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC meeting and following approval by the Meeting Lead, circulate them to the Trusts and action notes to all Members within ten (10) Working Days of the relevant Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC meeting.

13.2 The agenda for the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC meetings shall be determined by the CMPC Programme Lead and agreed by the Meeting Lead prior to circulation.

13.3 The Meeting Lead shall be responsible for approval of the first draft set of minutes for circulation to Members and shall work with the CMPC Programme Support to agree such within five (5) Working Days of receipt.

APPENDIX A – DECISIONS OF THE WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

The Board of each Trust within CMPC remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to Warrington and Halton Teaching Hospitals NHS Foundation Trust's Scheme of Delegation, the matters or type of matters that are fully delegated to the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC to decide are set out in the table below.

If it is intended that the CMPC CiCs are to discuss a proposal or matter which is outside the decisions delegated to the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC, where at all practical, each proposal will be discussed by the Board of each Trust prior to the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC meeting with a view to Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by Warrington and Halton Teaching Hospitals NHS Foundation Trust's Board). Any proposals discussed at the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC meeting outside of these parameters would come back before Warrington and Halton Teaching Hospitals NHS Foundation Trust's Board.

References in the table below to the "Services" refer to the services that form part of the CMPC Agreement for joint working between the Trusts (as set out in Clause 2.6 of the CMPC Agreement and which may be supplemented or further defined by an annual CMPC Work Programme) and may include both back office and clinical services.

	Decisions delegated to Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC
1.	Providing overall strategic oversight and direction to the development of the CMPC programme ensuring alignment of all Trusts to the vision and strategy;
2.	Promoting and encouraging commitment to the key Rules of Working;
3.	Seeking to determine or resolve any matter within the remit of the Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC referred to it by the CMPC Programme Steering Group or any individual Trust;
4.	Reviewing the key deliverables and ensuring adherence with the required timescales including determining responsibilities within workstreams; receiving assurance that workstreams have been subject to robust quality impact assessments; reviewing the benefits and risks associated in terms of the

	Decisions delegated to Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC
	impact to CMPC Programmes and recommending remedial and mitigating actions across the system;
5.	Formulating, agreeing and implementing strategies for delivery of CMPC Programmes;
6.	In relation to services preparing business cases to support or describe delivery of agreed CMPC priorities or programmes (including as required by any agreed CMPC annual work programme);
7.	Provision of staffing and support and sharing of staffing information in relation to Services;
8.	Decisions to support service reconfiguration (pre consultation, consultation and implementation), including but not limited to: a. provision of financial information; b. communications with staff and the public and other wider engagement with stakeholders; c. support in relation to capital and financial cases to be prepared and submitted to national bodies, including NHS England; d. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; e. support in relation to any competition assessment; f. provision of staffing support; and g. provision of other support.
9.	Decisions relating to information flows and clinical pathways outside of the reconfiguration, including but not limited to: a. redesign of clinical rotas; b. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; and c. developing and improving information recording and information flows (clinical or otherwise).
10.	Planning, preparing and setting up joint venture arrangements for the Services, including but not limited to: a. preparing joint venture documentation and ancillary agreements for final signature; b. evaluating and taking preparatory steps in relation to shared staffing models between the Trusts;

	Decisions delegated to Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC
	c. carrying out an analysis of the implications of TUPE on the joint arrangements; d. engaging staff and providing such information as is necessary to meet each employer's statutory requirements; e. undertaking soft market testing and managing procurement exercises; f. aligning the terms of and/or terminating relevant third party supply contracts which are material to the delivery of the Services; and g. amendments to joint venture agreements for the Services.
11.	Services investment and disinvestment as agreed within Trust Board parameters and delegated authority;
12.	Reviewing the Terms of Reference and CMPC Agreement on an annual basis.

APPROVED BY BOARD OF DIRECTORS: [DATE]