

TRUST BOARD MEETING – PART 1 (Held in Public)
Wednesday 6 August 2025, 10.00am – 12:45pm
Conference Room, Education Centre, Halton Hospital

Agenda Item	Time	Agenda Item	Objective/ Desired Outcome	Process	Presenter
BM/25/08/52	10:00	Engagement Story – Mia's Story	<i>To note</i>	Presentation	Susan Dean, Deputy Head of Patient Experience and Inclusion
BM/25/08/53	10:15	Welcome, Apologies and Declarations of Interest	<i>To note</i>	Verbal	Chair
BM/25/08/54	10:17	Minutes and Action Log of the previous meeting held on 4 June 2025	<i>For approval</i>	Minutes	Chair
BM/25/08/55	10:20	Matters Arising	<i>To note for assurance</i>	Verbal	Chair
BM/25/08/56	10:25	Chief Executive's Report	<i>For assurance</i>	Report & Verbal	Deputy Chief Executive
BM/25/08/57	10:35	Chair's Report	<i>For info/update</i>	Verbal	Chair
BM/25/08/58	10:40	Board Assurance Framework	<i>For approval</i>	Report	Company Secretary
Strategic aims:	 QUALITY We will always put our patients first, delivering safe and effective care and an excellent patient experience  PEOPLE We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future  SUSTAINABILITY We will work in partnership with others to achieve social and economic wellbeing in our communities				
BM/25/08/59 (a)	10:45	Integrated Performance Reports (IPR) and Assurance Committee Reports IPR Dashboard	<i>For assurance</i>	Report	All Executive Directors
		Quality Dashboard Including Assurance Reports Quality Assurance Committee 10.06.25, 08.07.25 and 31.07.25	<i>For assurance</i>	Report	Chief Nurse Cliff Richards, Committee Chair
		People Dashboard Including Assurance Reports Strategic People Committee in Common 18.06.25, 16.07.25	<i>For assurance</i>	Report	Chief People Officer Julie Jarman, Committee Chair
(b)					

(c)		Sustainability Dashboard - <i>including Cash Support</i>	<i>For assurance</i>	<i>Report & Presentation</i>	Chief Finance Officer
	(d)	Including Assurance Reports Finance and Sustainability Committee/Committee in Common 23.06.25, 28.07.25			John Somers, Committee Chair
		Charitable Funds Committee Assurance Report 12.06.25	<i>For assurance</i>	<i>Report</i>	Director of Communications and Engagement Committee Chair. Steve McGuirk
(e)		Audit Committee Assurance Report 23.06.25	<i>For assurance</i>	<i>Report</i>	Committee Chair. Mike O'Connor
Strategic aim:		Quality			
BM/25/08/60	11:20	Fragile Clinical Services Update	<i>To note for assurance</i>	Report	Chief Nurse /Executive Medical Director, Chief Operating Officer & Deputy Chief Executive
BM/25/08/61	11:25	Mortuary Licensed Activity Bi-Annual Report (Including Fuller update)	<i>To note for assurance</i>	Report	Chief Nurse
BM/25/08/62	11:30	Risk Management Strategy – Annual Report	<i>To note for assurance</i>	Report	Chief Nurse
BM/25/08/63	11:25	Compliance Update Q4	<i>To note for assurance</i>	Report	Chief Nurse
BM/25/08/64	11:40	Maternity Review of Year Progress Report	<i>To note for assurance</i>	Report	Director of Midwifery
BM/25/08/65	11:45	Maternity Overview Paper	<i>To note for assurance</i>	Report	Director of Midwifery
BM/25/08/66	11:55	SHMI – Update	<i>To note for assurance</i>	Report	Executive Medical Director
Strategic aim		People			
BM/25/08/67	12:05	Bimonthly Communications and Engagement Report	<i>To note for assurance</i>	Report	Director of Communications and Engagement
Strategic Aim		Sustainability			

BM/25/08/68	12:10	Emergency Preparedness Annual Report	To note for assurance	Report	Chief Operating Officer
BM/25/08/69	12:15	Bimonthly Strategy Highlight Report	To note for assurance	Report	Chief Strategy & Partnerships Officer
BM/25/08/70	12:20	Strategy Biannual Delivery Report	To note for assurance	Report	Chief Strategy & Partnerships Officer

Governance					
BM/25/08/71	12:25	Code of Governance Compliance	To note	Report	Company Secretary
BM/25/08/72	12:30	Fit and Proper Persons Test - Annual Report on Board Members	To note	Report	Company Secretary
BM/25/08/73	12:35	Committee Chairs Annual Reports I) Quality Assurance Committee II) Strategic People Committee in Common III) Finance and Sustainability Committee	To note	Report	Cliff Richards, Committee Chair Julie Jarman, Committee Chair John Sommers, Committee Chair
BM/25/08/74	12:40	Finance, Sustainability and Performance Committee in Common Terms of Reference and Cycle of Business	To approve	Report	Company Secretary
BM/25/08/75	12:43	Cheshire and Merseyside Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common	To approve	Report	Company Secretary

SUPPLEMENTARY PAPERS for noting (see Supplementary Pack)

To Note For Assurance					
BM/25/08/76	Complaints Annual Report	Quality Assurance Committee Date: 13.05.2025 Ref: QAC/25/05/036 Outcome: Noted	To note for assurance	Report	Chief Nurse
BM/25/08/77	Learning From Deaths Q4	Quality Assurance Committee Date: 10.06.2025 Ref: QAC/25/06/062 Outcome: Noted	To note for assurance	Report	Executive Medical Director
BM/25/08/78	Medicines Management	Quality Assurance Committee Date: 10.06.2025 Ref: QAC/25/06/067 Outcome: Noted	To note for assurance	Report	Executive Medical Director

BM/25/08/79	Controlled Drugs Annual Report	Quality Assurance Committee Date: 10.06.2025 Ref: QAC/25/06/068 Outcome: Noted	<i>To note for assurance</i>	Report	Executive Medical Director
BM/25/08/80	Infection Prevention and Control BAF Bi-annual report	Quality Assurance Committee Date: 10.07.2025 Ref: QAC/25/07/086 Outcome: Noted	<i>To note for assurance</i>	Report	Chief Nurse
BM/25/08/81	Learning From Experience Summary Report Q4	Quality Assurance Committee Date: 10.06.2025 Ref: QAC/25/06/061 Outcome: Noted	<i>To note for assurance</i>	Report	Chief Nurse
BM/25/08/82	Director of Infection Prevention and Control Annual Report	Quality Assurance Committee Date: 31.07.2025 Ref: QAC/25/07/101 Outcome: Noted	<i>To note for assurance</i>	Report	Chief Nurse
BM/25/08/83	Health and Safety Annual Report	Quality Assurance Committee Date: 31.07.2025 Ref: QAC/25/07/102 Outcome: Noted	<i>To note for assurance</i>	Report	Chief Nurse
BM/25/08/84	Safeguarding Report	Quality Assurance Committee Date: 08.07.2025 Ref: QAC/25/07/087 Outcome: Noted	<i>To note for assurance</i>	Report	Chief Nurse
BM/25/08/85	Safe Nurse Staffing	Quality Assurance Committee Date: 31.07/2025 Ref: QAC/25/07/096 Outcome: Noted	<i>To note for assurance</i>	Report	Chief Nurse
BM/25/08/86	Violence Reduction Strategy	Quality Assurance Committee Date: 31.07.2025 Ref: QAC/25/07/097 Outcome: Noted	<i>To note for assurance</i>	Report	Chief Operating Officer
BM/25/08/87	Health and Wellbeing Report	Strategic People Committee Date: 18.06.2025 Ref: SPCIC/25/06/056 Outcome: Noted	<i>To note for assurance</i>	Report	Chief People Officer
BM/25/08/88	Guardian of Safe Working Annual Report	Strategic People Committee Date: 16.07.2025 Ref: SPCIC/25/07/078 Outcome: Noted	<i>To note for assurance</i>	Report	Executive Medical Director
BM/25/08/89	Digital Strategy Group Update	Finance and Sustainability Committee Date: 28.07.2025 Ref: FSC/25/06/070	<i>To note for assurance</i>	Report	Executive Medical Director

		Outcome: Noted			
BM/25/08/90	Trust Senior Management Organograms	N/A	<i>To note for assurance</i>	Report	Company Secretary
Closing					
BM/25/08/91	12:45	Review of the Meeting	To discuss	Verbal	Chair
BM/25/08/92		Any Other Business	To discuss	Verbal	Chair
Date and Time of next meeting – 10am, Wednesday 1 October 2025 – Lecture Theatre, Education Centre, Halton Hospital					

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

Kicked off course by the waiting list

Patient Story by Mia Kelly



Working
Together



Excellence



Inclusive



Kind



Embracing
Change

Background

17 year old college student and an avid footballer playing for Blackpool Ladies

Admitted to Warrington A&E November 2023 with football injury to knee

Dad attended all appointments with Mia

Diagnosed with tear of the anterior cruciate ligament (ACL) and meniscus



My Experience what went well

Communication

Consistency of care and engagement

Compassion and reassurance

Treatment

My Experience what could be improved

Information on pathways

Mental health wellbeing

Waiting list

Option to continue at Warrington



Learnings

Sharing the positive feedback with the teams involved in the care

Improved communications to patients to explain waiting list and regular updates and/or reviews

Recognising the importance of consistent care from the same practitioner

Emphasising the importance of seeing the person in the patient to improve their overall wellbeing



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 benefit¹ 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 association¹ 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 4 June 2025
Trust Conference Room/Via MS Teams

Present	
Steve McGuirk (SMcG)	Chair
Cliff Richards (CR)	Non-Executive Director & Deputy Chair
Michael O'Connor (MOC)	Non-Executive Director & Senior Independent Director
Julie Jarman (JJ)	Non-Executive Director
John Somers (JS)	Non-Executive Director
Jayne Downey (JD)	Non-Executive Director
Nikhil Khashu (NK)	Chief Executive
Dan Moore (DM)	Chief Operating Officer and Deputy Chief Executive
Ali Kennah (AK)	Chief Nurse
Michelle Cloney (MC)	Chief People Officer
Paul Fitzsimmons (PF)	Executive Medical Director
Jane Hurst (JH)	Chief Finance Officer
Apologies	
Jan O'Driscoll	Partner Nonexecutive Director - Chester University
In Attendance	
Lucy Gardner (LG)	Chief Strategy and Partnerships Officer
Kate Henry (KH)	Director of Communications & Engagement
John Culshaw (JC)	Company Secretary
Jen McCartney (JMcC)	Head of Patient Experience and Inclusion BM/25/06/30
Susan Dean	Deputy Head of Patient Experience and Inclusion BM/25/06/30
Teddy Dean	Patient BM/25/06/30
Emily Kelso	Corporate Governance and Membership Manager (minutes)
Observing	
Sue Fitzpatrick	Lead Governor – Public Governor
Katie Hurst	HBSUK

Agenda Ref	Agenda Item
BM/25/06/30	Engagement Story – My Patient Story JMc introduced patient TD to present his story, about his positive experience in the Trust's paediatric A&E department, highlighting how the staff listened to him and made him feel comfortable. The key highlights were taken from the presentation and board discussion were as follows: TD explained that he had fallen off his bike and been knocked unconscious. He was brought to the paediatric A&E department by his friends' parents. Overall, it had been a positive experience despite his injury (a broken collar

	bone), he explained that he felt listened to and comfortable. The staff treated him with respect, explained procedures, and made efforts to save his favourite jumper, which made a significant positive impact on his experience. • The Trust Board praised the staff in the paediatric A&E department for their interaction with the patient and his family. They communicated effectively, ensuring he understood the procedures and felt safe and supported throughout his visit. • SD, TD's mother shared her perspective, emphasising the importance of communication and how the staff made both her and her son feel safe and reassured. She appreciated the staff's efforts to involve her son in decisions and explain medical procedures in an understandable way appropriate for his age. The Trust Board thanked TD and his mother for sharing their story. The Trust Board discussed and noted the Engagement story
BM/25/06/31	Welcome, Apologies and Declarations of Interest SMcG welcomed the Trust Board, attendees and observers to the meeting and apologies were noted as detailed above, there were no declarations of interest made. The changes to maternity papers being presented to board were noted, it was explained that the Director of Midwifery would continue to present at Quality Assurance Committee (QAC) meetings each month, however Board reports would be less frequent in line with revised national requirements. SMcG informed all in attendance that the meeting was to be recorded for minuting purposes using AI, in line with the Digital Acceptable Use Policy, there were no objections. The Trust Board noted the apologies and declarations of interest.
BM/25/06/32	Minutes and Action Log of the previous meeting held on 2 April 2025 The minutes of the meeting held on 2 April 2025 were agreed as an accurate record subject to some minor amendments to the bimonthly strategy highlight report agenda item, which would be corrected following the meeting and sent to LG for approval. CR raised a query regarding the timeline for the six-month review by QAC in follow up to the actions agreed around the patient story presented to the Board at its April meeting. AK provided an update on the follow-up with the patient's family. The family had since met with PF, AK and the ward manager. The meeting was constructive, and the family expressed reassurance that learning had taken place. The ward manager had spoken candidly about the challenges and improvements made. The patient's daughter had been invited to return and visit the ward to experience the changes firsthand.

	The board suggested that the patient's daughter be invited to a future board meeting to provide feedback and help offer potential closure for her, and further assurance for the board. SMcG requested that a comprehensive note of the follow-up be included within the minutes, and that the board should formally record the engagement and outcome. The Trust Board approved the minutes of the meeting held on 2 April 2025 and noted the Action Log
BM/25/06/33	Matters Arising There were no further matters arising. The Trust Board noted that there were no matters arising.
BM/25/06/34	Chief Executive's Report NK introduced the paper, which was taken as read, and highlighted the following key points: • Proposed national pay awards had been communicated to union bodies. Feedback was awaited from unions; subsequent updates would be brought to the Board for consideration. • NHS annual planning guidance was expected imminently. Core strategic focus remained on community services, prevention, public health, and digital innovation. • CMAST internal planning was taking place to ensure it modernises its approach • Steve Broomhead had been formally appointed to Warrington Borough Council; it was noted that he was a keen supporter and key stakeholder for Trust activities. • Mandy Nagra had been appointed System Improvement Director for the ICS, tasked with enhancing collaboration efforts across the system. • The Trust had achieved a 6.3% improvement in patient discharges during the coordinated MADE at Easter, with emphasis on facilitating timely discharge to home to support patient recovery and flow. JD queried whether the improvements could be sustained. DM responded that the Quality Improvements taken from MADE, would become mainstream in the transformation programme. However, the staffing levels required during MADE were not sustainable to enable the events to become business as usual. • Positive progress had been reported in dermatology services through early-stage joint working with Bridgewater colleagues. A presentation had been shared demonstrating benefits of integrated community care. • International Nurses Day had taken place 12 May, celebrating nursing contributions to healthcare. • The start-of-year conference held with approximately 150 staff members from BCH and WHH; focused on past performance and setting future goals. Dr. Kate Allat delivered an impactful presentation emphasising the importance of patient-centred care.

	• The staff Thank You Awards event had been successful, thanks was extended to organisers for smooth and meaningful event execution JS queried the NHS 10-year plan's focus on neighbourhoods and accountable care organisations. NK responded that no formal system-level planning was currently established in the local area. The board agreed the topic should be scheduled for a future board development session to clarify the local interpretation and implementation of neighbourhood care models. It was agreed that Trust had a good opportunity to lead on neighbourhood care models particularly with the integration work with BCH and the success of collaboration projects including the Living Well Hub. PF provided an update of AI being used in dermatology explaining that advances in machine learning for dermatology, including infrared detection beyond human visual capabilities. It was anticipated that surpassing of human eye performance by machine diagnostics would soon be possible. It was noted that Governors had completed an observation visit of the dermatology department and agreed a revisit would be scheduled for 6 months' time, to review the progress in technological developments and patients feedback on the service. The Trust Board noted the Chief Executive's Report
BM/25/06/35	Chair's Report SMcG provided a verbal update on activities since the last board meeting, highlighting the following: • Price Waterhouse Coopers (PWC) had been commissioned to undertake a financial review of the drivers of the deficit across the Cheshire and Merseyside ICS. The PWC team had conducted diagnostic reviews involving Trust Chairs, Directors of Finance, and Chief Executives, from those Trusts in greatest deficit including WHH. Feedback from these diagnostics would be shared as further stages of the review were completed, and further discussion on the meetings would take place in Part 2 of the Trust Board meeting. The reviews were not solely on cost-cutting but focus on balancing quality of care with financial constraints. • Political factors were influencing NHS financial decision-making. • Devolution remained a key but complex element within the political and financial landscape. • Reports revealed severe financial strain on local authority partners, with Warrington's debt estimated at £1.8 billion. • Local organisations must now independently develop new care models, as external funding for Accountable Care Organisations was no longer available. Early adopters stand to benefit the most, despite uncertainty about how success will be measured. SMcG acknowledged the success of the Thank You Awards event. SMcG noted his apologies, and thanked CR for effectively deputising in his absence. Positive feedback was received around the venue and the overall conduct of the event.

	The Trust Board noted the verbal update from the Chair.
BM/25/06/36	Board Assurance Framework (BAF) JC introduced the report which provided the board with an update on each of the Trusts strategic risks. The key highlights from the report, were as follows • The current BAF report continues to monitor 10 principal risks, consistent with previous meetings. The 10 risks encompass critical areas such as Emergency Department (ED) capacity, delays in elective procedures, service sustainability, financial pressures, workforce equality and acquisitions • Since the last meeting, there had been no new risks added, closed, or de-escalated, and no changes to risk descriptions or ratings. • Updates to the controls, assurances, and identified gaps were detailed in section 2.6 of the report. • The majority, of these risks were to be actively discussed within the current meeting agenda, ensuring alignment of risk oversight with operational priorities. JD highlighted that some of the actions had surpassed their completion date, JC confirmed this would be updated prior to the next meeting. The Board noted that updates on the progress of these action plans will continue to be provided to ensure transparency and accountability. The Trust Board approved the changes and updates to the Strategic Risk Register and Board Assurance Framework
BM/25/06/37	Integrated Performance Report NK introduced the agenda item which provided a summary of Trust performance. The executives presented a set of summary slides which highlighted the indicators within the IPR that were both failing and had special cause variation of a concerning nature. JD commented that while it was encouraging to see improvements in the IPR, there was still further improvements to be made around making definitive statements based on a single data point. It was highlighted that the language used should reflect longer-term trends rather than short-term fluctuations, as performance could easily revert in the following month. JH provided an update on the one failing Finance and Sustainability indicators: • 58. Capital Programme – % delivered against plan – The capital programme was slightly off plan in Month 1 due to timing shifts from last year. Capital programme value estimated in the high £20 million range, including additional bids. The risk associated with delivering the 2025/26 capital plan was being monitored at CPG and reported to FSC.

- **59. Better Practice Payment Code** – payment performance dropped significantly to 53% (target is 95%) due to planned cash flow management. The board discussed the cash flow challenges leading to delayed payments to suppliers to maximise available funds. JH highlight the risks of incurring interest charges from suppliers due to late payments, contrasted with lower borrowing costs from national funding. The emphasis was on maintaining payments within contract terms to avoid breaches and managing public funds responsibly. Assurance was provided that communication with suppliers, especially smaller companies, remained a priority. It was explained that other Trusts were experiencing similar cash flow pressures.
- **61. CIP (recurrent)** - £0.5m CIP had been delivered recurrently against the target of £0.8m. Where recurrent CIP had not been realised, efforts had been made to deliver the CIP on a non-recurrent basis rather than not achieving. The board discussed the need to focus on recurrent schemes to avoid financial gaps in future years.

PF presented on the two **Quality** indicators with special cause variation of a concerning nature and do not have a target, these were:

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

Mortality ratios (HSMR and SHMI) had increased since October 2023 due to a shift to Type 5 coding, which excludes many low-risk, short-stay admissions. This has resulted in a higher baseline but remained within expected ranges. No significant concerns were found in recent mortality alert reviews; pre-alerts related to stroke and minor injury codes were explained by case mix and coding differences. Comparison with peer trusts indicates the higher mortality baseline is likely due to coding variations rather than actual increased deaths. Further analysis was underway to better understand coding impacts and align data with peers. Ongoing monitoring and clear communication were emphasised to avoid misinterpretation of data. SMcG asked that a paper be brought to the August Trust Board meeting following presentation to the QAC explaining the increase in ratio and the impact of the shift to Type 5 reporting and confirming that the Trust was not a mortality outlier. It was asked that a line be added to the IPR report to indicate when type 5 reporting was introduced.

CR highlight the following key items from QAC assurance reports:

- **Theatre Improvements Following MIAA Audit** - – monthly reporting improvements were now being presented at QAC meetings, showing clear progress since MIAA audit. A proposal had been put forward to introduce theatre safety champions to improve culture and visibility of progress. JD emphasised the importance of combining data with direct observation of theatre culture through programmes such as Leadership Observation Visits.
- **Chronic pain service** – had been entered into fragile services oversight. The service was outdated, with a focus on prescriptions/injections; transformation to a community-based rehab model was required. There

were no national audits; and given this there had been slow recognition of issues. An action plan created for short, medium, long-term improvements. The future model was aimed to be nurse/ANP-led with consultant support. PF explained cultural and clinical engagement challenges existing which would be a focus for improvements.

The following positives were noted from a Quality perspective:

- **Acute Kidney Injury Service (AKI)** – had been identified a few years ago as a gap by a Nephrologist who advocated for its creation. Evolving from Initial consultant-led into a largely nurse-led trust-wide service. The service was now well established and improving patient morbidity and mortality.
- **DNR/CPR Process** - Patient and family involvement in “Do Not Resuscitate” decisions were well managed. The process, led by the palliative care consultant, was effective and Trust wide. There are plans to extend this communication framework to broader patient deterioration scenarios, beyond just DNR/CPR. Positive feedback had been given to staff leading these efforts.

JJ highlighted the following key items from **SPCiC** assurance reports from a people perspective:

- The committee was operating a a committee “in common” with Bridgewater colleagues with potential to strengthen focus and unify messaging. Different governance arrangements across the two Trusts were acknowledged.
- The annual report on Gender Pay Gap had been received which were now published and would also be included in the Trusts Annual Report and Accounts 2024/25
- The staff survey had noted an increased response rate from multi-ethnic staff backgrounds which was a positive development. The committee had discussed reported increases in racism incidents: This was recognised as complex, with triangulation being undertaken against other data sources like employee relations cases to understand better. Overall staff survey results returned to pre-pandemic levels, outperforming national response rates. MC explained that the staff survey was one of multiple tools to assess workplace culture, alongside Freedom to Speak Up data and other intelligence. Comparison with Bridgewater staff survey revealed learning opportunities, particularly regarding younger staff experience improvements.
- Safe staffing in relation to patient safety and experience – there was reiteration that safety remains paramount but patient experience was also crucial. AK commented on the example of Corridor care whilst deemed safe and fairly effective it did often come with a negatively impact on patient experience. Reference was made to the April Board patient story highlighting the gap between safety and experience outcomes. The committee urged to confront difficult conversations about the trade-offs between safety and experience in current care models.

NK raised concerns around about declining flu and COVID-19 vaccine uptake nationally, regionally, and locally. He highlighted the importance of early committee focus to develop plans to mitigate risks for the upcoming winter season. MC explained ongoing vaccine campaigns and strategies; noting less animosity toward vaccines compared to previous years. It was explained that local uptake rates were comparatively higher than some other trusts but vigilance was required. KH confirmed the ICB had commissioned research into vaccine hesitancy insights to inform this year's approach; results were expected soon, from these communication strategies and public engagement, including visual campaigns would be actioned.

JS presented the highlight from the Finance and Sustainability Committee:

- The April meeting assurance report was taken as read with focus given to the content of the 2 June 2025 meeting, where and discussion was centred on system assurance and the grip control letter:
- CIPs -The PwC meeting referenced; strong emphasis on delivering CIPs effectively. There was agreement by the committee on the importance of achieving targets as a critical priority.
- Theatre productivity remains a persistent challenge with some metrics trending negatively. The deep dive confirmed ongoing issues around utilisation and cultural/leadership barriers. Frustrations were expressed by the committee about repetitive identification of problems without visible solutions or progress. Concerns were raised about leadership within the theatre teams, specifically a lack of visible, unified leadership and management. DM provided further insight into the data which showed continuous improvement over 12-18 months especially after FDP deployment. JD commented on the culture work which had been identified as siloed across disciplines. MC responded that there were Organisational Development interventions underway to engage theatre teams separately with plans to integrate efforts in a phased approach. The board agreed concerns remained about the speed and scale of improvement relative to benchmarks and expectations
- Capital Investment and funding – it was emphasised that future capital investments would be conditional on demonstrated organisational delivery and performance. Failure to meet CIP and performance targets risks losing funding opportunities. It was acknowledged that the stakes for achieving credible delivery had increased.

JS noted that there would be further detailed discussion and scrutiny around finance matters planned for Part 2 of the Board

Audit

MG highlighted the importance of active oversight by the Audit committee through triangulation across committees led by committee chairs, the continued good work by the finance team around preparation of the Annual Report and Accounts, and the emerging financial risks related to going concern

	and guarantees. He anticipated that these issues would be central to future committee discussions as pressures evolve. The Trust Board noted the contents of the report.
QUALITY	
BM/25/06/38	Fragile Clinical Services Update PF introduced the report which provided a status update on the Trust's oversight of services currently designated as fragile, Chronic Pain Service Urology, Orthopaedics – Fractured Neck of Femur, ENT, The following key highlights were taken from the report: • ENT - Following successful recruitment of consultant staff, gains from clinic template standardisation and stabilisation of the middle grade rota, improvements had been seen in waiting lists and staffing sustainability. Given this, PSCECSC has recommended that ENT is de-escalated from Fragile Service Oversight • Cancer Services - To be escalated to Fragile Services Oversight following presentation as a Deep Dive to QAC in May 2025, several harm incidents had been identified and discussed. A deep dive into urology cancer services highlighted issues with clinical service processes related to tracking and escalation. The team was addressing management, surveillance, and standardisation issues with a clear action plan. • Chronic Pan Service – had been escalated to Fragile Services Oversight following presentation as a Deep Dive to QAC. Initial steps are underway to align services with NICE guidance. Plans were in place to transform these services to be more community-based. • Urology services - remain fragile but stable, with ongoing weekly management of the P2 waiting list. • Cardiology - services were improving due to better job planning and consultant staffing. Work was ongoing to optimise the use of waiting list initiative (WLI) budgets. A clear management approach for patient groups and pending results was expected to enable removal of cardiology from fragile services oversight in the near future. MC commented that staff survey results and culture plans are closely aligned with fragile services findings. Targeted support was directed to fragile areas, ensuring staff concerns were addressed. CR reflected on the concerns around prompt NOF surgery in orthopaedics. Delays in time to surgery for fractures and related cases were discussed. Two main issues had been identified: - o Delays in transferring patients to specialist wards. - o Limited theatre capacity and scheduling inefficiencies. Variations in consultant workloads and case numbers were noted as a risk factor. It was explained that priority was given to open fractures and paediatric cases on theatre lists. It was identified that escalation processes for managing theatre lists may not be functioning optimally, this was to be reviewed. It was

	noted follow-up discussions with clinical leads had been scheduled. CR confirmed that an update would be reported through the QAC. The Trust Board: noted the current list of Fragile Services, associated clinical risk and high-level progress updates
PEOPLE	
BM/25/06/39	Communication and Engagement Dashboard Q4 KH introduced the report confirming that the Communications and Engagement update was to be provided on a bimonthly basis going forward, instead of quarterly to better align with the Board cycle of business. The following key highlights were taken from the report: • Key activities during the reporting period included: Coordination of Thank You Awards, integration campaigns, and awareness days. • A Government Digital Service audit of the Trust's website was completed. Accessibility improvements had been implemented, resulting in improved rankings. The charity website was currently being redeveloped. Once complete, all Trust-related websites will be hosted via NHS Informatics Merseyside. • Community Engagement - A maternity engagement event was held in April in collaboration with Walking Mums Cheshire and Bridgewater. The success of this event had prompted interest in future iterations. • Experts by Experience Programme - The Trust recruited an additional 21 experts, bringing the total to nearly 200 individuals contributing to various projects. The programme continued to provide valuable insight that influences decision-making and service design. • The Trust was participating in two pilot projects focused on improving health literacy, supported by NHS England North West and the Department of Health's Office for Health Improvement and Disparities. Pilots were focused on respiratory and maternity services. Health literacy statistics were highlighted. SMcG highlighted the complexity of some NHS communications, concerns were raised that overly complex surveys may deter feedback from patients, especially those recently discharged or in vulnerable states. KH confirmed that work was underway to improve survey accessibility. The Trust Board noted the report
SUSTAINABILITY	
BM/25/06/40	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: • Attention was drawn to the stakeholder engagement section of the report, emphasising its importance in maintaining strong relationships with local

	authorities, other trusts, voluntary sector councils, and similar partners. The value of these relationships was noted, particularly in the context of leading work on neighbourhood health. • The Trust welcomed its first patients at the new CDC, 10 days ahead of schedule. Initial patient trials were underway to monitor processes ahead of a full operational start planned for the following week. • It was noted that Sarah Hall, the local MP (Warrington South), was meeting with Wes Streeting, Secretary of State for Health and Social Care regarding the absence of an Urgent Treatment Centre in Warrington and the need for one. JJ raised concerns around the timeframe of the Laboratory Information Management System (LIMS) project, which had been agreed in June 2024 and was expected to take three years to complete. Questions were posed about the recruitment of consultants and whether the two-year operational timeline was typical. It was clarified that the Trust was intentionally placed later in the roll-out plan to align the LIMS project with ongoing pathology collaboration efforts. The objective was to integrate teams ahead of implementing a single LIMS, ensuring a smooth workflow. The project was being led by Cheshire Merseyside, and the Trust was still assessing potential impact of changes. The Trust Board noted the report.
GOVERNANCE	
BM/25/06/41	Compliance with Licence Annual Return – completion of G6 & Cos7 FT annually self-certify compliance with provider licence, continuity of services JC introduced the report explaining the requirement for FTs to annually self-certify compliance with two key statements as part of the provider licence obligations. • The first statement requested confirmation that the Board had taken all necessary precautions to comply with the licence. • The second statement concerned the continuity of services, confirming that the Board was satisfied the Trust had or would have the required resources for the forthcoming financial year. The Board discussed the rationale for confirming the compliance statements, referencing the going concern statement previously approved by the Audit Committee. While acknowledging some complexity and partial uncertainty around the going concern status. The Board agreed that, although there were concerns about fully endorsing the statement, the current position represented the best achievable under the circumstances. The Trust Board noted compliance with NHS Conditions G6 and CoS7 and approve the self-certification
BM/25/06/42	Review of Board Effectiveness – Survey Outputs

	JC introduced the report explaining the Board effectiveness survey had been completed, with positive overall results. The one area for improvement was in relation to Question 8, which addressed how clearly reports provide assurance to the Board. Feedback suggested executive summaries could be clearer and more concise, reducing lengthy and repetitive content. A Report Writing Guide was previously circulated to support better, focused reporting, with recommendation on producing concise and effective executive summaries. Board members agreed on the importance of continuing to improve report clarity and assurance. The Trust Board noted the survey outputs and actions
BM/25/06/43	Changes to the Constitution JC introduced the paper which proposed two amendments to the constitution, which had been supported by the Council of Governors and were now coming to the board for formal ratification. These were: - the removal of the requirement for a non-executive director from Chester University - the addition of a partnership governor from the Cheshire Walking Mums The Trust Board approved the amendments to the constitution
Supplementary Papers – To note for Assurance	
BM/25/06/44	Infection Prevention and Control Update Q4
BM/25/06/45	Patient Experience & Inclusion Sub Committee Bi-annual Report
BM/25/06/46	Hospital Volunteer Annual Report
BM/25/06/47	Guardian of Safe Working Report Q4
BM/25/06/48	Gender Pay Gap Annual Report
BM/25/06/49	Digital Strategy Group Update
Closing	
BM/25/06/50	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/25/06/51	Any Other Business No further business was raised. Meeting ended at 12:38pm
Date and Time of next meeting – 10am, Wednesday 6 August 2025 – Lecture Theatre, Education Centre, Halton Hospital	

TRUST BOARD

AGENDA REFERENCE	BM/25/08/54i	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
BM/25/06/37	04.06.25	Integrated Performance Report Mortality ratio – SHMI	A paper be bought to the August Trust Board meeting following presentation to the QAC explaining the increase in SHMI ratio and the impact of the shift to Type 5 reporting on data reporting	PF	06.08.25	06.08.25	To be presented at August meeting BM/25/08/66	

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	

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

REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/25/08/56			
SUBJECT:	Chief Executive's Report			
DATE OF MEETING:	6 August 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	<i>Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</i>			
	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/25/08/56

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

2. KEY ELEMENTS

2.1 National News

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

10 Year Health Plan for England: fit for the future: On 3 July 2025, the Government launched its new 10 year plan for England. The plan sets out the government's bold, ambitious and necessary new course for the NHS. The plan fundamentally reinvents our approach to healthcare so that we can guarantee the NHS will be there for all who need it for generations to come.

The plan has been shaped by the experiences and expectations of members of the public, patients, our health and care workforce and partner organisations – gathered through the Change NHS conversation which launched in October 2024. Over a million insights were received as part of this engagement exercise, reflecting the changes that people wanted to see.

Through the 'three shifts' – from hospital to community, from analogue to digital, and from treatment to prevention – we will personalise care, give more power to patients, and ensure that the best of the NHS is available to all.

You can read the full plan on the government website: [10 Year Health Plan for England: fit for the future - GOV.UK](#)

While the plan sets out the approach for the next 10 years, we know that much of the plan will be delivered more quickly than this. Our own integration journey is a great example of this and we are already well on our way to achieving our ambitious plans.

The Dash Review: Published on 7 July 2025, and authored by Professor Penny Dash, Chair of NHS England, this independent report—commissioned by the government—examined patient safety regulation across the health and care system. Key findings highlighted an excessive emphasis on safety over other aspects of quality, a fragmented and overcrowded organisational landscape, underutilisation of technology and data, and inconsistent board effectiveness with unclear lines of accountability.

The report set out nine recommendations for reform. These included the creation of a restructured National Quality Board, a much stronger focus on patient experience, and widespread improvements in how both patients and staff are engaged. Notably for our local context, the remit of Healthwatch was proposed to be split and redistributed nationally, as well as to local authorities and Integrated Care Boards (ICBs)

The Leng Review: The recent Leng Review, led by Professor Gillian Leng CBE and commissioned by the Secretary of State for Health and Social Care, was published on 16 July 2025. The independent review examined the roles of physician assistants (formerly physician associates) and physician assistants in anaesthesia (formerly anaesthesia associates) within multidisciplinary NHS teams. It focused on their safety, effectiveness, and how they are perceived by the public.

The review has produced 14 recommendations, further to its publication the National Medical Directors have directed Trust's to undertake 5 immediate actions based on these recommendations of which immediate changes of nomenclature, limitations to deployment, continuing current employment with a review of role and support for are relevant to the Trust. Each of these directions have been actioned, overseen by the Medical Director.

Following the publication of the report and the adoption of its recommendations, the Trust has been actively supporting affected staff and having completed the immediate actions required, will now move to work with physicians assistants, physician assistants in anaesthesia and Clinical Business Units to address the implications for workforce planning, role of physician assistants, and associated governance with consultation with the physician assistant workforce as required.

NHS Oversight Framework: The NHS Oversight Framework for 2025/26 was officially published by NHS England on 26 June 2025. This updated framework outlines how NHS England will assess the performance of Integrated Care Boards (ICBs), NHS trusts, and foundation trusts. It introduces a consistent and transparent approach to oversight, with segmentation scores ranging from 1 to 5, and is designed to support improvement, ensure accountability, and align with national priorities.

Resident Doctors Industrial Action: A five-day strike by NHS resident doctors (formerly junior doctors) began at 7am on Friday 25 July and continued until 7am on Wednesday 30 July.

To maintain patient safety and service continuity, the Trust implemented detailed contingency plans. These include revised staffing arrangements, suspension of non-essential clinical meetings, and support from consultants and non-medical professionals within their competencies.

Despite initial concerns—especially with the school holidays beginning—services were maintained effectively thanks to the strong planning and the dedication of clinical, community, and operational teams. Although some disruption and cancellations inevitably occurred, the impact on elective care was minimal, affecting only a small number of patients.

I would like to acknowledge the efforts of staff in maintaining patient safety and service continuity, which was echoed in a letter issued by Wes Streeting, Secretary of State and Jim Mackey, NHS England Chief Executive. You can read the letter here: [NHS England » Thank you letter to NHS staff from Secretary of State and Jim Mackey](#)

Maternity & Neonatal Care: In response to ongoing concerns and significant failings in maternity and neonatal services, the Secretary of State for Health and Social Care announced a rapid independent investigation and the formation of a national taskforce. The

announcement outlined the urgent need to address systemic issues in care quality, safety, and culture.

2.2 Regional Update

NHS Cheshire & Merseyside: - Raj Jain has announced his decision to retire from his post as Chair of NHS Cheshire and Merseyside Integrated Care Board (ICB), confirming that he will step down in October 2025. The announcement marks the conclusion of a significant chapter in regional health leadership and the beginning of a new era for the ICB.

Appointed as the inaugural Chair, Raj has played a central role in establishing the ICB and guiding it through its formative years.

“It has been an extraordinary privilege to serve as Chair of Cheshire and Merseyside ICB,” said Raj. “I want to express my heartfelt thanks to the dedicated staff, partners, and colleagues who have worked tirelessly to build a more integrated and compassionate health and care system. Their commitment and resilience have been nothing short of inspiring.”

Devolution: Following a request for a one-year deferral of the proposed mayoral election by Cheshire East Council, Cheshire West and Chester Council, and Warrington Borough Council; Mayoral elections have now been deferred to May 2027, to align with local elections and reduce costs

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

The CMPC Leadership Board most recently met on Friday 4th July and discussed a number of system wide issues currently in focus.

A significant portion of the meeting was handed over to a shared discussion with the ICB and NHSE colleagues and Trust Chairs for the Cheshire and Merseyside system to receive a summary of the outputs from the system wide rapid diagnostic review, led by Stephen Hay and supported by a team from PwC.

Individual Trust specific reports are expected to follow in month. Discussions are ongoing about how the system will respond to the recommendations arising from the review. Trusts have been notified of further in-depth discussions and exploration of month 3 positions imminently.

Next the Leadership Board received an update on the Efficiency at Scale Programme, specifically with relation to corporate back office and at scale opportunities. Support was provided to the more detailed work up of system wide opportunities covering: digital, procurement, occupational health and recruitment. Work will focus on exploring single solutions for C&M where feasible to ensure maximum benefit realisation.

CEOs reflected on the system agreement and position in respect of bank rates and next steps.

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

2.5 Opening of Ward K25 - Older Persons Short Stay Unit

On 2 June, Ward K25 changed its name and function to become the Older Persons Short Stay Unit (K25 – OPSSU). This new unit is part of the Department of Medicine for Older People and is designed to care for patients aged 65 and over who are likely to be discharged within 72 hours of admission via the Frailty Assessment Unit.

The unit operates 24/7 and aims to reduce the risks associated with longer hospital stays—such as infection, delirium, and deconditioning—by enabling quicker, safer discharges. It uses the expertise of a multidisciplinary team including doctors, nurses, therapists, pharmacy staff, and discharge facilitators, all working together to ensure patients can return home promptly without disrupting existing care arrangements.

The opening of K25 – OPSSU is seen as a major step forward in improving care for frail patients. Early results have been promising, with 50% of patients discharged by day three. The team is optimistic about building on this early success to further enhance care for vulnerable patients.

2.6 Pride in who we are

June was Pride Month, and Staff networks from both organisations reflected on the importance of Pride, describing it as a space for advocacy, peer support, and visibility. WHH's Progress LGBTQ+ Network highlighted its role in fostering a workplace where everyone feels seen and valued, while BCH's LGBTQIA+ Staff Network emphasised dignity, respect, and the need to challenge discrimination.

Everyone was invited to join the Warrington Pride parade on Saturday 14 June at Time Square, with WHH extending a warm welcome to BCH colleagues to march together and showcase the connection between hospital and community services.

2.8 Showcasing our success

Also in June, Louise Shepherd CBE, North West Regional Director for NHS England, visited WHH to tour several key services, including the Emergency Department, Same Day Emergency Care centre, and the newly opened Older Persons Short Stay Unit. She also spent time in maternity services, such as Maternity Triage, The Nest, and the Birth Suite, where she learned how these teams are working closely with community services to improve care and reduce waiting times.

A highlight of the visit was the official opening of the Warrington and Halton Diagnostics Centre at Halton Hospital. This new £11 million facility, part of a wider £16 million Community Diagnostic Centre programme, will serve over 30,000 patients annually with advanced MRI and CT services. The technology includes AI-powered MRI scanners that reduce scan times by up to 70% and CT scanners that deliver significantly lower radiation doses, making diagnostics faster, safer, and more comfortable.

Louise was impressed by the innovation and teamwork she witnessed, praising the “can-do attitude” of staff. The visit was seen as a strong endorsement of WHH’s efforts to integrate hospital and community services and lead the way in modern, patient-centred care.

2.9 77 Years of the NHS

The weekend of 5 July marked the 77th anniversary of the NHS and it was a chance to celebrate the compassion, dedication, and innovation that define the NHS, and to thank everyone—past and present—who has contributed to its legacy.

Despite ongoing challenges like rising demand and system complexity, there’s a strong sense of pride in the resilience and skill of NHS staff. The recently published 10 Year Health Plan offers a clear direction for the future, focusing on prevention, personalisation, integration, and the smart use of technology to help people live healthier lives for longer.

A highlight of the weekend was the BBC North West Tonight feature on the Living Well Hub in Warrington, which showcased how collaborative, community-based care is already making a difference. It was a timely reminder of the NHS’s ability to evolve and lead with purpose.

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:

June

- Pride Month
- Volunteer’s Week
- Intensive Care Week
- Dieticians Week
- Biomedical Science Day
- Carers Week
- Men’s Health Week
- Learning Disability Week
- World Diabetes Awareness
- Cervical Screening Awareness Week

July

- Alcohol Awareness Week
- South Asian Heritage Month

2.14 Signed under Seal

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

2 RECOMMENDATIONS

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

3 APPENDICES

Appendix 1: CEO Dashboard – Month 3 (June 2025)

Appendix 1 - CEO Dashboard Month 3 – June 2025

Quality							
Operational Performance				Quality of Care			
Indicator	Target/Limit	Actual	SPC	Indicator	Target/Limit	Actual	SPC
Diagnostic waiting times - 6 Weeks	above 95%	96.19%		Incidents open over 40 days	0	21	
RTT 18 Weeks	above 92%	56.78%		Sepsis Screening Emergency	above 90%	65.00%	
RTT - patients waiting 52+ Weeks	0	1635		Sepsis Screening Inpatients	above 90%	67.00%	
RTT - patients waiting 65+ Weeks	0	130		Sepsis Antibiotics Emergency	above 90%	61.00%	
Elective Outpatient activity	104%	98%		Sepsis Antibiotics Inpatient	above 90%	81.00%	
A&E % patients seen within 4 hours	Below 78.00%	64.78%		Inpatient Falls	30 (10% reduction from 2024/25)	42	
A&E % waiting longer than 12 hours	Below 2.00%	24.29%		VTE	above 95%	93.66%	
Cancer 28 Day Faster Diagnostic Standard	above 75%	72.00%		Pressure Ulcers	11 (20% reduction from 2024/25)	13	
Cancer 62 Day Wait	above 85%	80.80%		Medication Reconciliation (within 24 hrs)	above 80%	37.00%	
Ambulance Vehicle Handovers within 45 mins	100%	63.62%		Complaints over 6 months	0	1	
Cancelled Operations – 28 days	0	3		Healthcare Infections - MRSA	0	0 YTD	
Capped Theatre Utilisation	above 85%	77.35%		Healthcare Infections - MSSA	below 8 YTD	11 YTD	
Sustainability				Healthcare Infections – CDI (cumulative)	below 15 YTD	19 YTD	
Finance				Healthcare Infections - E. coli (cumulative)	below 20 YTD	21 YTD	
Indicator	Target/Limit	Actual	SPC	Healthcare Infections – Klebsiella (cumulative)	below 7 YTD	9 YTD	
Income & Expenditure (£m)	-£4.22	-£4.23		Healthcare Infections - P. aeruginosa (cumulative)	below 2 YTD	3 YTD	
Capital Spend (£m)	£3.68	£0.63		Maternity Postpartum Haemorrhage >1500ml	below 3.7%	4.70%	
Cash Balance (£m)	£4.48	£13.79		MUST nutritional assessment completion	above 85%	73.69%	
Better Practice Payment Code (£m)	above 95%	56%		People			
Agency Reduction (£m)	£0.73 (30% reduction from 2024/25 plan)	£0.60		Workforce			
Bank Reduction (£m)	£6.91 (10% reduction from 2024/25 plan)	£7.20		Indicator	Target/Limit	Actual	SPC
CIP In Year Delivered in relation to plan	90% of plan	100%		Supporting Attendance	Below 5%	6.00%	
CIP In Year Delivered in relation to plan (Recurrent)	90% of plan	65%		Turnover	Below 13%	11.28%	
				Core/Mandatory Training	above 85%	91.19%	
				PDR Compliance	above 85%	79.00%	

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. The ICB have been asked to support this. - 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 64,000 views with the membership growing daily. The platform showcases over 600 activities that support living well across Warrington. - Work continues to implement the new post menopausal bleeding pathway within the CDC in Halton. This will enable women to access a one stop clinic for diagnosis of gynaecological cancers and is expected to go live in August this year. - The full business case for development of the East Pathology Hub and has been shared with the executive team before being presented to the Board in August.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/25/08/58			
SUBJECT:	Board Assurance Framework			
DATE OF MEETING:	6 August 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	<i>Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</i>			
	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 10 strategic risks as per the Board Assurance Framework, following review by the assigned monitoring Committee. Each strategic risk is linked to one or more of the Trust's strategic objectives. A Risk Review Group has been established for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately. Since the last Trust Board meeting: It is proposed that risk 1757 concerning industrial action is re-escalated from the Corporate Risk Register to the Strategic risk register/BAF, a change in description and an increased risk rating is also recommended, details are provided in section 2.1 of the report.			

	- No risk descriptions to current risks have been updated - 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: <i>(please select as appropriate)</i>	Approval	To note ✓	Decision
RECOMMENDATION:	The Board is asked to: - Discuss and note the updates to the Strategic Risk Register and Board Assurance Framework - Approve the re-escalation from the corporate risk register to the strategic risk register/BAF, increased risk rating and updated description of risk 1757		
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: <i>(if relevant)</i>	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework	AGENDA REF:	BM/25/08/58

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 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 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	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
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
1757 Re-escalated from CRR	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

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

2. UPDATES SINCE THE LAST MEETING

2 Since the last meeting

2.1 New risks

Re-escalation of Risk 1757

Following the announcement from the British Medical Association (BMA) regarding industrial action by resident doctors in England, scheduled from 7:00am on Friday 25 July to 7:00am on Wednesday 30 July, it is recommended that **Risk 1757** be re-escalated from the Corporate Risk Register to the Strategic Risk Register. This risk outlines the potential for significant workforce gaps across critical services during periods of industrial action, which may disrupt operational service delivery and compromise the Trust's ability to maintain safe, effective, and timely patient care. In view of the increased likelihood of further action and the broad impact across multiple service lines, the risk now requires strategic oversight and mitigation. Ongoing monitoring will be undertaken via the Quality Assurance Committee, with executive oversight provided by the Executive Medical Director.

Updated Risk Description

An amendment to the risk description is proposed to reflect the broader assurance gaps now evident beyond GP collective action alone

From: *If GP collective action continues to take place, then operational delivery may be negatively impacted affecting delivery of services.*

To: *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.*

Risk Rating Adjustment

In light of the increased likelihood and potential impact, it is recommended that the risk rating be revised:

- **From:** 9 (3 – Likelihood × 3 – Consequence)
- **To:** 12 (4 – Likelihood × 3 – Consequence)

The table below outlines how the risk has been previously described and rated.

Risk ID	Exec Lead	Risk Description	Q2 2025/26	Q1 2025/26	Q4 2024/25	Q3 2024/25	Q2 2024/25
1757	CPO	Q2 2025/26: 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. Q3 2024/25: If GP collective action continues to take place, then operational delivery may be negatively impacted affecting delivery of services. Q2 2024/25: If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action then this could result in significant workforce gaps which would negatively impact service delivery and patient safety	Re-escalated to the SRR 12 (L4xC3) ↑	CRR 9 (3Lx3C)	CRR 9 (3Lx3C)	Risk description on updated and risk De-escalated 9 (3Lx3C) ↓	20 (L5xC4) ↔

2.3 Amendment to risk ratings

There have been no amendments to current risk ratings.

2.4 Amendments to descriptions

There have been no amendments to risk current descriptions

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
224	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival resulting in an overcrowded Emergency Department.	Controls • QI led project to support improving Ambulance handover times	20	None ↔
1215	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.	Controls • Recruitment and development of Transfer of care hub team is gaining maturity • 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	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. • 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. • PWC final report signed off, recommendations actioned and monitored each has an Exec lead and PID. • 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	20	None ↔

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		Assurances 2024/25 CIP £18.5m achieved of which £12.5m was the recurrent higher CIP achieved. - 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. Control and Assurance Gaps - Risk of over performance of activity which may not be paid due to cap on income and affordability 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.		
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.	Assurances: ENT Surgery has been deescalated from Fragile Services Oversight	20	none ↔
1114	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	Assurances - All servers and desktops are currently under Microsoft support. Gaps in Controls - 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.	16	none ↔
1372	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	Assurances - PME launched July 2025 Gaps In Assurance - Brokering of FD funds for use in future years not fully agreed	16	None ↔
115	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity	Assurances Increase in registered nursing establishment in the Emergency Department, November 2024 reducing band 5 vacancy rate to 32.51 In April 2025 WTE from 46.84 WTE in May 2024. 18	12	none ↔

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	and dependency then this may impact the delivery of basic patient care.	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 9.86% in April 2025 - Overall CHPPD sustained between 7.3-7.5 in Q4. Noted at 7.6 in April 2025 - Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 14.28% in April 2025 - Cost avoidance of £2,363,508 m (end April 2025) from agency managed service contract started August 2022 19 wards achieved the 90% fill rate on day shifts and 24 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 - 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 - 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.		
1134	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	Sickness Absence The rolling 12-month sickness absence rate is 5.99% as at June 2025 and is showing a slight increase from April 2025 (5.92%). Trust target from April 2025 is 5% as approved by the Strategic People Committee following a benchmarking exercise across the C&M region and consideration of health inequalities in the community we recruit staff from. Controls - Review of Supporting Attendance Policy and processes in progress. - Review of absence data by OH to ensure all relevant cases have been referred to OH. 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. Turnover and Attraction Turnover in June 2025 remains below the target of 13% at 11.28%, a 1% decrease from the figure	12	none ↔

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		reported in February 2025. Turnover of permanent staff in June 2025 was 10.6%. The Trust's June 2025 vacancy rate is 7.75% from 7.00% in April 2025, Trust target is below 9%. Controls - Rugby League Cares have been supporting WHH since July 2021 and have been working in areas offering drop-in sessions and tailored programmes to support teams and individuals to keep well in work with funding secured to continue with this programme. . Assurances - The responses to Exit Interviews are positive, only 11.49% as at June 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 target at 3.3%, target is 2.3% Temporary Staffing and Agency spend Bank and Agency reliance in June 2025 has decreased to 10.48% . The Trust target is 9%. Bank reliance has reduced to 9.06% from 11.82% in April 2025 and agency reliance continues to reduce to 0.76%. 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.		
2253	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.	Controls - 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 Assurances - 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	9	none

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
1757 Re-escalated from CRR	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.	Controls - 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 - 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 - Supporting materials available on the Trust intranet including FAQs and the response plan Assurances - 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 - 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 Assurance Gaps - 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 closes on 1st September 2025. The first instance of industrial action for this group could potentially commence Monday 15th September - 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	12	increased ↑

3. RECOMMENDATIONS

The Board is asked to:

- Discuss and note the updates to the Strategic Risk Register and Board Assurance Framework
- Approve the re-escalation from the corporate risk register to the strategic risk register/BAF, increased risk rating and updated description of risk 1757

Board Assurance Framework August 2025

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

		short-term fixes, non-compliance, and adverse effects on patient safety, outcomes, reputation, and finances					
115	CN	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	1	12 (L3xC4)	8 (L2xC4)	Minimal	Quality Assurance Committee
1134	CPO	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	2	12 (L3xC4)	8 (L2xC4)	Open	Strategic People Committee
2253	CSPO	If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities, and ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, including the limited capacity of shared Board members to effectively manage competing demands, potentially impacting both Trusts' decision-making and service management	1,2,3	9 (L3xC3)	2 (1LxC2)	Open	Executive Management Team
1757 Re- escala ted to SRR	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)	Cautious	Quality Assurance Committee

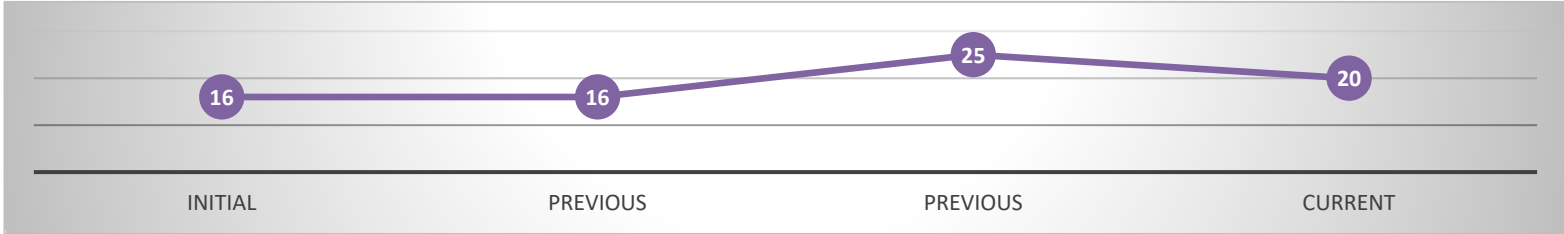
Strategic Objective 1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.

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)

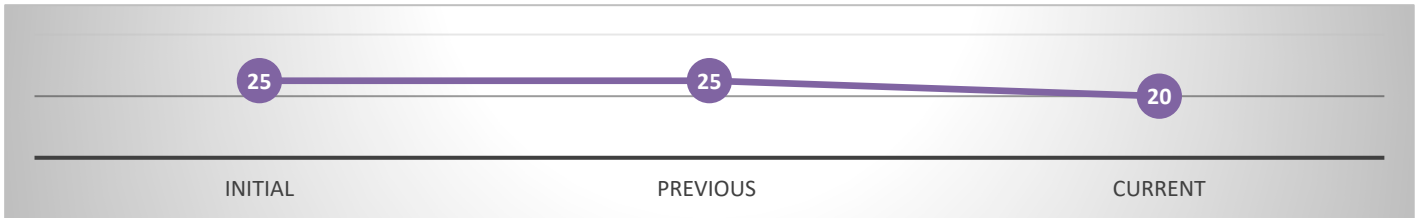
Board Assurance Framework

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)
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 Group 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	<u>Gaps in Controls</u> - Ongoing industrial action across a number of staffing groups including junior medical staff. <u>Gaps in Assurances</u> - 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 National report and benchmarking outcome	Ongoing monitoring of risk via daily report SITREP, Daily Capacity and Demand report from 4* daily bed meetings.	Bowman, Karen	(ongoing)	

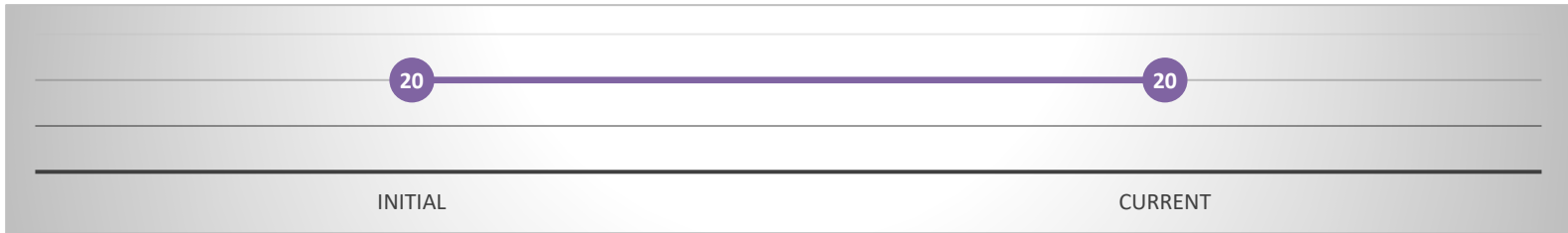
	UEC north dashboard Robust ongoing monitoring	Weekly PRG and monthly Unplanned Care Performance Meetings.			
Working with wider system on wider sustainability	Undertake System UEC improvement work focussing on admission avoidance	Complete project in line with timelines	Moore, Dan	ongoing	

Board Assurance Framework

Risk ID	1215	Executive Lead	Chief Operating Officer		
Strategic Objective	Strategic Objective 1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.			Rating	
Risk Description	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.			Initial	25 (L5xC5)
				Current	20 (L4xC5)
				Target	6 (L3xC2)
Risk Appetite	Open: Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Assurance Details	Controls. - Inpatient capacity is reviewed with the patient flow and CBU teams daily through the Bed Meetings to ensure that there is adequate capacity for all patient groups to be admitted. - Weekly review meetings with C&M diagnostics hub, Mutual aid opportunities utilised across C&M to reduce delays - Recruitment 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 Assurances - All elective patients have been clinically reviewed and categorised in line with national guidance. - New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. - Post Anaesthetic Care Unit (PACU) operational from January 2021				

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

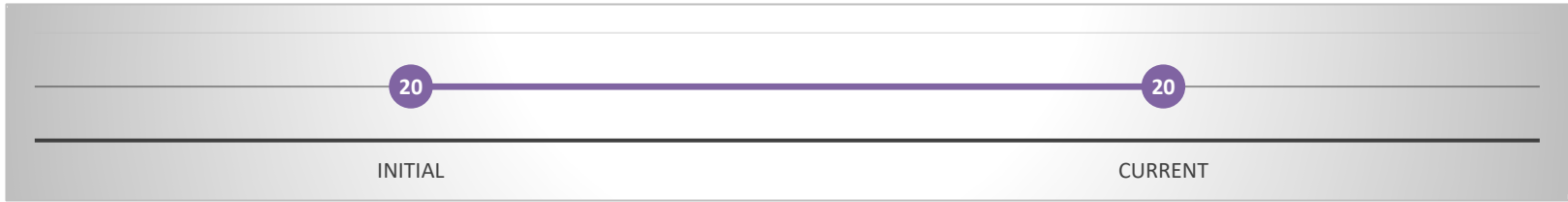
Board Assurance Framework

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)
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 and 5 PAs allocated, Head of Improvement • Financial strategy developed to support improvement in financial sustainability. 2022-2027 Financial Strategy approved by the Trust Board in May 2022 • High Level 5-year plan presented to the Finance & Sustainability Committee in April 2024, High level 4-year plan shared with PWC, Chair and CEO • Capital Plan for 2025/26 approved at 2 April 2025 Trust Board meeting. • Revenue plans 2024/25. Operational Plan approved by Trust Board 28.04.2025 • Introduced system of escalation where there are risks to CIP delivery • 2024/25 deficit position £16.8m was in line with the forecast, for £5.5m off plan. • 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 catalogue spend and implemented cease option to purchase some items • Cash Support received for 2024/25 was £12.145m. • Enhanced ECF meetings in place with Chief Executive sign off, with ICS invited. Bridgewater Community Healthcare NHS FT in attendance. • Urgent & Emergency Care System Improvement (UECSIP) Lead with Place support • Introduced system of escalation where capital paperwork has not been produced by Q1 • Executive Review of CIP gap and unfunded cost pressures. • Review of non-recurrent CIP and move to recurrent if possible				

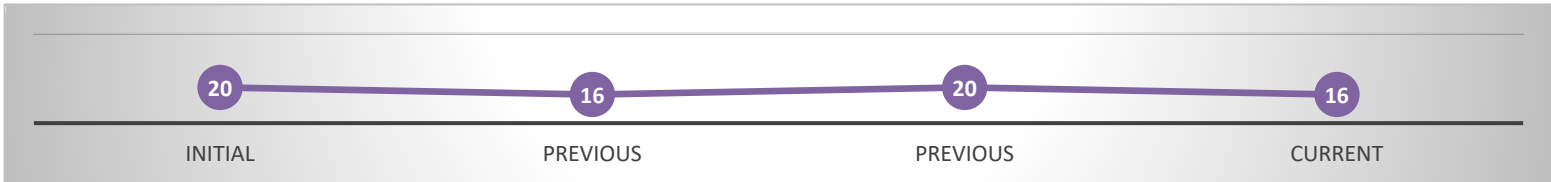
	• Fortnightly Executive led meeting to monitor spend on WLI/ Insourcing/ LLP to support 65- & 52-Week recovery. • PWC final report signed off, recommendations actioned and monitored each has an Exec lead and PID. • 2024/25 received high assurance for general ledger, accounts receivable, accounts payable, 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 • National cash team have indicated that they will not accept cash support application in April 2025 / Q1, the suggested new process will be a meeting with Provider Dof and NHSE Deputy CFO. • 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 23/24 the control total was exceeded by the stretch target set by the ICS. The 2024/25 position was £16.8m deficit which was in line with the forecast and £5.5m off plan. The Trust has highlighted the level of risk throughout the year. • Delivered 2023/24 and 2024/25 Capital Plans • Unqualified audit opinion (2024/25) submitted on time • Completed MIAA Governance Checklist received by Audit Committee • Monthly Report to Executive Team Meeting and FRG highlights the number of retrospective waivers compared to the previous year, the number of staff trained and the number of staff who have received training but not followed the correct process. • Refresher training offered to those who undertook training over 12 months ago but then submitted a retrospective waiver • Capital is reported monthly to FSC detailing all schemes above £500k monitoring underspends against plan and expected end date. This is in line with MIAA recommendations. • Changes to WTE have been reviewed by the Finance & Sustainability Committee during the year and the Trust has seen a significant reduction in agency with an increase in bank and substantive staff. The 2024/25 challenge was to keep agency to below the 3.2% ceiling and reduce bank. For 2024/25 agency was 1.3% of payroll, lower than the 3.2% ceiling. • C&M ICS have indicated that there should be a 4% reduction in staffing in the 2025/26 plan in line with the 5% CIP target • HFMA self-assessment completed and audited. • 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. • 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 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) COP £12M • 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.				
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 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)	
Risk Appetite				Current	20 (L5xC4)	
				Target	6 (L2 xC3)	
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 with escalation to QAC and board as required	PF	Monthly		

Board Assurance Framework

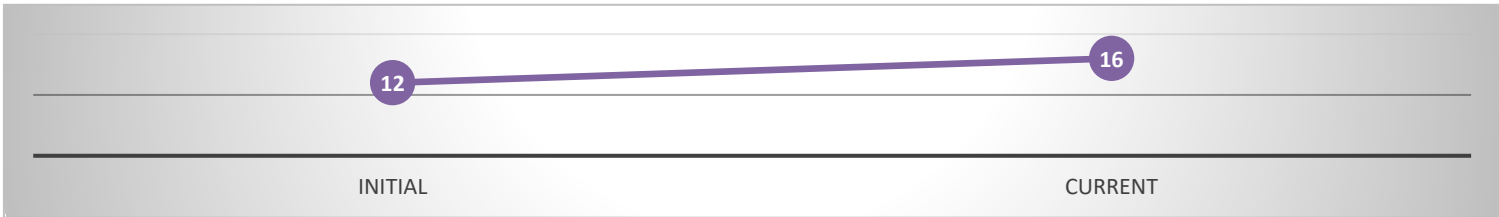
Risk ID	1114	Executive Lead	Executive Medical Director		
Strategic Objective	Strategic Objective 1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.			Rating	
Risk Description	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.			Initial	20 (L5xC4)
				Current	16 (L4xC4)
				Target	8 (L2xC4)
Risk Appetite	Minimal – Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Risk Movement					
Assurance Details	Assurance • 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 ITHHealth 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 systems. Consequently, any server	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

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	Multifactor authorisation (MFA) review of Trust critical systems as data has shown that majority of cyber attacks can be prevented within 20 minutes of the initial attack starting with MFA compared to organisations who don't use MFA.	National monies identified and obtained for the purchase of a Privilege Access Management (PAM) system. This will protect network accounts with elevated admin controls, whether on the network or on the critical systems. Evaluation and purchase of a common PAM system between WHHT & BW is being considered. Once purchased the system will need to be installed and configured.	Deacon, Stephen	31/05/2025	
Migrate Windows 10 to Windows 11	Migrate Windows 10 to Windows 11 before end of life date of 30/10/25	Migrate Windows 10 to Windows 11 before end of life date of 30/10/25 Process: Testing in IT Services (COMPLETE) Testing with critical systems (COMPLETE) Rollout with new devices (STARTED) Rollout with rebuilt devices (STARTED)	Waterfield, Tracie	31/10/2025	
Migrate/decommission Windows Server 2016	Migrate/decommission Windows Server 2016 to the newest version of Windows Server as support for security updates case in Oct 2026	Develop action plan for migration for the more difficult servers to migrate. Currently 8/67 (12%) have been migrated or decommissioned.	Waterfield, Tracie	29/01/2027	
Removal of generic Window accounts	Removal of generic Window accounts	Plan for the removal of generic Window accounts in clinical areas to reduce cyber risks. Staff to log in as their own accounts. Planning of the removal is required to minimise clinical disruption to patient care.	Waterfield, Tracie	31/12/25	
Mitigate the unsupported software used in BadgerNet	BadgerNet products have been discovered to have 2 3rd party		Deacon, Stephen	31/07/25	

	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.			
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.	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.	Whitfield, Simon	30/09/25	

Board Assurance Framework

Risk ID	1372	Executive Lead	Executive Medical Director	Rating	
Strategic Objective	Strategic Objective 3: We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description	If the Trust is unable to procure a new Electronic Patient Record then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and a risk to patient safety			Initial	12 (L3 xC4)
Risk Appetite				Current	16 (L4xC4)
				Target	8 (L2 xC4)
Risk Movement	Cautious – Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential. 				
Assurance Details	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 post to be advertised • Financial modelling of realistic options to provide genuine 5, 10 and 15 year options to control whole life costs • Partnership procurement will lead to identification of further realistic cash releasing / cost reduction benefits • The collaboration agreement has been developed and endorsed by EMT and Board • Approach to convergence and single instance architecture agreed with FD team				
Assurance Gaps	Gaps In Assurance • FD convergence guidance remains a potential risk – though agreement of a single instance architecture with multiple tenants with FD has largely mitigated this • Complexity of coterminous LIMS implementation 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 Gaps In Controls • Lorenzo is at end of life and is unlikely to see significant future development or enhancements • Delay to implementation could push implementation date past Lorenzo contract and Lorenzo sunsetting date with significant financial and clinical risk				

Board Assurance Framework

• 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	30/8/25	

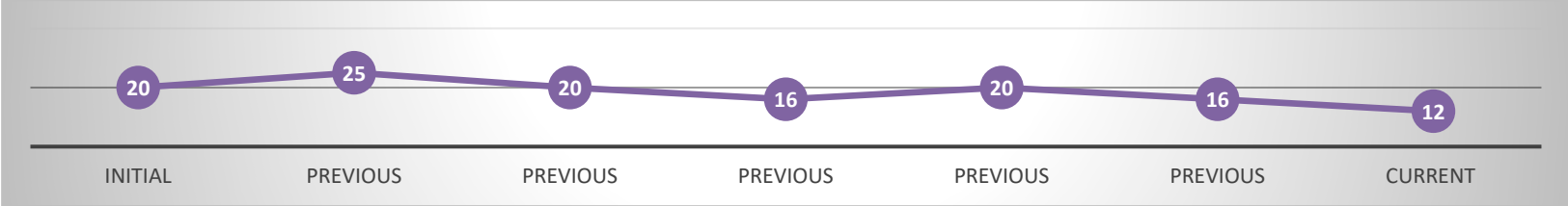
Board Assurance Framework

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

Board Assurance Framework

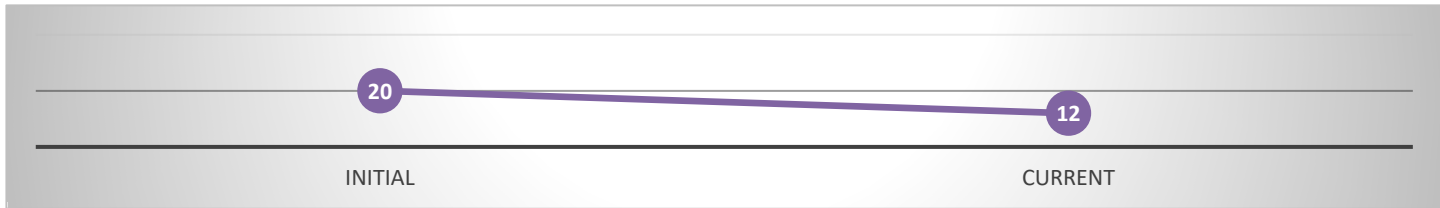
	Trust allocates depreciation generated capital funds to mandated and statutory estates projects and is therefore reliant on external funding via bids for strategic development.				
	Staffing and Resource Constraints - Staffing shortages further exacerbated by the requirement to meet non-clinical Cost Improvement Program (CIP) targets, adding strain to already stretched resources.				
	Operational and Infrastructure Issues - Some equipment is difficult or impossible to access for maintenance due to age and design, and the absence of a permanent decant ward complicates this further, particularly for ongoing repairs or upgrades.				
	Governance Development at Place Level: Self-assessments indicate that Halton is in the early stages of its place-based governance development, while Warrington is more established. There is a need for further development to ensure that both boroughs can benefit from potential future autonomy				
Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Phased redevelopment plan	Develop phased redevelopment plan with support from architects and cost advisors	Funding reallocation supported by Trust Board. Formally reallocate funding via CPG and FSC. Commission/appoint team to develop plan. Awaiting release of funding prior to commencing work	Lucy Gardner	30.03.2026	
Continue to raise profile and importance of need for new hospitals in Warrington and Halton.	Partners to attend new hospitals oversight meeting and raise case of need via appropriate channels.	Ensure meetings and appropriate updates take place.	Lucy Gardner	31.03.2026	
Actively participate in and contribute to the development of integrated care partnerships at Place & provider collaboratives at regional level.	Participate in meetings and influence new governance development.	Participate in meetings and influence new governance development.	Lucy Gardner	30/04/2025	
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	Completed 30.4.25

Board Assurance Framework

Risk ID	115	Executive Lead	Chief Nurse		
Strategic Objective	Strategic Objective 1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience.				Rating
Risk Description:	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.				
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:	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 managed in line with Trust policy. • Monthly Cost Pressure Clinics in place reviewing sickness management/recruitment/skill mix/supernumerary status/maternity leave cover plans Monthly review of bank use/staffing challenges at Executive Management Team Meeting, • Weekly review of bank use/staffing challenges by Chief Nurse/ Deputy Chief Nurse/Director of Governance • Gant Chart mapping projections of Maternity Leave and Supernumery Staff • Sickness Clinics held monthly with Chief Nurse • Twice daily Acuity Recording on Safe Care Assurances • Increase in registered nursing establishment in the Emergency Department, November 2024 reducing band 5 vacancy rate to 32.51 In April 2025 WTE from 46.84 WTE in May 2024. 18 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 9.86% in April 2025				

	- Overall CHPPD sustained between 7.3-7.5 in Q4. Noted at 7.6 in April 2025 - Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 14.28% in April 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 contract started August 2022 - CSWD 5 cohorts of 15 CSWDs will be deployed throughout 2025, The first cohort commenced April 2025 - Part of the Cheshire and Mersey staff Retention Forum to share and benchmark retention plans and receive support from ICS Retention Lead - Minimum staffing levels agreed for every ward, analysis of monthly shift fill completed with mitigation plans in place and reported to Trust Board bi-monthly. - Site Manager and Matron on site until 8pm (Warrington and Halton site) on weekends - Rolling recruitment for RN and HCA posts, weekly interviews - Leaver data is closely monitored, and the Board of Directors have supported a position of over recruitment to enable replacement of leavers in a timely manner. - Internal Transfer process in place for staff to support retention. - Nurse Staffing and Clinical Outcomes Group provides a forum through which nurse staffing and clinical outcomes data sets could be reviewed and triangulated to highlight wards or departments at risk. 19 wards achieved the 90% fill rate on day shifts and 24 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 - Increased requests to provide enhanced care. - Necessity to consistently 'board on wards' with 1 extra patient and to ensure safety is maintained – the decision to increase to 2 extra patients. - Continued escalation during winter of ward A10 and intermittent escalation of Cardiac Catheter Lab and overnight in Discharge lounge. Discharge lounge moved to A10 in April to provide more flexibility for discharge - Partially funded revenue requests - Time to post when recruiting new staff. 326 Red Flags reported in April 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		
Strategic Objective	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.			Rating	
Risk Description	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff			Initial	20 (L4xC5)
				Current	12 (L3xC4)
				Target	8 (L2xC4)
Risk Appetite	Open: Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Control & Assurance Details	Sickness Absence The rolling 12-month sickness absence rate is 5.99% as at June 2025 and is showing a slight increase from April 2025 (5.92%). Trust target from April 2025 is 5% as approved by the Strategic People Committee following a benchmarking 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.. - 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. 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. - 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.				

Board Assurance Framework

- Deep dive focus into Nursing and Midwifery sickness absence currently taking place due to rates being higher according to Model Hospital data.
- Welcome Back Conversations annual compliance was 72.31% in June 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 June 2025 remains below the target of 13% at 11.28%, a 1% decrease from the figure reported in February 2025. Turnover of permanent staff in June 2025 was 10.6%.
- Retirements are reducing, with relocation the fastest growing reason for people leaving. Work/life balance remains the main reason for leaving.
- The Trust's June 2025 vacancy rate is 7.75% from 7.00% in April 2025, Trust target is below 9%.

Controls

- Exit Interview process - collation and analysis of data captured enables themes to be identified and targeted actions implemented. This information is available on the Trust Workforce Information Dashboard for all managers to review.
- Further review of the leavers process is underway with the development of a SOP for stay conversations and an options appraisal review of the current exit interview process.
- Rugby League Cares have been supporting WHH since July 2021 and have been working in areas offering drop-in sessions and tailored programmes to support teams and individuals to keep well in work with 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 launched through the #MYFlex campaign which includes two wards going live with preference rostering from Jan 2025.
- Implementation of ECF panels throughout the organisation ensuring vigorous scrutiny of vacancies across the Trust. Promoting internal recruitment and secondment opportunities and also collaborative ring fenced opportunities for Bridgewater 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/scrutiny.
- The responses to Exit Interviews are positive, only 11.49% as at June 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 target at 3.3%, target is 2.3%

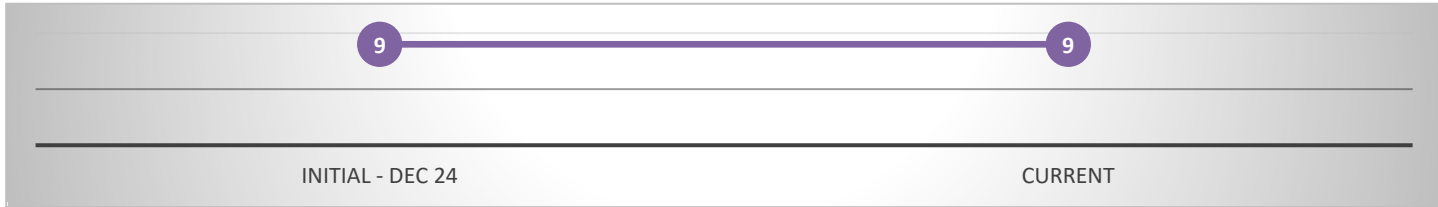
Temporary Staffing and Agency spend

Bank and Agency reliance in June 2025 has decreased to 10.48%. The Trust target is 9%. Bank reliance has reduced to 9.06% from 11.82% in April 2025 and agency reliance continues to reduce to 0.76%.

Board Assurance Framework

	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: - ECF process for non-clinical vacancies, overtime and medical agency. - The Resourcing Task and Finish group previously worked with staff group leads to benchmark the Trusts compliance with Job Planning, Rostering and Workforce Reporting against the nationally expected standards. The gap analysis enabled the organisation to develop plans to improve the effectiveness of workforce deployment. The recent PWC audit has reviewed the plans and developed an action plan to address some of the gaps to enable the Trust to effectively and cost efficiently deploy it's workforce.				
	Assurances - Compliance against our processes and rate cards is monitored through the Finance and Sustainability Committee - To support agency controls, a refined ECF process has been introduced. - Compliance with Job Planning, Rostering Levels of Attainment and Workforce Reporting against the nationally expected standards have been shared with Executives.				
Assurance Gaps	- Sickness absence continues to be above target. It is demonstrating 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 proactive health interventions for staff - Develop a plan for implementation of proactive health support for staff	Laura Hilton & Carl Roberts	31.08.25	
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	31.07.25	
Secure funding for Rugby League Cares for next 12 months	Following the cessation of the RLC funding on 31/03/25 the Trust will scope out and look at alternative methods of funding RLC for another 12 months.	- Establish potential internal funding streams - Establish potential external funding streams - Write a business case / bid to access relevant funding - Funding secured, service to continue	Caroline Eardley	30.06.25	30.06.2025

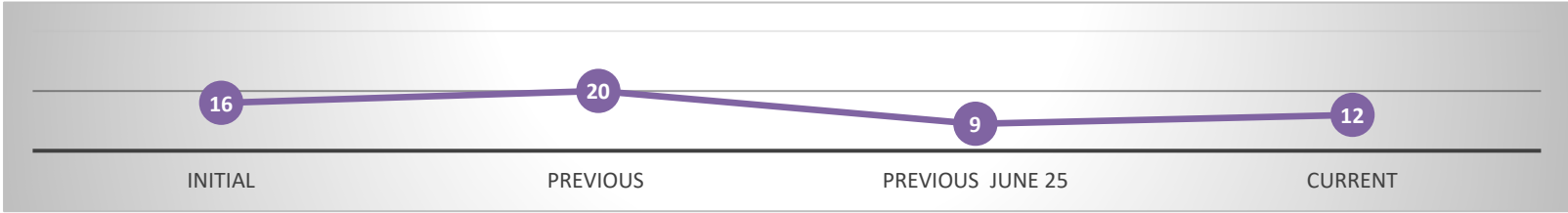
Board Assurance Framework

Risk ID	2253	Executive Lead	Chief Strategy and Partnerships Officer	Rating	
Strategic Objective	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description	If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities and ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, including the limited capacity of shared Board members to effectively manage competing demands, potentially impacting both Trusts' decision-making and service management.			Initial	9 (L3 x C3)
				Current	9 (L3 x C3)
				Target	2 (L1 x C2)
Risk Appetite	Open: Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Assurance Details	The integration programme- “Better Care Together” has been established. Each workstream is developing a delivery plan and working with partners to deliver objectives. Over the coming months, we will be working to finalise governance arrangements, introduce a shared executive team, and make progress in delivering improved pathways for our patients. Together, we will develop new and improved ways of working, starting first with services identified as an urgent priority. Subject to all necessary approvals, we hope to become a single organisation as soon as possible. Controls - Nikhil Khashu commenced as Chief Executive Officer for both Trusts on the 1st November - Paul Fitzsimmons appointed as joint Executive Medical Director - Dan Moore appointed a joint Chief Operating Officer - Summary case for change – approved – Novembver 2024 - Signed data sharing agreement - 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 - Communication and Engagement Plan approved - Strategic case for integration of WHH and Bridgewater approved by both boards and supported by ICB				

Board Assurance Framework

	- 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 5 th and 6 th of February 2025	Proposal for WHH to acquire BCH to be presented to respective Boards on 5 th and 6 th 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

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				

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 closes on 1st September 2025. The first instance of industrial action for this group could potentially commence Monday 15th September • 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

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

Appendix 2

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.

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	BM/25/08/59	
SUBJECT:	Integrated Performance Report	
DATE OF MEETING:	6 th August 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: <i>(Please select as appropriate)</i>	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): <i>(Please DELETE as appropriate)</i>	224 If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety. 1215 If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) as a consequence of the COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. 134 If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton. 115 If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. 1134 If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk	

	delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	Yes	No	N/A
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	Yes	No	N/A
				✓
	Further Information:			
3. Foster good relations between people who share a protected characteristic and those who do not	Yes	No	N/A	
			✓	
Further Information:				
EXECUTIVE SUMMARY (KEY ISSUES):	The Trust 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 (NEW) • 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 (NEW) Five metrics were previously reported in the escalated metric section at the June 2025 Trust Board meeting, two metrics have been escalated this month, and no metrics have been removed.			

	Ambulance Handover Indicators 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, NWS 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. The revised KPIs are as follows: • 31. Ambulance Handovers (A2VH) within 15 minutes • 32. Ambulance Handovers (A2VH) within 30 minutes • 33. Ambulance Handovers (A2VH) within 45 minutes Financial Position At Month 3 the Trust has recorded a deficit position of £13.5m (before deficit support) which is in line with plan. After deficit support funding the deficit reduces to £8.9m.		
PURPOSE: <i>(please select as appropriate)</i>	Approval ✓	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Approve cash support of up to £5.087m from NHSE for September 2025. 2. Approve the Cash Preservation MOU issued by the ICB. 3. Note the changes to capital contingency as supported and approved by the Finance, Sustainability and Performance Committee in Common. 4. Note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	Committee	Finance, Sustainability and Performance Committee in Common	
	Agenda Ref.	FSPCiC/25/07/09 FSPCiC/25/07/16	
	Date of meeting	28/07/2025	
	Summary of Outcome	Cash support application supported for approval at Trust Board. Cash Preservation MOU 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: <i>(if relevant)</i>	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	AGENDA REF:	BM/25/08/59

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

Ambulance Handover Metrics – National Standard Update

The national standard for ambulance handover metrics has been updated in line with the latest AmbSYS specification, specifically Section 12: Hospital Handovers. Of particular importance is the guidance on the “Operational (Resource) Handover Clock Stop”, which defines the point at which the handover process is considered complete.

Key points from the guidance include:

- The operational handover clock stop occurs once the clinical handover is fully completed and the patient has been physically transferred onto hospital apparatus. At this point, ambulance equipment must be returned, enabling the crew to leave the department.
- Handover times should ideally be agreed and recorded jointly by the ambulance service and the hospital at the time of handover. Where this is not possible, the time recorded by the ambulance crew on their vehicle system should be used.
- If a patient is transferred to a second vehicle (e.g. during a shift change), the clock stops when the second crew completes the handover to the hospital or a designated cohorting function. If the original crew hands over directly to a cohorting function, the clock stops at that point, provided clinical responsibility is transferred and the crew is released.

In alignment with this national guidance, NWAS has updated its reporting methodology for ambulance handover times. The previous Key Performance Indicators (KPIs), which measured the duration from arrival to patient handover (A2PH), have now been revised to reflect the time from arrival to vehicle handover (A2VH).

Previous KPIs:

- **31.** Ambulance Handovers (A2PH) within 15 minutes
- **32.** Ambulance Handovers (A2PH) within 30 minutes
- **33.** Ambulance Handovers (A2PH) within 60 minutes

Revised KPIs:

- **31.** Ambulance Handovers (A2VH) within 15 minutes
- **32.** Ambulance Handovers (A2VH) within 30 minutes
- **33.** Ambulance Handovers (A2VH) within 45 minutes

These changes reflect a shift in focus from clinical to operational handover, aligning with national guidance and supporting more accurate performance monitoring.

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 FAILING TARGET & DECLINING PERFORMANCE	CONSISTENTLY FAILING TARGET & VARYING PERFORMANCE	CONSISTENTLY FAILING TARGET & IMPROVING PERFORMANCE	CONSISTENTLY FAILING TARGET & NO SPC
 Consistently Fails the Target (based on the last 7 months)	<u>Quality</u> 15. Complaints over 6 months (1 complaint- 0 target) ↓ <u>Finance</u> 58. Capital Programme (£0.09m - £0.33m target) 59. Better Payment Practice Code (53% - 95% target)	<u>Quality</u> 1. Incidents 11. Medication Safety - Reconciliation within 24 hours 17. Friends and Family (ED and UCC) 18. Mixed Sex Accommodation Breaches (Non ITU) 19. Sepsis - % screening for all emergency patients 20. Sepsis - % screening for all inpatients 21. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1h of diagnosis 26. MUST nutritional assessment completion <u>Access & Performance</u> 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 <u>Workforce</u> 52. Supporting Attendance	<u>Workforce</u> 55. PDR compliance	<u>Finance</u> 61. Cost Improvement Programme (recurrent forecast) – % delivered against plan 63. Bank Reduction ↓

 Inconsistently Passes/Fails the Target	INCONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE	INCONSISTENTLY PASSING TARGET & VARYING PERFORMANCE	INCONSISTENTLY PASSING TARGET & IMPROVING PERFORMANCE	INCONSISTENTLY PASSING TARGET & NO SPC
		<u>Quality</u> 3. Healthcare Acquired Infections (MSSA) 4. Healthcare Acquired Infections (CDI) 5. Healthcare Acquired Infections (Ecoli) 6. Healthcare Acquired Infections (Klebsiella) 7. Healthcare Acquired Infections (PA) 8. VTE Assessment 9. Inpatient Falls & harm levels 10. Pressure Ulcers 23. Acute Kidney Injury ↓ 24. Maternity Postpartum Haemorrhage <u>Access & Performance</u> 35. Patients seen in the Fracture Clinic within 72 hours ↑ 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 ↑	<u>Quality</u> 22. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1h of diagnosis <u>Access & Performance</u> 36. Diagnostic Waiting Times 6 Weeks	<u>Finance</u> 62. Agency Reduction
 Consistently Passes the Target (based on the last 7 months)	CONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE	CONSISTENTLY PASSING TARGET & VARYING PERFORMANCE	CONSISTENTLY PASSING TARGET & MAINTAINING/IMPROVING PERFORMANCE	CONSISTENTLY PASSING TARGET & NO SPC
		<u>Quality</u> 16. Friends and Family (Inpatients & Day cases) <u>Access & Performance</u> 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. <u>Finance</u> 60. Cost Improvement Programme – In year performance to date (£m)	<u>Workforce</u> 53. Turnover 54. Core/Mandatory Training	

 No SPC/Not Enough Datapoints/Not Applicable	NO ASSURANCE SPC & DECLINING PERFORMANCE	NO ASSURANCE SPC & VARYING PERFORMANCE	NO ASSURANCE SPC & IMPROVING PERFORMANCE	NO ASSURANCE SPC & NO SPC
	Quality 13. Mortality ratio – HSMR 14. Mortality ratio - SHMI	Quality 2. Healthcare Acquired Infections (MRSA) 25. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT)) Access & Performance 30. Average time in department ED 42. Reduction in Outpatient Follow Ups 46. Super Stranded Patients 47. No Criteria to Reside (NCTR)	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 June 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 level 1 & 2 CIP plan (£21.5m).
- Delivery of system wide savings of £12m (level 3 CIP).
- Achieving the income plan through core capacity and risk of overperformance not being funded.
- Receipt of deficit support funding.
- Cash level and ability to access revenue cash support.
- Funding for pay award.
- Funding for the cost of Industrial Action.

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

Cash

The cash balance at the end of June is £13.8m of which £3.1m relates to capital creditors. Given the current cash position and the planned deficit for 2025/26 the Trust requires cash support in September 2025 of £5.087m. The Finance, Sustainability and Performance Committee in Common discussed and supported the September 2025 application for cash support from NHSE. The Trust Board is asked to approve up to £5.087m cash support for September 2025. 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 13 days which is an improvement from last month (12 days) due to cash measurement measures however is a decrease from April 2025 (18 days) due to the decreasing cash balance.

The Cash Preservation MOU issued by the ICB was taken to their Finance Committee on 23 July 2025 for approval. The Finance, Sustainability and Performance Committee in Common discussed and supported the Cash Preservation MOU. It sets out the actions that should be taken by system partners in order to preserve cash during 2025/26 and sets out the priority order of those actions. A cash group has been established by the ICB with representatives from Providers to work through the requirements of the Cash Preservation MOU. The

Trust is an active participant of this group. The Trust Board is asked to approve the Cash Preservation MOU.

CIP

At 30 June 2025, the Trust has delivered a CIP of £2.5m which is on plan. However, it should be noted that £0.9m 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 £3.2m 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. The full year effect of schemes delivering later in the year mitigates the non-recurrent schemes into 2026/27.

In addition to the £21.5m CIP, there is a £12m target relating to level 3 system CIP schemes. These will be led, monitored and delivered at system 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 3 is £0.63m which is £3.05m below the Trust plan of £3.68m. This is mainly driven by the late start of schemes, ward refurbishment paused and replace 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 3		317
Proposed changes in month		
VAT Recovered		13
Requests supported at CPG		
ICU High Level Replacement Gutters Addendum	- 6	
Sub Total		- 6
Contingency as at end of month 3		324

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 £5.087m from NHSE for September 2025.
2. Approve the Cash Preservation MOU issued by the ICB.
3. Note the changes to capital contingency as supported and approved by the Finance, Sustainability and Performance Committee in Common.
4. Note the contents of this report.

Statistical Process Control - Assurance & Variation

Appendix 1

Key:



Special Cause Variation of an improving nature.



Common Cause (Normal Variation).



Special Cause Variation of a concerning nature.



Consistently passes the target



Inconsistently passes and fails the target



Consistently fails the target

QUALITY	Latest				Previous		Assurance
	Plan/Target	Actual	Period	Variation	Actual	Period	
1 Incidents	0	21	Jun-25		11	May-25	
2 Healthcare Acquired Infections (MRSA)	Thresholds not yet set for 2025/26	0	Jun-25		0	May-25	
3 Healthcare Acquired Infections (MSSA)	Thresholds not yet set for 2025/26	0	Jun-25		5	May-25	
4 Healthcare Acquired Infections (CDI)	Thresholds not yet set for 2025/26	9	Jun-25		7	May-25	
5 Healthcare Acquired Infections (Ecoli)	Thresholds not yet set for 2025/26	7	Jun-25		6	May-25	
6 Healthcare Acquired Infections (Klebsiella)	Thresholds not yet set for 2025/26	4	Jun-25		2	May-25	
7 Healthcare Acquired Infections (PA)	Thresholds not yet set for 2025/26	1	Jun-25		1	May-25	
8 VTE Assessment	95.00% (quarterly position)	93.66%	Jun-25		93.97%	May-25	
9 Inpatient Falls & harm levels	10% reduction from 2024/25	42	Jun-25		36	May-25	
10 Pressure Ulcers	20% reduction from 2024/25	13	Jun-25		12	May-25	
11 Medication Safety Reconciliation within 24 hours	80.00%	37.00%	Jun-25		40.00%	May-25	
12 Staffing - Average Fill Rate	90.00%	N/A - grouped indicator	Jun-25		90.43%	May-25	

Statistical Process Control - Assurance & Variation

Appendix 1

Key:



Special Cause Variation of an improving nature.



Common Cause (Normal Variation).



Special Cause Variation of a concerning nature.



Consistently passes the target



Inconsistently passes and fails the target



Consistently fails the target

13	Mortality ratio - HSMR	No target set	94.15	Jun-25		94.15	May-25	
14	Mortality ratio - SHMI	No target set	104.51	Jun-25		104.51	May-25	
15	Complaints	Zero complaints open over 6 months old/in the backlog	1	Jun-25		2	May-25	
16	Friends and Family (Inpatients & Day cases)	95.00%	97.00%	Jun-25		96.00%	May-25	
17	Friends and Family (ED and UCC)	87.00%	70.00%	Jun-25		75.00%	May-25	
18	Mixed Sex Accommodation Breaches (Non ITU)	0	16	Jun-25		12	May-25	
19	Sepsis - % screening for all emergency patients.	90.00%	65.00%	Jun-25		61.00%	May-25	
20	Sepsis - % screening for all inpatients	90.00%	67.00%	Jun-25		80.00%	May-25	
21	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag	90.00%	61.00%	Jun-25		67.00%	May-25	
22	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90.00%	81.00%	Jun-25		84.00%	May-25	
23	Acute Kidney Injury	Less than previous month	174	Jun-25		133	May-25	
24	Maternity Postpartum Haemorrhage	3.70%	4.70%	Jun-25		5.10%	May-25	
25	Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	15%	Jun-25		12%	May-25	
26	MUST nutritional assessment completion	above > 85%	73.69%	Jun-25		77%	May-25	

Statistical Process Control - Assurance & Variation

Appendix 1

Key:



Special Cause Variation of an improving nature.



Common Cause (Normal Variation).



Special Cause Variation of a concerning nature.



Consistently passes the target



Inconsistently passes and fails the target



Consistently fails the target

	ACCESS & PERFORMANCE	Latest				Previous		Assurance
		Plan/Target	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%	64.78%	Jun-25		65%	May-25	
28	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (including WUTC).	78%	69.84%	Jun-25		69%	May-25	
29	A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	24.29%	Jun-25		21.5%	May-25	
30	Average time in department ED	No Target	394	Jun-25		390	May-25	
31	Ambulance Vehicle Handovers within 15 minutes (updated)	65%	33.88%	Jun-25		43.28%	May-25	
32	Ambulance Vehicle Handovers within 30 minutes (updated)	95%	44.73%	Jun-25		74.18%	May-25	
33	Ambulance Vehicle Handovers within 45 minutes (updated)	100%	63.62%	Jun-25		82.94%	May-25	
34	Type 5 attendances	No Target set	2189	Jun-25		2295	May-25	
35	Patients seen in the Fracture Clinic within 72 hours	95%	87.80%	Jun-25		91%	May-25	
36	Diagnostic Waiting Times 6 Weeks	95.00%	96.19%	Jun-25		96.24%	May-25	
37	Referral to treatment Open Pathways	92.00%	56.78%	Jun-25		56.48%	May-25	
38	Referral to treatment - Number of patients waiting 52+ weeks	0	1635	Jun-25		1537	May-25	
39	28 Day Faster Cancer Diagnosis Standard	75%	72.00%	May-25		73.70%	Apr-25	

Statistical Process Control - Assurance & Variation

Appendix 1

Key:



Special Cause Variation of an improving nature.



Common Cause (Normal Variation).



Special Cause Variation of a concerning nature.



Consistently passes the target



Inconsistently passes and fails the target



Consistently fails the target

40	Cancer 31 Day Wait	96%	98.40%	May-25		98.50%	Apr-25	
41	Cancer 62 Day Wait	85%	80.80%	May-25		77.60%	Apr-25	
42	Reduction in Outpatient Follow Ups compared to 19/20 activity	No Target set	88%	Jun-25		84%	May-25	
43	Elective Recovery Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA		NA	NA	
44	Elective Recovery Diagnostic Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA		NA	NA	
45	Elective Outpatient Activity	104%	98%	Jun-25		84%	May-25	
46	Super Stranded Patients	Trajectory	132	Jun-25		143	May-25	
47	No Criteria to Reside (NCTR)	No Target set	195	Jun-25		203	May-25	
48	% Patients discharged to their usual place of residence	No Current Threshold	96%	Jun-25		96%	May-25	
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%	0.57%	Jun-25		0.65%	May-25	
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	Jun-25		1	May-25	
51	Capped Theatre Utilisation	85%	77.35%	Jun-25		77%	May-25	

Statistical Process Control - Assurance & Variation

Appendix 1

Key:



Special Cause Variation of an improving nature.



Common Cause (Normal Variation).



Special Cause Variation of a concerning nature.



Consistently passes the target



Inconsistently passes and fails the target



Consistently fails the target

	WORKFORCE	Latest				Previous		Assurance
		Plan/Target	Actual	Period	Variation	Actual	Period	
52	Supporting Attendance	5.00%	6.00%	Jun-25		5.52%	May-25	
53	Turnover	Below 13%	11.28%	Jun-25		11%	May-25	
54	Core/Mandatory Training	85.00%	91.19%	Jun-25		90.11%	May-25	
55	PDR compliance	85.00%	79.00%	Jun-25		79.22%	May-25	

Statistical Process Control - Assurance & Variation

Appendix 1

Key:



Special Cause Variation of an improving nature.



Common Cause (Normal Variation).



Special Cause Variation of a concerning nature.



Consistently passes the target



Inconsistently passes and fails the target



Consistently fails the target

		Latest				Previous		Assurance
FINANCE & SUSTAINABILITY		Plan/Target	Actual	Period	Variation	Actual	Period	
56	Trust Financial Position (£m)	-£4.22	-£4.23	Jun-25	No SPC	-£4.60	May-25	No SPC
57	Cash Balance (£m)	£4.48	£13.79	Jun-25	No SPC	£12.92	May-25	No SPC
58	Capital Programme (£m)	£3.68	£0.63	Jun-25	L	£0.31	May-25	F
59	Better Payment Practice Code	>95%	56%	Jun-25	L	44%	May-25	F
60	Cost Improvement Programme - In year (£m)	90% of plan	100%	Jun-25		100%	May-25	P
61	Cost Improvement Programme (recurrent) – In year (£m)	90% of plan	65%	Jun-25	No SPC	64%	May-25	F
62	Agency Reduction (£m)	£0.73	£0.60	Jun-25	No SPC	£0.43	May-25	?
63	Bank Reduction (£m)	£6.91	£7.20	Jun-25	No SPC	£4.83	May-25	F

Quality Improvement - Trust Position

Appendix 2 Trust Performance

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

2. Healthcare
Acquired
Infections
(MRSA)
Target: not yet
set for 2025/26

3. Healthcare
Acquired
Infections
(MSSA)
Threshold for
2025/26: 32

4. Healthcare
Acquired
Infections (CDI)
Threshold for
2025/26: 60

5. Healthcare
Acquired
Infections (E.coli)
Threshold for

6. Healthcare
Acquired
Infections
(Klebsiella)
Threshold for
2025/26: 28

7. Healthcare
Acquired
Infections
(PA)
Threshold for

There was 21 incident over 40 days old.

MRSA cases YTD
annual threshold exceeded by 0

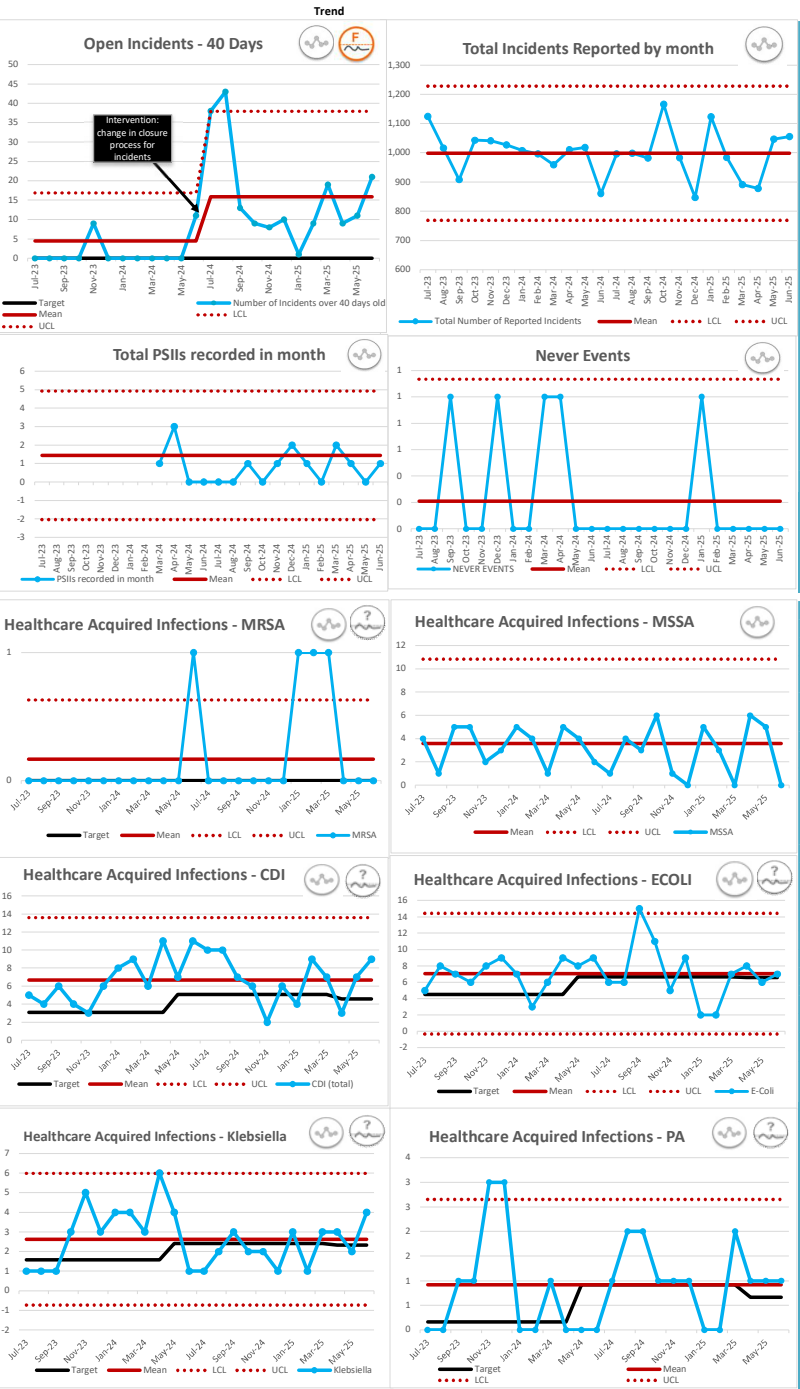
MSSA 11 cases YTD
no threshold set

CDI 19 cases YTD
annual threshold exceeded by 0

E. coli 21 cases YTD
annual threshold exceeded by 0

Klebsiella spp. 9 cases YTD
annual threshold exceeded by 0

P. aeruginosa 3 cases YTD
annual threshold exceeded by 0



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)?

There were 1 PSII and 0 Never Events identified in June 2025.

There were 26 learning response responses underway at the time of reporting.

No incidents have been reported to MNSI in June.

There were 0 Never Events

There were 21 incidents open over 40-days at the time of reporting this is an increase on the previous month.

Assurance: The Trust consistently fails the target.

Variation: Common cause (normal) variation

(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.

A weekly Governance Dashboard is overseen by the Executive Team monitoring trends of reporting alongside triangulation of incidents, complaints, claims and inquests.

Incidents overdue 40 days- The incident position is escalated daily to the triumvirates for the relevant areas, and this work is being prioritised. This position has weekly Executive oversight at the Safety Oversight Meeting.

Datix system alerts at an additional lower threshold (30 days) to enable further support to be provided. A daily report of learning responses and associated actions is produced for Care Group Triumvirates oversight, to enable them to address any areas required.

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

There were no MSSA or MRSA cases reported in this period.

Revised reporting rule since April 24 where decision to admit (instead of admission date) is used, resulting in additional HCAI cases being apportioned to acute Trusts.

Regional/national increase in C. difficile cases. UKHSA has declared the rise in cases as a national standard incident. The Trust remains a low outlier for C. difficile cases.

There was an increase in klebsiella cases in month no single theme has been identified as a route cause. 2 associated with hospital acquired pneumonia, one UTI and 1 IV associated.

NHSE HCAI thresholds have been agreed for 2025/26 as:-
E. coli BC = 69
Klebsiella spp. BC = 28
P. aeruginosa BC = 8
CDI = 60
MRSA BC = zero tolerance to avoidable cases
MSSA BC = no threshold

MRSA/MSSA Prevention -A plan is in place to review peripheral cannula dwelling times in line with EPIC 3 guidance and revise the Trust Cannulation Policy in Q3. A programme of training is in place for peer ANTT assessors and improvement in competency assessments of ANTT procedures is being sought via the Clinical Business Units.

CDI Prevention Action Plan in place. Spike in cases in June 25. Ribotyping results from toxin positive cases are different, suggesting they are not related cases.

Review of patients with recurrent CDI in progress.
Swarm Huddles in place for all hospital onset healthcare associated cases. Antimicrobial Stewardship/Intravenous to Oral Switch (IVOS) monitoring programme in place.

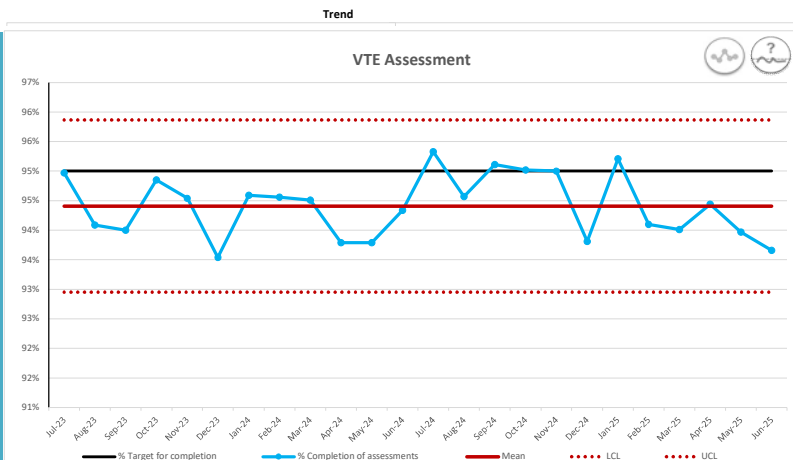
ECOLI: Klebsiella: Pseudomonas aeruginosa: CAUTI surveillance commenced May 2025. Revision and relaunch of the Gram-Negative Blood Stream Infection (GNBSI) Prevention Group with medical staff membership agreed; increased focus and support from the IPC Team for wards with 2 or more GNBSI reported cases per month

Quality Improvement - Trust Position

Appendix 2 Trust Performance

8. VTE Assessment
Target: 95% (quarterly position)

The Trust did achieve the required target at 93.66% for VTE assessments in month.



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)?

Assurance: The Trust inconsistently passes/fails the target.

Variation: Common Cause (Normal) variation.

VTE risk assessment (RA) performance target in June 2025 was below the mandatory threshold at 93.66 %. This is a reduction from previous months. There is no single identified cause for this.

Ward-based teams encouraged to make use of real time data to complete outstanding VTE risk assessments using GIRFT Inpatient Ward Productivity Dashboard.

Each CBU has improvement plans to meet the mandatory target > 95%. These are overseen by the Care Groups and at the VTE Group. Clinical lead/Clinical Directors/CBUs and Care Group are undated at the end of every month so they can drive compliance improvement in their respective clinical areas.

Quality Improvement initiatives being trailed to use the real time data from the above ward productivity dashboard to ensure outstanding numbers of "VTE not completed" is reset to "zero" at morning board rounds to ensure there is a focus on outstanding assessments

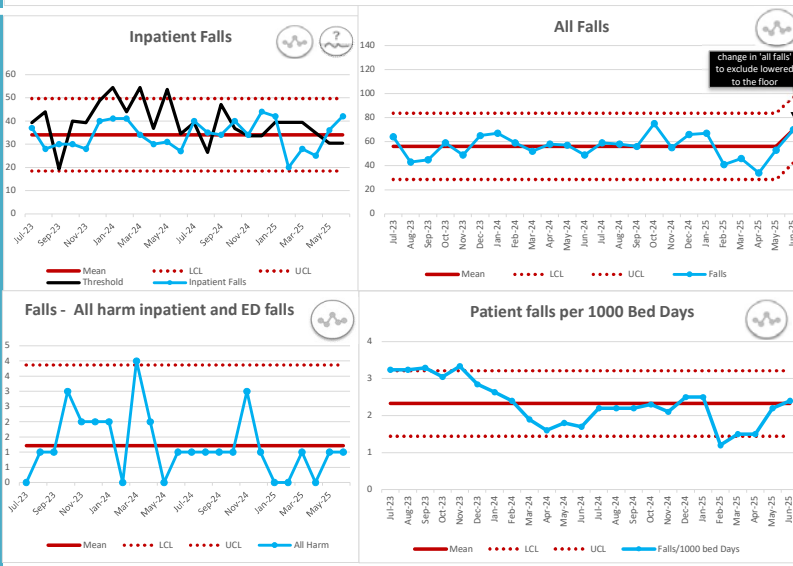
Thrombosis Group will continue to monitor the data trends and drive further improvement plans.

9. Inpatient Falls & harm levels
Target: 10% reduction from 2024/25

70 total falls were reported in month. 42 of these were inpatient falls. There was 1 fall(s) in month with harm.

There were 503 total falls in 2023/24. There have been 687 total falls YTD in 2024/25. We are expecting a 9% decrease in falls from last year.

There were 309 inpatient falls in 2023/24. There have been 405 inpatient falls YTD in 2024/25. We are expecting a 2% decrease in falls from last year.



Assurance: The Trust inconsistently passes/fails the target.

Variation: Common Cause Variation.

During June 2025, there were 29 inpatient falls with no harm, 12 with low harm, and 1 with moderate harm.

The Patient who had a fall with moderate harm sustained a factored fibula. A deep dive has been commissioned to understand key drivers for the increase in falls in month.

Although falls within the Emergency Department and inpatient areas remained within normal variation for the month, an increase was observed in the overall 'All Falls' category. A review of the data identified 10 staff falls and 11 patient falls occurring outside of ED and inpatient settings. No recurring themes were identified. This will continue to be monitored over the coming months.

From June 2025 there has been a change in the reporting of 'All Falls' to exclude 'lowered to the floor'.

The bedside eyesight test was launched in Q1. An audit is planned for Q2 to assess compliance with the tool.

The Deconditioning Prevention Meeting commenced from May 2025. The Patient Safety Improvement Nurses are supporting pilot wards with Tests of Change.

Quality Summits commenced in Q1 with the Chief Nurse/Deputy Chief Nurse where all Quality Metrics including falls are reviewed. Quality Summits are planned quarterly.

Volunteers are being recruited for positive engagement activities with patients who have dementia or are vulnerable. This initiative is expected to assist in the prevention falls.

Quality Improvement - Trust Position

Appendix 2 Trust Performance

10. Pressure
Ulcers (Category 2
and above)

Target: 20%
reduction from
2024/25

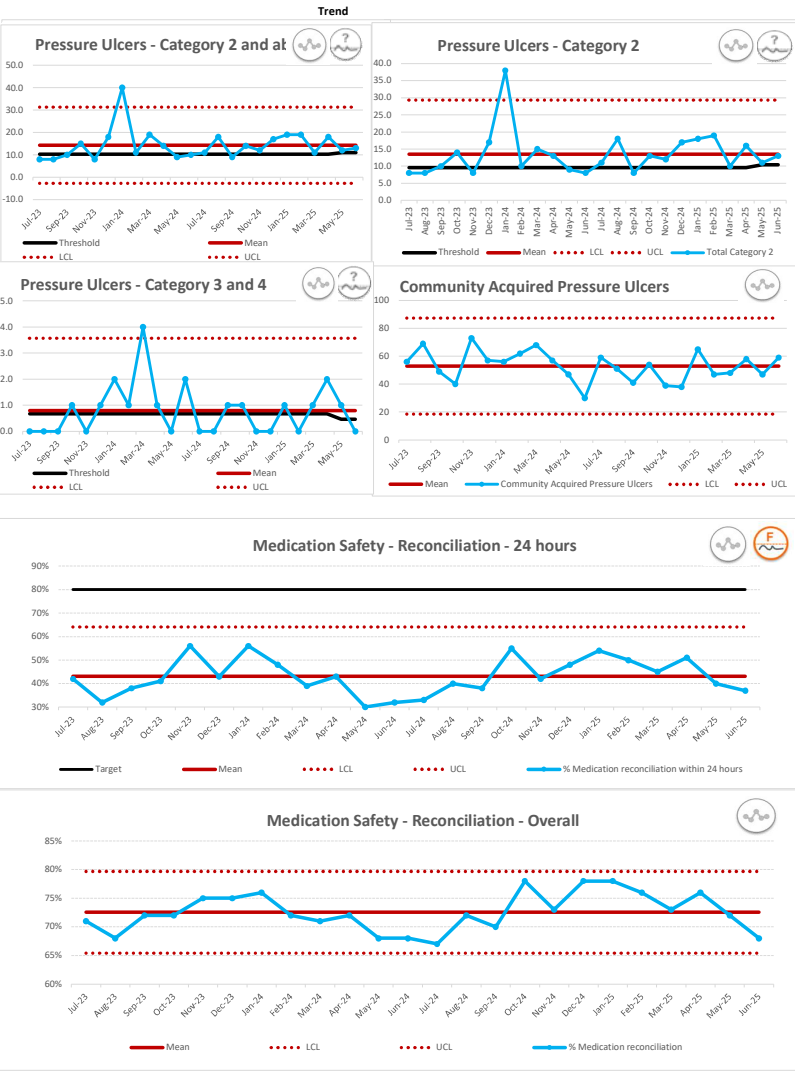
In month there were 13 hospital acquired category 2 pressure ulcers, 0 Category 3 pressure ulcers and 0 Category 4 ulcers in month.

There were 59 community acquired pressure ulcers in month.

11. Medication
Safety

Reconciliation
within 24 hours
Target: 80%

Medicines reconciliation was completed within 24 hours of admission for 37% of patients. 68% of patients had MR completed during inpatient stay.



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)?

In June 2025, there were 13 category 2 pressure ulcers:

There were no category 3 or 4 pressure ulcers.

There were 3 device related pressure ulcers in June 2025. This is a reduction on previous months.

Assurance: The Trust inconsistently passes/fails the target.

Variation: Common Cause (Normal) variation.

Improvement plans in place for both Unplanned Care and Planned Care Groups overseen by the Associate Chief Nurses.

Essential Healthcare (pressure relieving mattress provider) now have a technician on site to check mattress pumps and replace any faulty ones. Film dressings are being applied to patients heels in ED to reduce friction and shear damage.

A trail of a new dressing (tape)) has taken place to prevent pressure damage from masks/oxygen devices, following the success of the trail this is being initiated Trust wide from July 2025.

Performance varies between care groups with 51% in 24 hours and 92% total for a patients in Unplanned Care, compared to 25% in 24 hours and 54% total for patients in Planned Care.

Pharmacy staffing levels do not permit all inpatient areas to be covered, with workforce deployed according to activity, risk and acuity of patients. 49% of patients who did not receive medicines reconciliation were in the W&C CBU, primarily Maternity patients in Birth Suite and the Midwifery Led Unit. Previous analysis of this cohort has shown 90% of women were on no regular medication.

Assurance: The Trust consistently fails the target.

Variation: Common Cause (Normal) variation.

25% of patients not receiving medicines reconciliation were in the Surgical Specialties CBU - analysis has shown 69% of patients were discharged on day 2 of admission.
Medicines are reconciled by Pharmacy as part of TTO clinical check process.

Team working pilot underway in Surgical Specialties/Digestive Diseases to review alternative deployment of Pharmacy staff to ensure resources are deployed as productively as possible.

Midwives are recording medicines reconciliation status as per agreed SOP for patients on no regular medicines/ pregnancy supplements only.

Monitored via Pharmacy Performance Meeting and Medicines Safety and Optimisation Group.

Quality Improvement - Trust Position

Appendix 2 Trust Performance

12. Staffing - Average Fill Rate

Target: 90%

In month, the average staffing fill rates were:

Day (Nurses/Midwife) 90.14%

Day (Care Staff) 93.04%

Night (Nurses/Midwife) 94.39%

Night (Care Staff) 109.67%

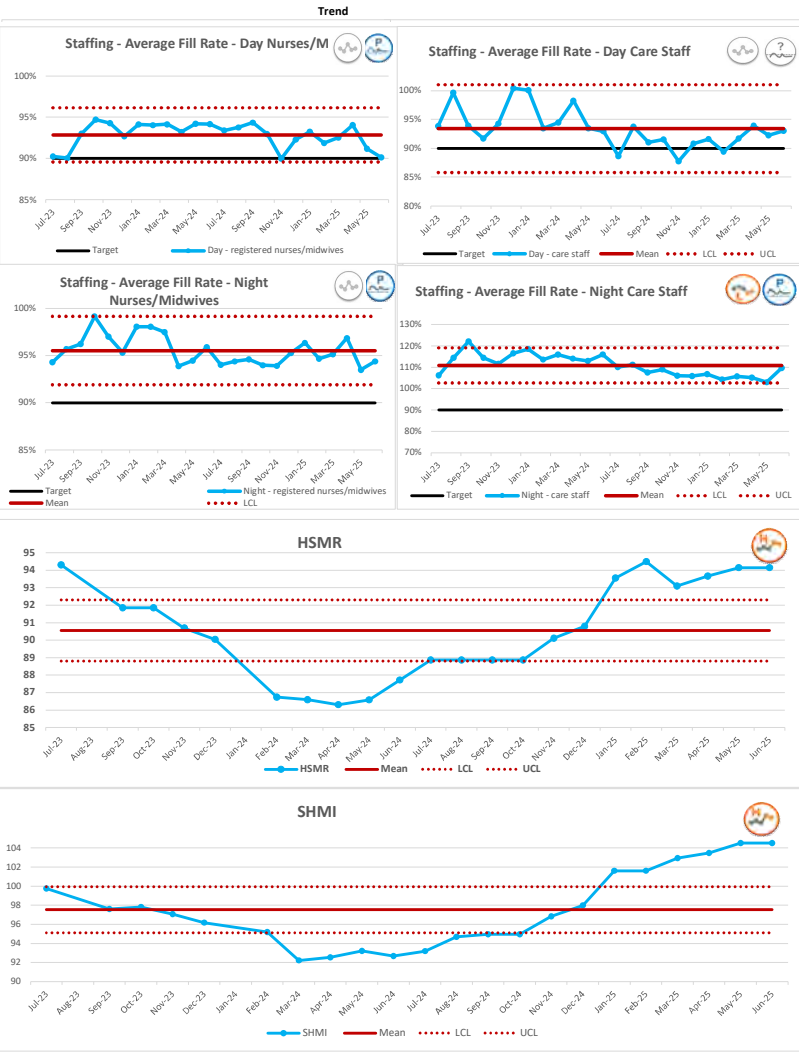
13. Mortality ratio - HSMR

Target: Plan

SHMI and HSMR are not within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 94.15. The Summary Hospital Level Mortality Indicator (SHMI) ratio in month was 104.51.

14. Mortality ratio - SHMI

Target: Plan



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)?

Assurance: N/A Grouped Indicator

Variation: N/A Grouped Indicator

Additional beds in use across the Trust due to the high number of patients with no criteria to reside unable to be discharged due to the lack of Social Care capacity.

There was a reduction in fill rates in June this relates to an increase in Health Care Support Worker sickness and an increase in Registered Nursing vacancy. The main reasons for leaving is personal e.g. relocation or promotion elsewhere or retirement.

Staffing is reviewed twice daily by the Senior Nursing Team and acuity and activity are monitored to ensure safe patient care at all times. All wards have senior nurse oversight by a Matron and Lead Nurse.

The current percentage vacancy for June 2025 for registered staff is 9.45% against a Trust target of 9%. This is mainly due to Emergency Department (ED) increased establishment and a remaining ED Band 5 vacancy of 33.51 WTE.

The remaining vacancy has been readvertised with Band 6 & Band 5 interviews taking place in July. Specialist recruitment is taking place within areas with remaining vacancy. There were 13 HCA's appointed to the Trust in May 2025 who are now being supported through the recruitment process with an additional 15 x NHSP CSWD's who have commenced their 6-month training programme with the next cohort of 15 commenced 30th June 2025.

The current percentage vacancy for June 2025 for unregistered staff is 11.21% against a Trust target of 9%. Monthly recruitment is taking place alongside specialist recruitment with 30 candidates shortlisting for interviews in July 2025.

(HSMR) Assurance: NA - no target

Variation: Special Cause
Variation of a concerning nature.

Recent SHMI spike was clarified with HED team and discussed in MRG- it was felt to be secondary to SDEC activity related impact & will be monitored closely.

MRG now maintains a workstream to monitor clinical harms from prolonged ED waits using following measures
All deaths are screened for ED wait>12 hours and database maintained
SJR reviews with ED long wait where poor care is identified in first 24 hours will be brought to MRG for discussion and appropriate governance escalations followed if concerns identified.

(SHMI) Assurance: NA - no target

Variation: Special Cause
Variation of a concerning nature.

Quality Improvement - Trust Position

Appendix 2 Trust Performance

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

16. Friends and Family (Inpatients & Day cases)

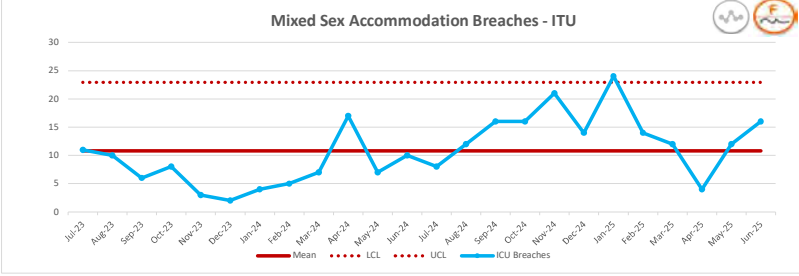
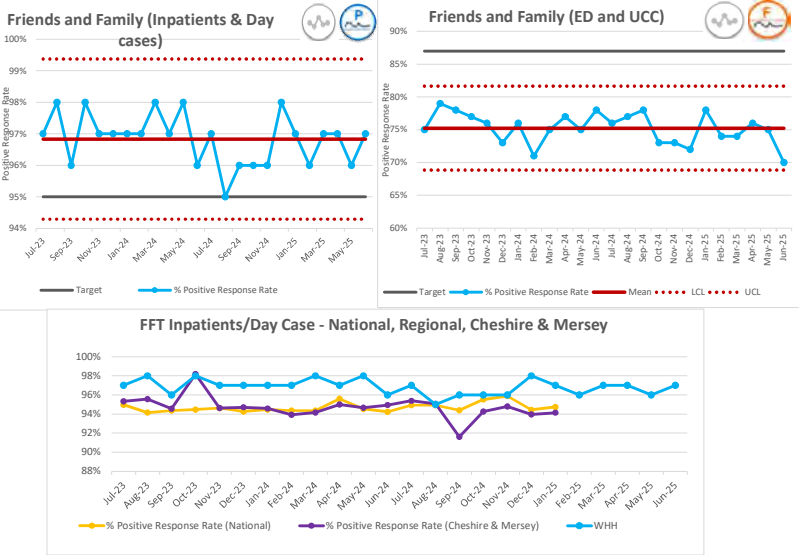
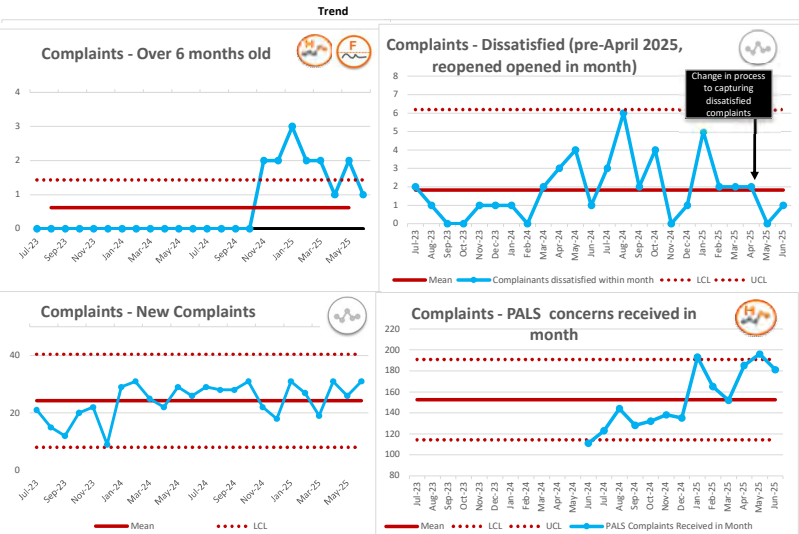
17. Friends and Family (ED and UCC)
Target: 87%

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

In month, 31 new complaints were received to the Trust which was an increase of 5 from the previous month. There were 1 cases reopened in month, which is an increase from

The Trust achieved 97% in month for Inpatient & Day case FFT and 70% for ED/UCC FFT.

There were 0 mixed sex accommodation (MSA) incident(s) outside of the ITU in month. There were 16 MSA incident(s) within the ITU.



Statistical Narrative

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'.

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

The Trust continues to sustain performance in the timely completion of complaints.

At the time of reporting on 02/06/2025, there was 1 complaints over 6 months old. This was at the request of the family to put the complaint on hold while they dealt with personal matters.

There were no dissatisfied complaints in May 2025.

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

Complaints position of 77 open complaints at the time of reporting on 02/06/2025. All complaints continue to be closely monitored to ensure that a timely response is completed. Where appropriate, complaints are directed to PALS for local resolution.

All complainants are offered an initial meeting with the clinical teams, as well as follow up meetings upon receipt of the initial response letter. All CBUs have a designated complaints case handler to ensure consistency.

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

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

WHH achieved 97% positive response rate in June 2025 which remains above the recommend target for response rate. WHH also continue to achieve higher positive response rates in comparison to regional and national figures.

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

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

ED/UCC - The Trust achieved a 70% positive feedback in Friends and Family Test results for June 2025. The main negative feedback theme continues to be waiting time, staff attitude and the environment. It is important to note these themes also feature frequently in positive feedback.

Themes are monitored at Trust and Clinical Business Unit level, through the FFT Dashboard to identify themes. Action plans are in place and monitored at Patient Experience and Inclusion Committee.

Ward Departments receive feedback form Trust Board, Governors, Senior Leaders, PLACE and Patient Experience Team observations. Action plans are created and monitored via Care Group governance structures. Accessible Information Standards is a key priority with initiatives to support patients with reasonable adjustments as required.

Patient Experience and Inclusion Team undertaking improvement work to increase response rates. Plans are in place to move to digital solutions to support real time feedback.

ED/UCC specific
Key themes include communication, waiting times and the environment. ED have visual communication screens visible in prominent areas following a charity bid approval, Patient Experience Volunteers are increasing opportunities to leave FFT feedback by supporting completion of FFT. Further funding approved for fixed FFT stations, which will be placed in main entrance to capture visitor/carer/friends and family feedback

Assurance: The Trust consistently fails the target.

Variation: Common Cause (Normal) variation

There were 16 mixed sex breaches in June 2025, this is an increase of 4 compared to May 2025. These were all within the Intensive Care Unit. Any delays in discharges are escalated to Patient Flow Team and the Tactical Manager of the day. They are also discussed at each Bed Meeting throughout the day. There were 0 breaches within any other ward areas.

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

There are a high number of patients who have no criteria to reside within the Trust.

Delivering Same Sex Accommodation Policy has been updated to support reduction of breaches.

Quality Improvement - Trust Position

Appendix 2 Trust Performance

The Trust achieved:

- 65% Sepsis screening for all emergency patients with suspected sepsis within 1 hour.
- 67% screening for all inpatients with suspected sepsis within 1 hour.

Blood Cultures:

- 73% screening for Emergency patients with suspected sepsis within 1 hour.
- 70% screening for Inpatients with suspected sepsis within 1 hour.

Lactate:

- 80% screening for Emergency patients with suspected sepsis within 1 hour.
- 95% screening for Inpatients with suspected sepsis within 1 hour.

The Trust achieved:

- 61% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made.

- 97% of emergency patients with suspected sepsis were administered antibiotics within 6 hours of a diagnosis of sepsis being made.

- 81% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.

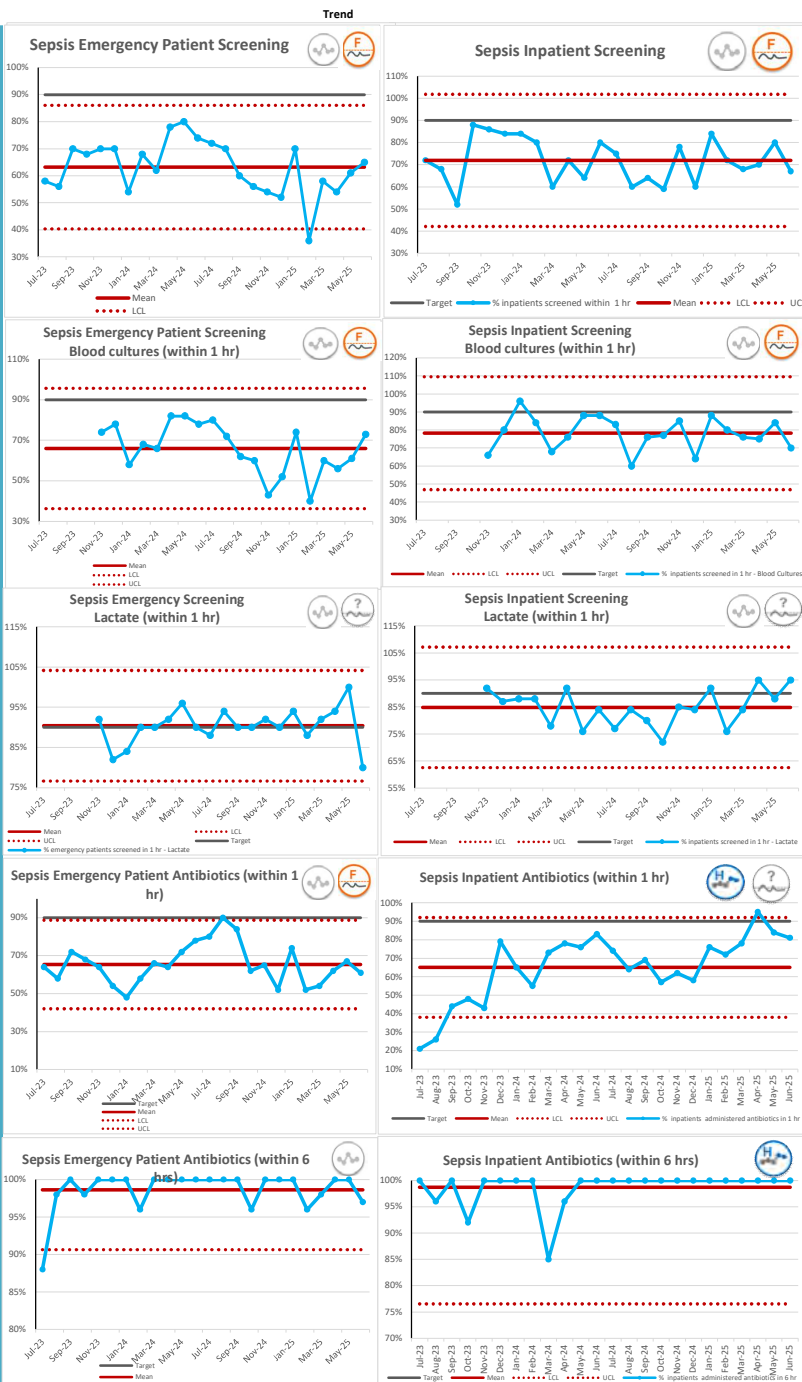
- 100% of inpatients had antibiotics administered within 6 hours of a diagnosis of sepsis being made.

19. Sepsis - % screening for all emergency patients.
Target: 90%

20. Sepsis - % screening for all inpatients
Target: 90%

21. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag
Target: 90%

22. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis
Target: 90%



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)?

(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.

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

Variation: Common cause (normal) cause variation.

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

Variation: Special Cause
Variation of a concerning nature.

Challenges remain in completing screening timely within the Emergency Department due to the volume of patients presenting. NS1 was introduced in September 2024 that changed the metric/ time the 1-hour time window for screening and treatment commences. This used to be once sepsis suspected was written within the clinical record. Now this is when the NEWS score triggers which often for Emergency Department patients is on arrival within triage.

Training for Health Care Assistants to undertake blood cultures in ED has commenced. The Sepsis Tool is being promoted across all areas.

A Sepsis prompt sticker has been introduced in ED to highlight visually and patients who are high risk of sepsis. The Emergency Department Team have commenced a test of change to introduce a new nursing model to the ambulance corridor to enable timely assessment of patients with suspected sepsis. There is a dedicated area identified within the department patients being treated for suspected Sepsis.

ED blood trollies have been adapted with the bottom two drawers now containing sepsis screening equipment/consumables. Department Manager is undertaking biweekly audits of the completion of the sepsis pathway. Compliance data is shared monthly with Lead Nurses and discussed at Operational Patient Safety Group.

WHH continues to administer antibiotics within 6 hours (n=100%). For inpatients there has been a continual improvement since December 2024 in compliance with antibiotics administered within 1 hour (with a slight decrease May and June 2025 (n=81%). The new NICE Guideline 51 was implemented in September 2024. A key change from the guidance is that time zero (the time at which the one hour clock starts ticking), is now taken from when the patient observations (NEWS2 score) resulting in the identification of level of risk e.g. moderate or high risk as opposed to red and amber flags.

Training and education continues for all clinical staff groups. Individual conversations are held with clinicians for learning where it has been identified STAT doses of antibiotics have not been prescribed. A single point lesson on how to access the tool continues to be promoted Trust-wide. Compliance data is shared monthly with Lead Nurses and discussed at Operational Patient Safety Group.

Quality Improvement - Trust Position

Appendix 2 Trust Performance

23. Acute
Kidney Injury

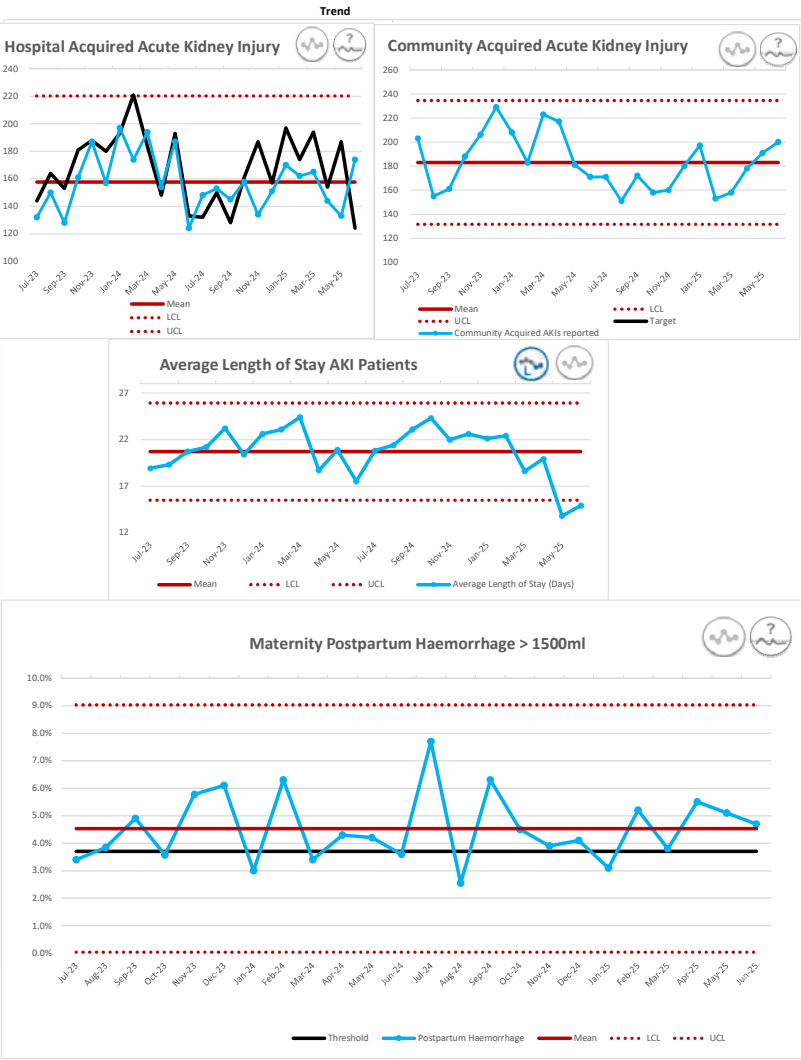
Target: Less
than month in
previous year

There were 174 acute kidney
injuries reported in month
compared to 133 last month.

24. Maternity
Postpartum
Haemorrhage
>1500ml

Threshold: <
3.7%

There were 4.7% Postpartum
Haemorrhages >1500ml in
month.



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)?

Assurance: The Trust
inconsistently passes/fails the
target.

Variation: Common Cause
(Normal) variation.

Length of stay remains low. There were a
higher number of AKIs reported in June the
reason for this is unknown.

There is ongoing education for both medical and Nursing Teams on the key
management principles of AKI to aid recognition and early detection of
deterioration. Discharge AKI clinics are now held weekly following the
appointment of additional Renal Consultant. On going focus work to
support patient following AKI on discharge with Pharmacy review of
medications. Trust wide data is shared at Deteriorating Patient Group
monthly meeting.

PPH >1500mls will continue to be reviewed on an individual basis via
governance processes but will also be subject to additional review through
the Intrapartum Incident Review Group which meets regularly to review
patterns and themes from incidents of PPH >1500ml.

In addition a PPH QI Group has been working through WHH processes. A
number of actions are now underway including sharing of good practice
and implementation of bespoke training for resident doctors in relation to
management of the 3rd stage of labour. A new regional guideline regarding
PPH is due to be published shortly. Colleagues from WHH have participated
in the regional working groups tasked with developing this guideline and
many of the change ideas advocated by WHH will be included within the
guideline.

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

Assurance: The Trust
inconsistently passes/fails the
target.

Variation: Common cause
variation.

Rates for PPH >1500ml continue to
fluctuate. The service has received
comparator data from the Cheshire and
Mersey (C&M) LMNS which notes an
average rate for C&M of 34/1000 births.
The WHH rate is 47 cases per 1000 births.

Quality Improvement - Trust Position

Appendix 2 Trust Performance

25. Fractured Neck of Femur

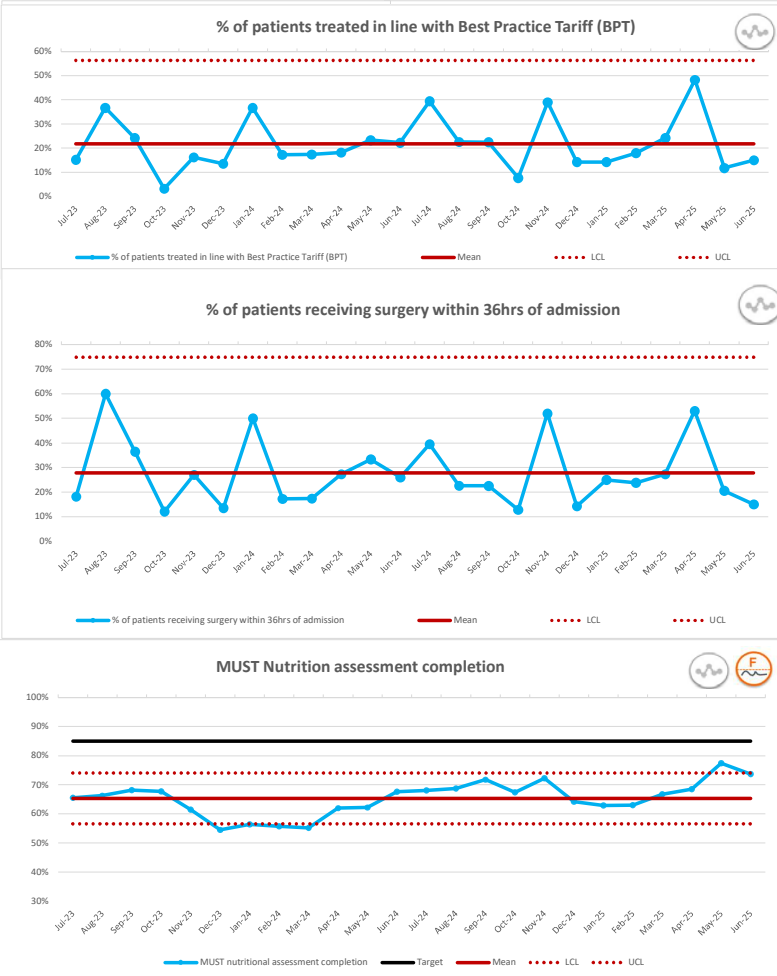
Target: Best Practice Tariff

15% of patients were treated in line with Best Practice Tariff (BPT) in Jun-25.

26. MUST nutritional assessment completion

Target: above 85%

MUST Nutrition assessment completion was 73.69% in month.



Statistical Narrative

Variation: Common Cause (Normal) variation.

Assurance: The Trust consistently fails the target.

Variation: Special cause variation of an improving nature.

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

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

28 patients included on the National Hip Fracture Database in June, of which a total of 20 would qualify for best practice tariff (BPT). A decrease was seen in the amount of fractured neck of femur patients being admitted directly from A&E to our Orthopaedic Ward dropping to only 39% in June.

15% of eligible patients were operated on in the recommended timeframe this was due to limited Theatre capacity.

Performance against KPI's and Best Practice Tariff is continuously reviewed and presented to the Neck of Femur(NOF) Group and Patient Safety and Clinical Effectiveness Group (PSCESC). An action plan has been developed and is overseen by PSCESC.

A NOF escalation standard operating procedure has been developed. This aims to increase the number of patients receiving surgery within 36 hours.

A hip fracture awareness day has been planned for Q3 to provide education around the importance of NOF care.

A business case is being drafted to explore options to increase Theatre capacity this is expected in Q3.

MUST compliance continues to improve, From the introduction of the LION dashboard in 2023/24 there has been an increase by 5% in 6 hourly assessment , 14% in 24 hourly assessment and by 29% in the 7 day assessment of patients.

The addition of MUST as a clinical indicator on Lorenzo has supported ward teams to identify patients who are in need of a MUST assessment or reassessment. As the indicator turns orange it provides Ward Teams a warning of 24 hours for the 7-day reassessment has contributed to the significant improvement in this metric. The Nutrition Food & Hydration monthly meeting drives a multi-disciplinary approach to the improvement of nutritional support to patients.

Clinical Business Units and key stakeholders produce high level briefing papers, action plans and quality improvement initiatives that can be shared Trust wide. MUST continues to be a Quality Priority for 25/26 with ward teams also presenting compliance data and action plans to improve at the Quality Summits with the Chief Nurse.

Access & Performance - Trust Position

Trust Performance

Trend

Statistical Narrative

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

Term)?

27. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Not including WUTC)
Target: 78%

The Trust achieved **64.78% excluding Widnes UTC in month.**

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

28. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (including WUTC)
Target: 78%

The Trust achieved **69.84% excluding Widnes UTC in month.**

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

29. Average time in department ED
No Target

24.29% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 394 minutes.

Target: 2% or less

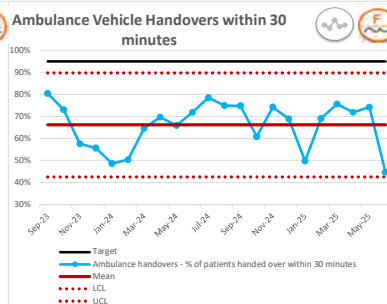
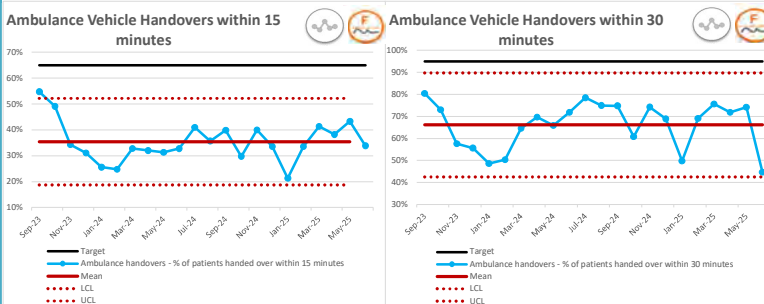
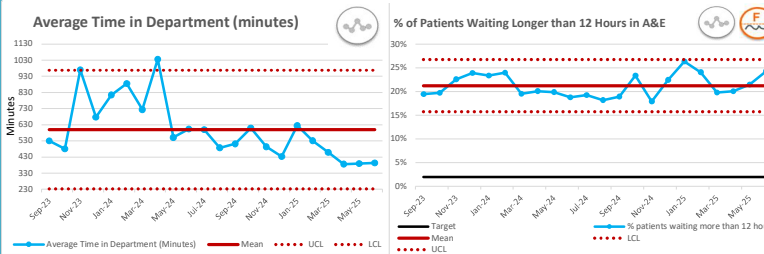
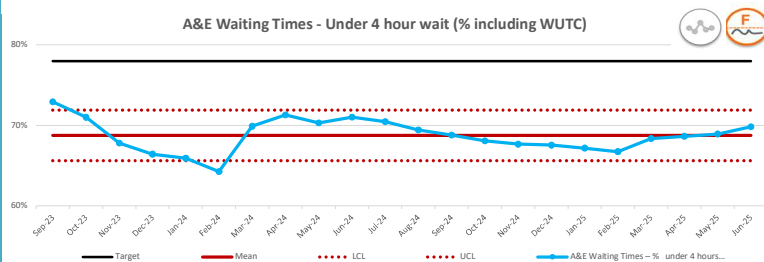
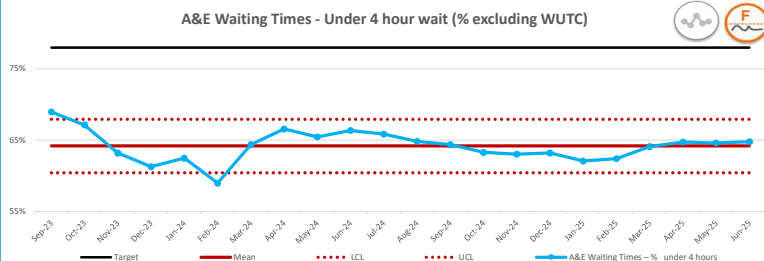
31. Ambulance Vehicle Handovers within 15 minutes
Target: 65%

In month the Trust achieved:

- 33.9% Ambulance Handovers within 15 minutes (65% target)

- 44.7% Ambulance Handovers within 30

32. Ambulance Vehicle Handovers within 30 minutes
Target: 95%



Assurance: The Trust consistently fails the target.

Variation: Common cause (normal) variation

Performance continues to be negatively impacted by long length of stay and a overall high bed occupancy.

The 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%.

Assurance: The Trust consistently fails the target.

Variation: Common cause (normal) variation

Assurance: No Target set

Variation: Common cause (normal) variation

Assurance: The Trust consistently fails the target.

Variation: Common Cause (Normal) Variation.

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

Variation: There is Common Cause (normal) Variation.

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

Variation: There is Common Cause (normal) Variation.

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

Please note that ambulance handover metrics are now measured to the point of vehicle handover, historically this was to the point of patient handover.

• 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

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

Access & Performance - Trust Position

33. Ambulance Handovers within 45 minutes
Target: 100%

34. Type 5 activity
No Target

35. Patients seen in the Fracture Clinic within 72 hours
Target: 95%

36. Diagnostic Waiting Times 6 Weeks
Target: 95%

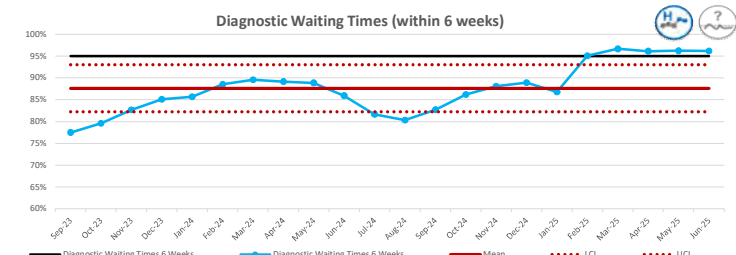
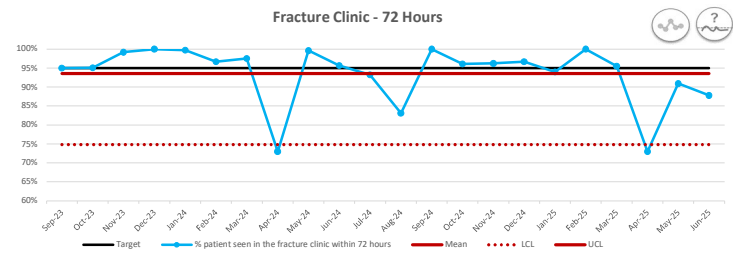
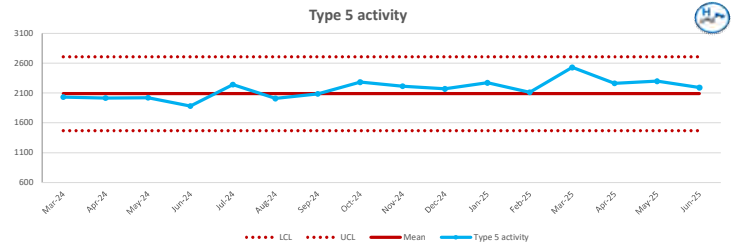
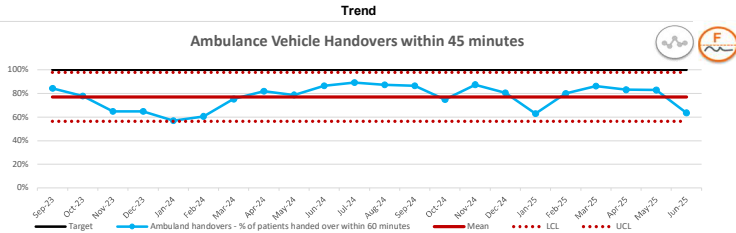
Trust Performance

minutes (95% target)
- 63.6% Ambulance Handovers within 60 minutes (100% target)

Pre-November 2024 activity has been estimated as attendances that would be considered a 'Type 5' attendance.
In month there were 2189 Type 5 Attendances.

In month, the fracture clinic saw 87.8% of patients within 72 hours.

The Trust achieved 96.19% in month.



Statistical Narrative

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

Term)?

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

Variation: There is Common Cause (normal) Variation.

'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.

Assurance: The Trust inconsistently passes/fails the target.

Variation: There is Common Cause (normal) Variation.

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

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 5 consecutive months

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

Access & Performance - Trust Position

Trust Performance

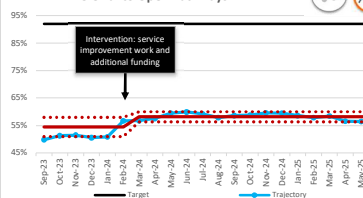
Trend

Statistical Narrative

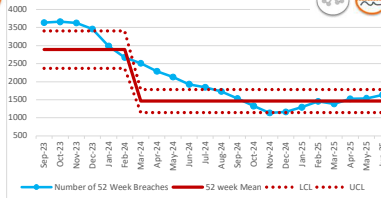
What are the reasons for the variation and what is the impact?

Term)?

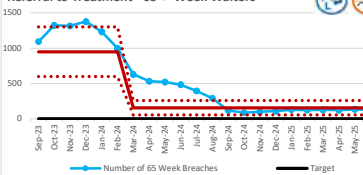
Referral to Open Pathways



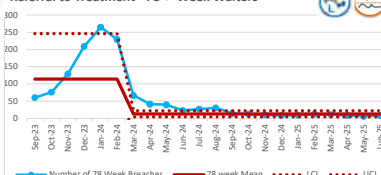
Referral to Treatment - 52+ Week Waiters



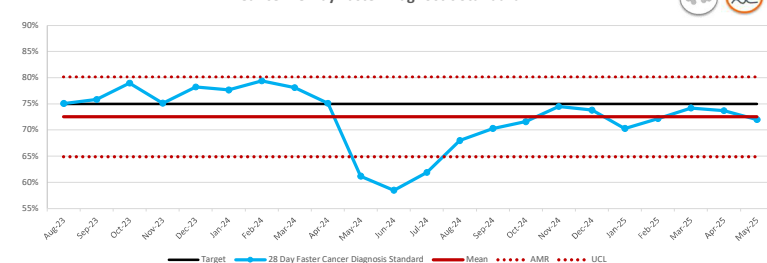
Referral to Treatment - 65+ Week Waiters



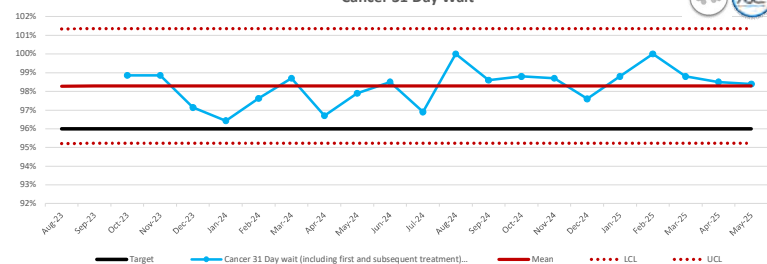
Referral to Treatment - 78+ Week Waiters



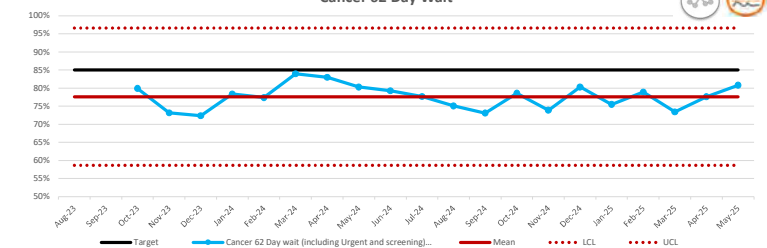
Cancer 28 Day Faster Diagnostic Standard



Cancer 31 Day Wait



Cancer 62 Day Wait



(Open Pathways) Assurance: The Trust consistently fails the target.

Variation: There is common cause variation.

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

Variation: There is common cause (normal) variation.

Assurance: The Trust consistently fails the target.

Variation: Common Cause (Normal) variation.

Assurance: Target met consistently.

Variation: There is Common Cause (normal) Variation.

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

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 130 submitted for June. This continues to be within a few specialties, T&O, Gynae, Pain and Max Fax.

Performance for the Faster Diagnosis Standard for May was 72%. 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 achieved the 31 day target.

62-day wait for first treatment performance for May was 80.8%. 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.

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.

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.

Access & Performance - Trust Position

Trust Performance

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

Outpatient follow ups have reduced to 87.65% of 19/20 activity in month.

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 96% of Daycase Procedures and 98% of Inpatient Elective Procedures.

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

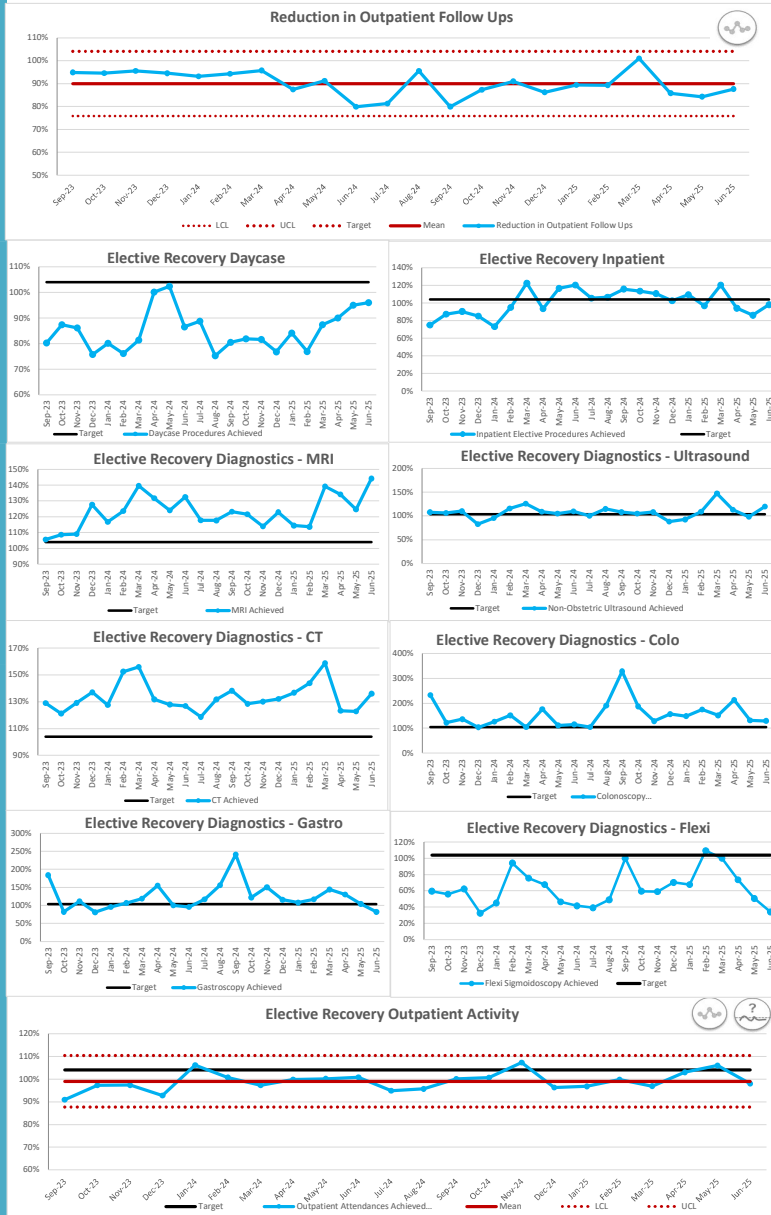
In month, the Trust achieved the following % of activity against 2019.

This included:
144.24% of MRI
136% of CT
120% of Non-Obstetric Ultrasound
34% of Flexi Sigmoidoscopy
129% of Colonoscopy
82% of Gastroscopy

45. Elective Recovery Outpatient Activity
Aggregate Target: 104%

In month, the Trust achieved 98% of Outpatient activity.

Trend



Statistical Narrative

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

Term)?

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.

N/A - Grouped indicator.

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

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

N/A - Grouped indicator.

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

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.

Challenges remain in Echo, mainly Stress Echo capacity.

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

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.

Access & Performance - Trust Position

Trust Performance

Trend

Statistical Narrative

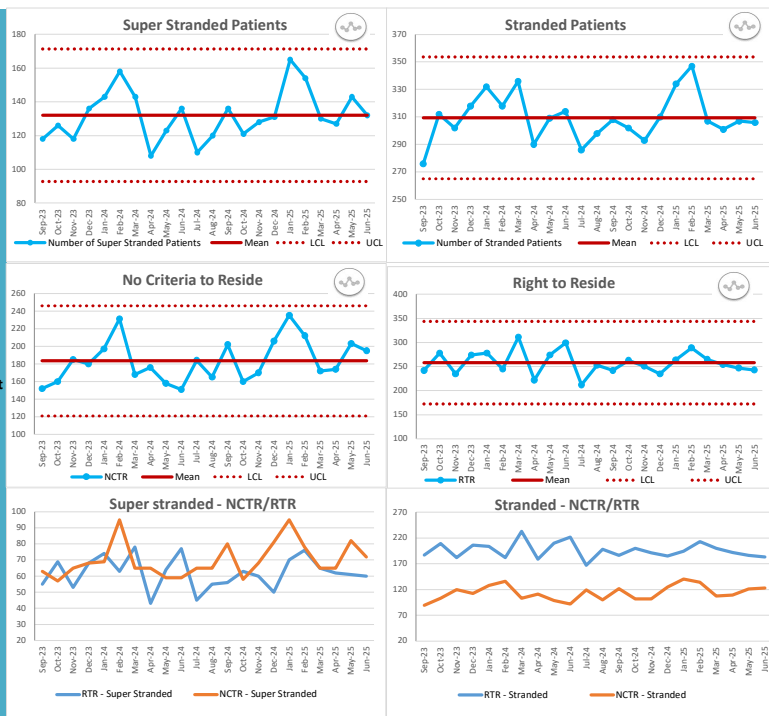
What are the reasons for the variation and what is the impact?

Term)?

46. Super Stranded Patients
Target: Trajectory

47. No Criteria to Reside (NCTR)

There were 306 stranded and 132 super stranded patients at the end of month. A Superstranded Patient Trajectory has not yet been agreed for 2025/26.



(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.

Access & Performance - Trust Position

48. % Patients discharged to their usual place of residence
Target: No Current Threshold

49. Cancelled Operations on the day for a non-clinical reason
Target: Less than 2%

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

51. Capped Theatre Utilisation
Target: 85%

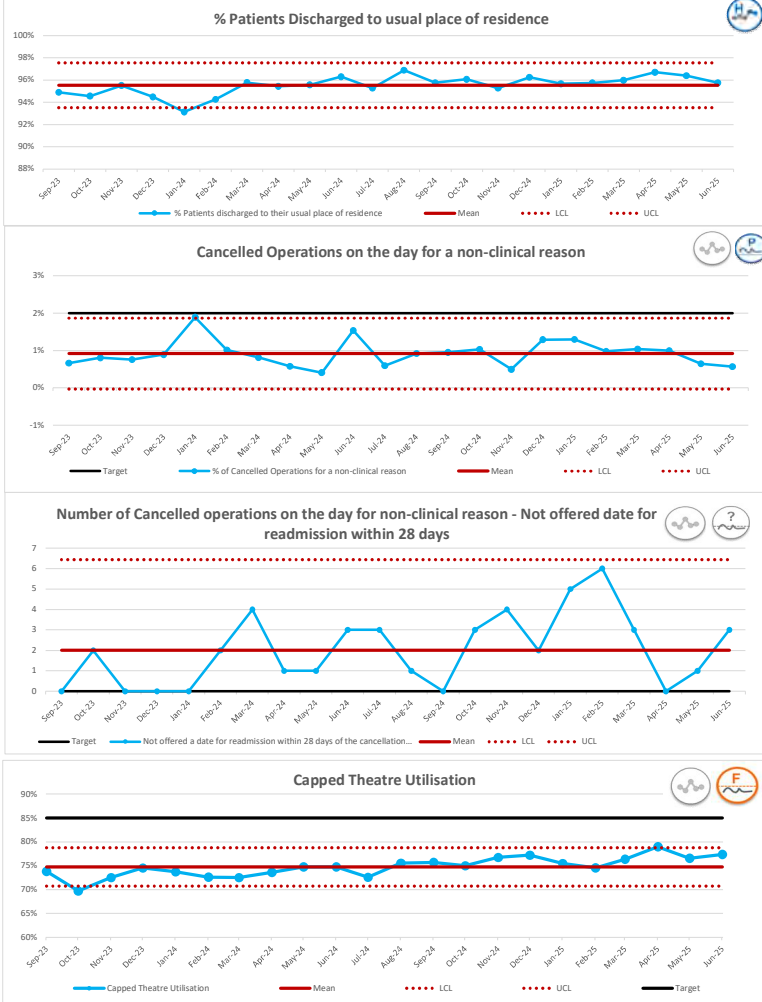
Trust Performance

95.74% patients in month were discharged to their usual place of residence.

Cancelled operations for a non-clinical reason was 0.57% in month. 3 cancelled operation were not offered a date for readmission within 28 days.

Capped Theatre Utilisation was 77.35% in month

Trend



Statistical Narrative

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

Term)?

Assurance: N/A Trajectory Not Agreed.

Variation: Special Cause Variation of an improving nature.

(Cancelled - non-clinical reason)
Assurance: The Trust consistently passes the target.

Variation: Common Cause (normal) variation.

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

Variation: Common Cause (normal) variation.

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

Variation: Common Cause (normal) variation.

Assurance: The Trust consistently fails 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.

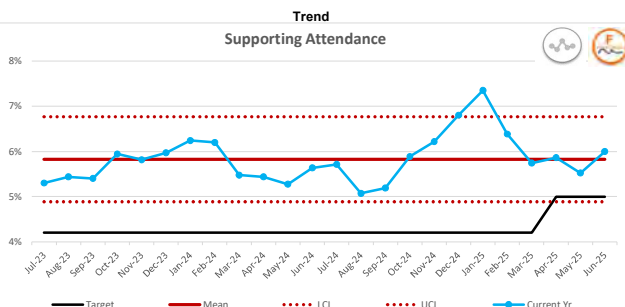
The Planned Care Transformation Group is working on aligning the activity to the British Association of Day Surgery and the opportunities to increase day case rates.

Areas of focus are on Urology, Breast Surgery & Gynaecology. The transformation team is working with the CBUs and clinical teams to increase the rates.

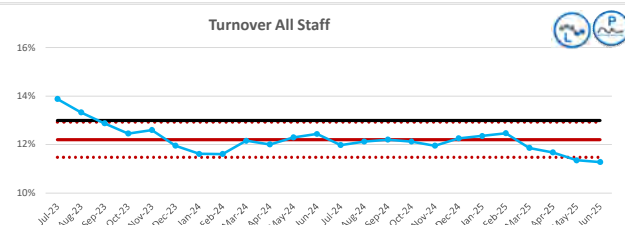
Workforce - Trust Position

Trust Performance

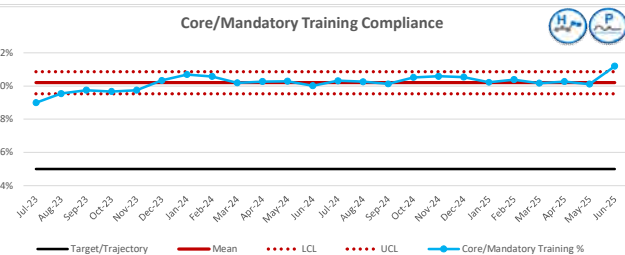
The Trust's sickness rate was 6% in month.



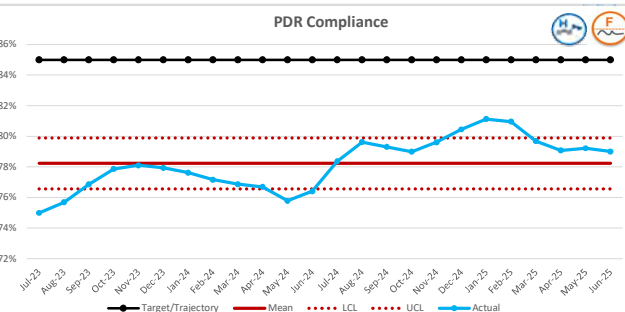
The Trust's turnover of all staff was 11.28% in month.



Core/Mandatory training compliance was 91.19% in month.



Annualised PDR compliance was 79% in month.



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)?

Assurance: The Trust consistently fails the target.

Variation: Common cause (normal) variation.

The monthly sickness absence percentage is consistently failing to meet the Trust target. There has been a reoccurring trend of higher levels of absence since November 24 running higher than the previous years absence rates.

Long-term sickness absence rates continue to show improvement, while short-term absence trends remain a concern.

An extraordinary OPC to deep dive into absence took place which provided assurance on the grip and control of absence management. It also outlined the impact of the Trusts pro-active health interventions and wellbeing offers. 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 2.8% in June 2025.

Actions to improve the position include:

A gap analysis was undertaken of East Cheshire's – 90-day sprint to achieve 1% reduction in sickness absence related to stress, anxiety and depression. A dedicated group meets fortnightly to implement quick sprint wins, medium and longer term initiatives. Proactive OH and HR support continues within areas of high sickness. Providing coaching support to managers, compliance audits and communication campaigns. The stage 3 absence process provides a compassionate and dignified exit out of the organisation on the grounds of ill health capability.

Assurance: The Trust consistently passes the target.

Variation: Special Cause Variation of an improving nature.

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

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

Work/life balance remains the main reason people leave WHH. The #MyFlex campaign continues to be promoted, and following successfully launching 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.

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

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

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.

Assurance of achieving the 85% target is sought through OPC, which 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.

Weekly appraisal reporting is now available Trustwide, to support leaders to further understand progress against agreed trajectories.

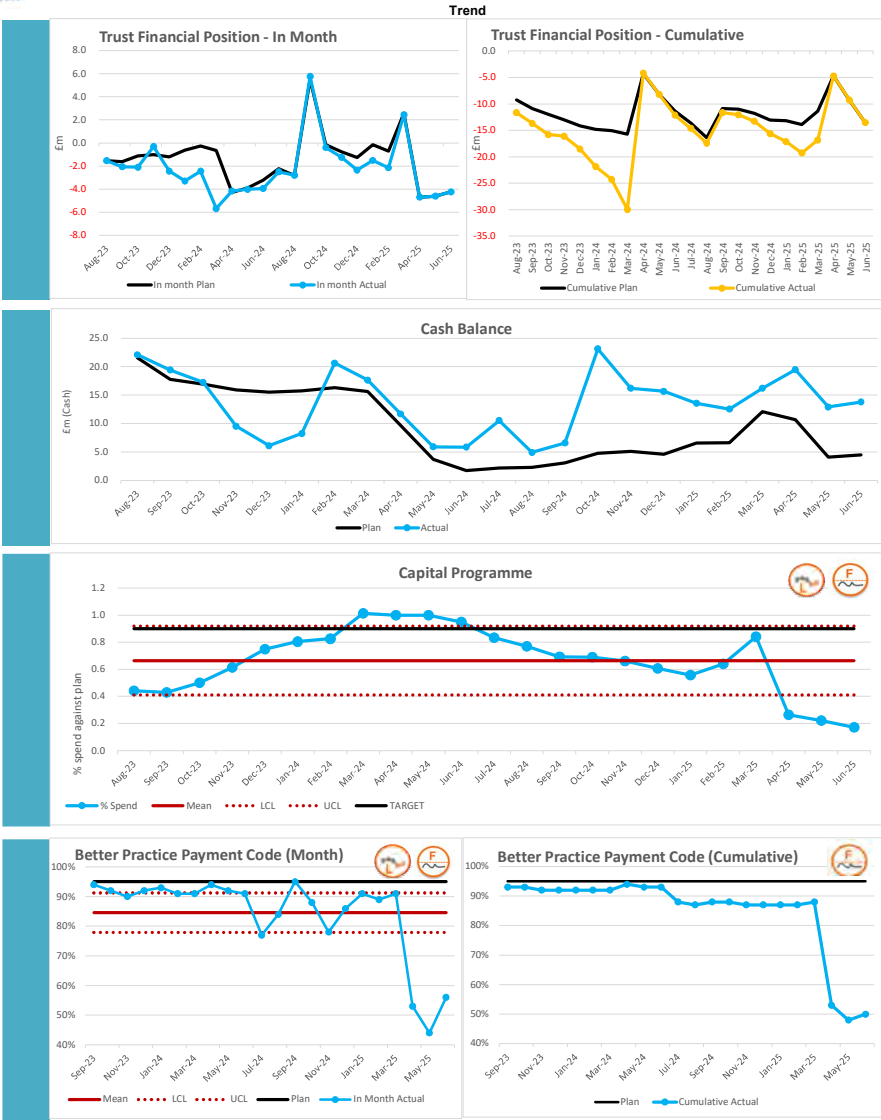
Finance and Sustainability - Trust Position

56. Trust Financial Position
Target: Plan

57. Cash Balance
Target: On or better than plan

58. Capital Programme
Target: On plan 90%-100%

59. Better Payment Practice Code
Target: Cumulative performance 95%



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)?
At month 3 the Trust has recorded a deficit position of £13.5m (before deficit support) which is in line with plan.	There is no variation at month 3, the deficit position is in line with plan.	Work is ongoing to identify additional CIP schemes, reduce cost pressures and increase activity delivery.
The cash balance at 30 June 2025 is £13.8m.	The current cash balance is £13.8m which is £9.3m higher than the cash plan. This is predominantly due to an increase in unpaid creditors in the first quarter. Of the £13.8m cash, £3.1m is related to capital creditors.	The deficit position has led to the Trust requiring external cash support. A request for £5.1m is required for September 2025, 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.
Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a declining nature.	Capital expenditure at the end of month 3 is £0.6m against a plan of £3.7m. This is mainly driven by the late start of schemes, ward refurbishment paused and replace 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.
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. There has been a small improvement since 31 May 2025 due to a smaller volume and value of invoices requiring payment in June 2025 meaning that a higher percentage of invoices could be paid compared to the previous month.	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.

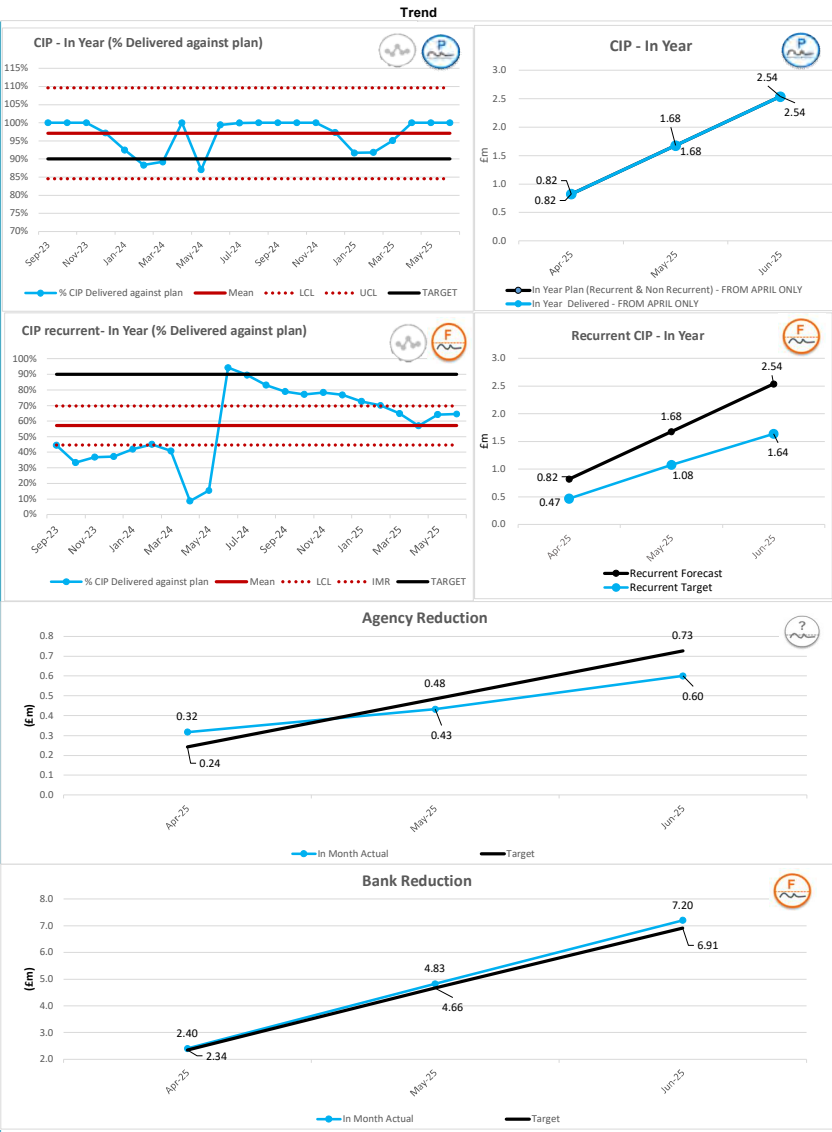
Finance and Sustainability - Trust Position

60. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date
Target: >90% plan delivered YTD

61. Cost Improvement Programme (recurrent) – In year performance to date
Target: >90% plan delivered YTD

62. Agency Reduction
Target: 30% reduction of 2024/25 plan

63. Bank Reduction
Target: 10% reduction of 2024/25 plan



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)?
Assurance: The Trust consistently passes the target. Variation: Common cause (normal) variation.	At month 3 £2.5m has been delivered which is in line with plan.	CIP progress is reviewed internally and externally on a weekly and monthly basis. The Medical Director and Director of Strategy and Partnerships are leading the Improvement programme with the Operational Teams supported by Finance and the Improvement Leads to drive greater efficiency across the Trust. Work continues on QIA and PID completion of identified schemes as well as identification of additional schemes.
Assurance: The Trust consistently fails the target. Variation: Common cause (normal) variation.	£1.6m CIP has been delivered recurrently against the target of £2.5m. The Trust aims to deliver CIP recurrently wherever possible and challenges if CIP is not recurrent. The full year effect of schemes delivering later in the year mitigates 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.
Agency expenditure is £0.6m at month 3 compared to a plan of £0.7m.	In line with operational planning guidance the agency reduction requirement is 30% of the 2024/25 plan (£5.1m). The annual budget has been set at a lower value (£2.9m). At month 3, agency expenditure is underspent by £0.1m 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.
Bank expenditure is £7.2m at month 3 compared to a plan of £6.9m	In line with operational planning guidance the bank reduction requirement is 10% of the 2024/25 plan which is the same as the annual budget (£27.6m). At month 3 bank expenditure is overspent by £0.3m. Actions have been taken to reduce bank spend and nursing bank spend is £0.3m behind plan at month 3. Medical bank spend is overspent by £0.6m due to vacancies.	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 PSIs in accordance with the nationally mandated Patient Safety Incident Response Framework.
	1	Number of incidents open over 40 days.	0	
		Total PSIs 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 (updated)	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 (updated)	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 (updated)	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?

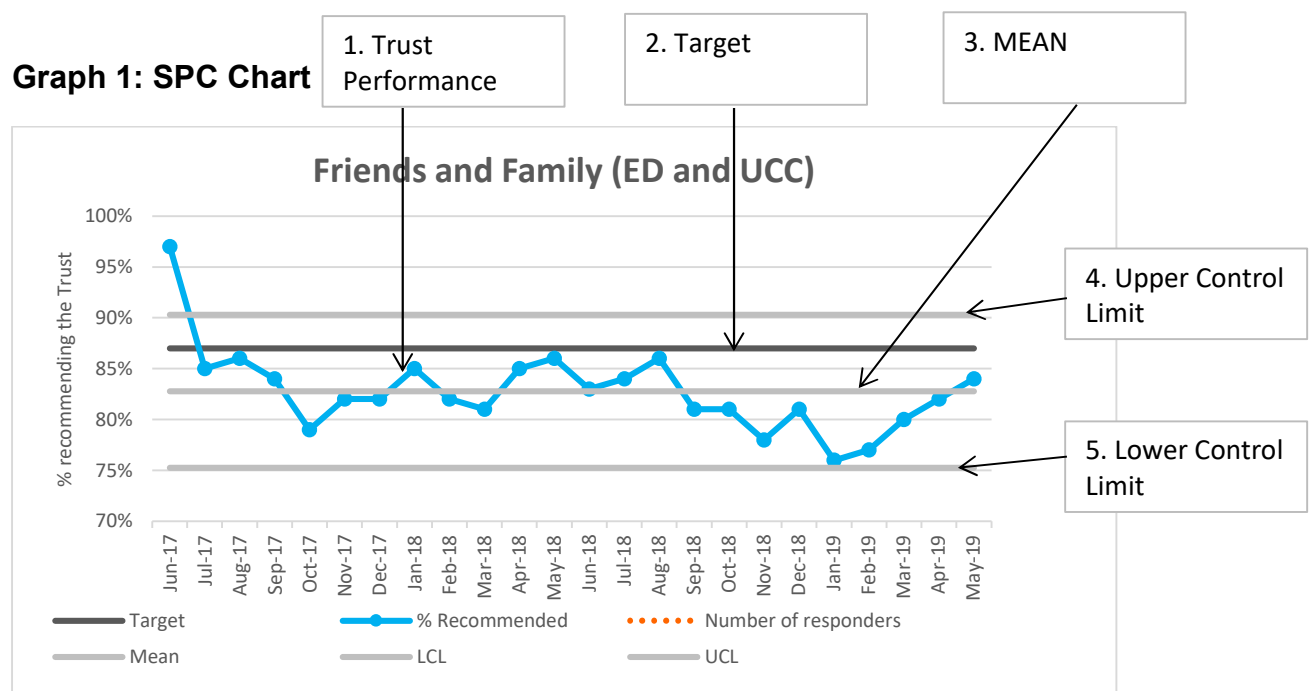
Statistical Process Control (SPC) is a method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing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

Graph 1: SPC Chart

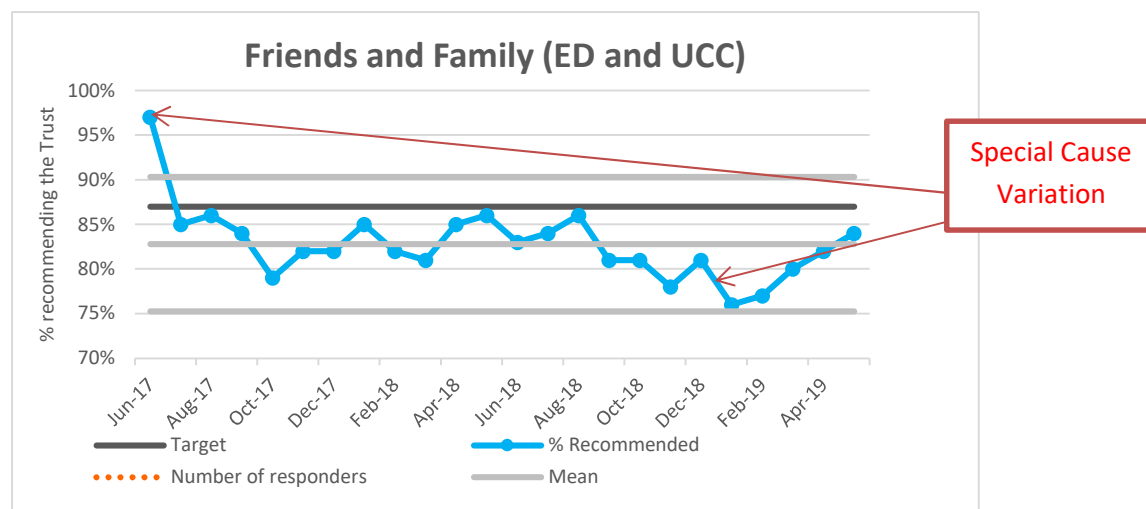


2.1 Interpreting a SPC Chart

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)ailing 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.

Income Statement at 30th June 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	364,820	29,896	29,362	-534	89,076	87,200	-1,875
Non NHS Clinical Income							
Private Patients	8	1	1	0	2	2	0
Non NHS Overseas Patients	70	6	2	-3	17	7	-11
Other non protected	750	63	83	21	188	230	42
Notional Pension Income	0	0	0	0	0	0	0
Sub total	828	69	87	18	207	238	31
Other Operating Income							
Training & Education	10,663	889	889	0	2,666	2,666	0
Donations and Grants	0	0	0	0	0	0	0
Miscellaneous Income	14,919	1,239	1,248	9	3,717	4,046	329
Sub total	25,583	2,128	2,137	9	6,383	6,712	329
Total Operating Income	391,231	32,093	31,586	-507	95,666	94,151	-1,515
Operating Expenses							
Employee Benefit Expenses	-281,958	-24,698	-24,464	233	-74,298	-73,518	780
Drugs	-23,121	-1,952	-1,659	292	-5,854	-5,392	462
Clinical Supplies and Services	-27,036	-2,369	-2,561	-192	-7,102	-6,846	256
Non Clinical Supplies	-47,404	-3,926	-3,840	87	-11,823	-12,054	-232
Depreciation and Amortisation	-17,659	-1,472	-1,472	0	-4,415	-4,415	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	-397,178	-34,417	-33,996	420	-103,491	-102,225	1,266
Operating Surplus / (Deficit)	-5,948	-2,324	-2,410	-86	-7,825	-8,074	-249
Non Operating Income and Expenses							
Profit / (Loss) on disposal of assets	0	0	0	0	0	0	0
Interest Income	520	43	118	75	130	384	254
Interest Expenses	-138	-11	-9	2	-34	-37	-3
PDC Dividends	-5,501	-458	-458	0	-1,375	-1,375	0
Total Non Operating Income and Expenses	-5,119	-427	-349	77	-1,280	-1,028	252
Surplus / (Deficit) - as per Accounts	-11,066	-2,750	-2,759	-9	-9,104	-9,102	3
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	167	165	-2
Total Adjustments to Financial Performance	669	56	55	-1	167	165	-2
Adjusted Surplus / (Deficit) as per NHSI Return	-10,397	-2,695	-2,704	-10	-8,937	-8,937	0
Deficit Support Funding	-18,327	-1,527	-1,527	0	-4,582	-4,582	0
Adjusted Surplus / (Deficit) - without deficit support funding	-28,724	-4,222	-4,231	-10	-13,519	-13,518	0



**Warrington and Halton
Teaching Hospitals**
NHS Foundation Trust



IPR – June 2025 Detail

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 **(NEW)**
- **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:

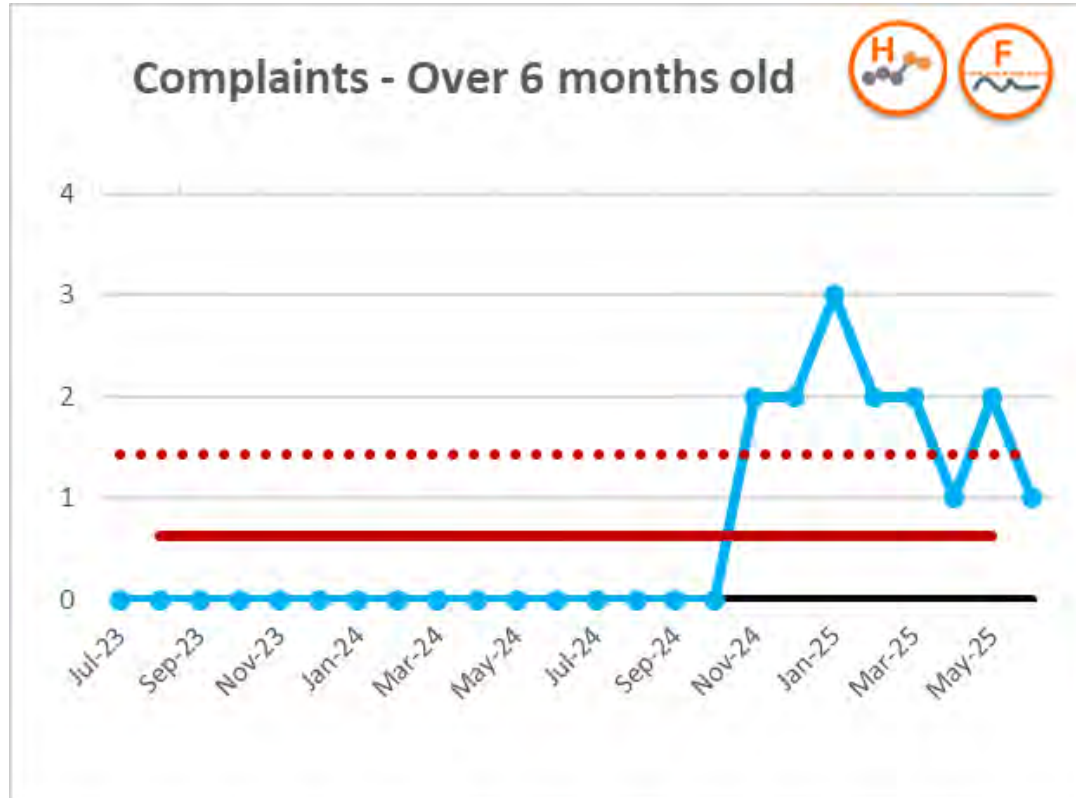
- **61. CIP (recurrent)** – % delivered against plan
- **63. Bank Reduction** – delivery against 10% reduction of 2024/25 plan **(NEW)**

April 2025 IPR by Exception - Quality



**Warrington and Halton
Teaching Hospitals**
NHS Foundation Trust

15. Complaints (NEW)



In June there was one complaint over six months old. This was raised by the complainant in January 2025. The complainant requested time to review the patients records before providing questions in April 2025. There was a further request from the complaint to put the complaint on hold to schedule a meeting to take place after July 2025 to allow the family time to deal with family matters.

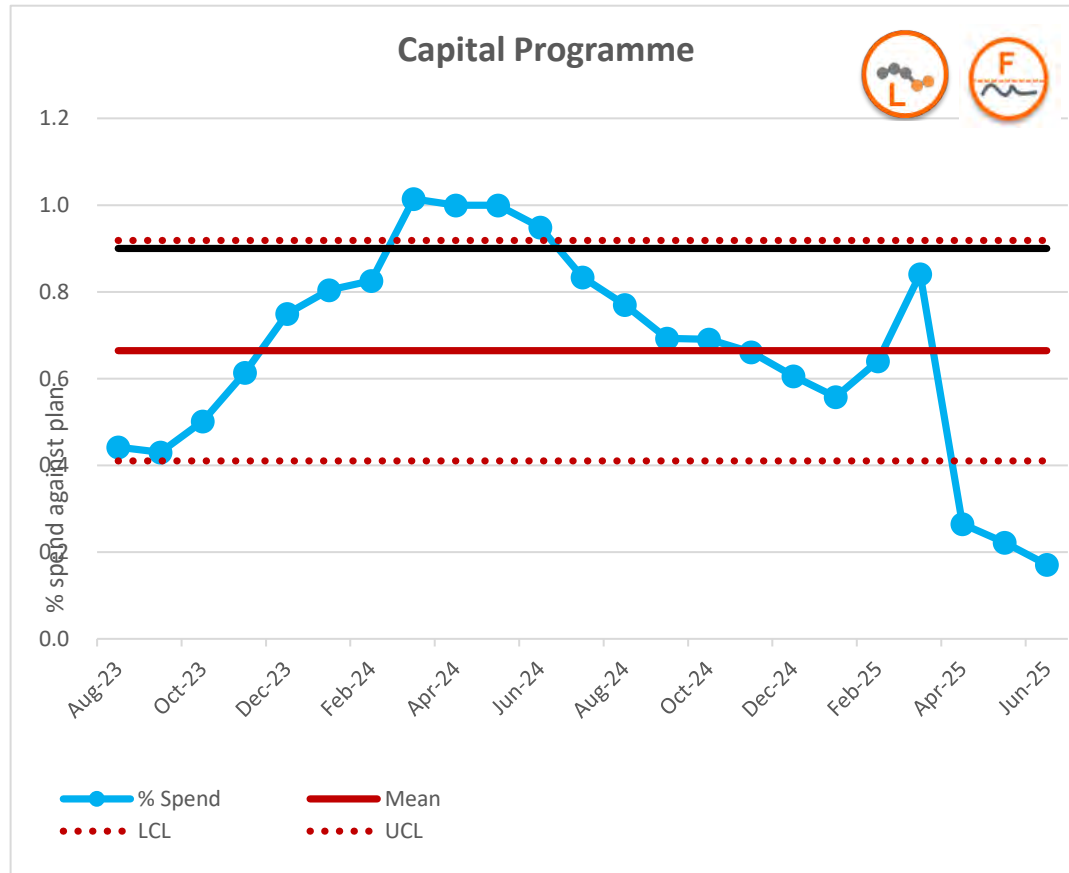
The meeting was planned for July however was cancelled at short notice due to unforeseen sickness. The meeting has been rescheduled for August 2025. It is anticipated this complaint will be closed in August 2025 following the scheduled meeting.

June 2025 IPR by Exception – Finance



**Warrington and Halton
Teaching Hospitals**
NHS Foundation Trust

58. Capital Programme – % delivered against plan



Capital expenditure at the end of month 1 is £0.6m against a plan of £3.7m.

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

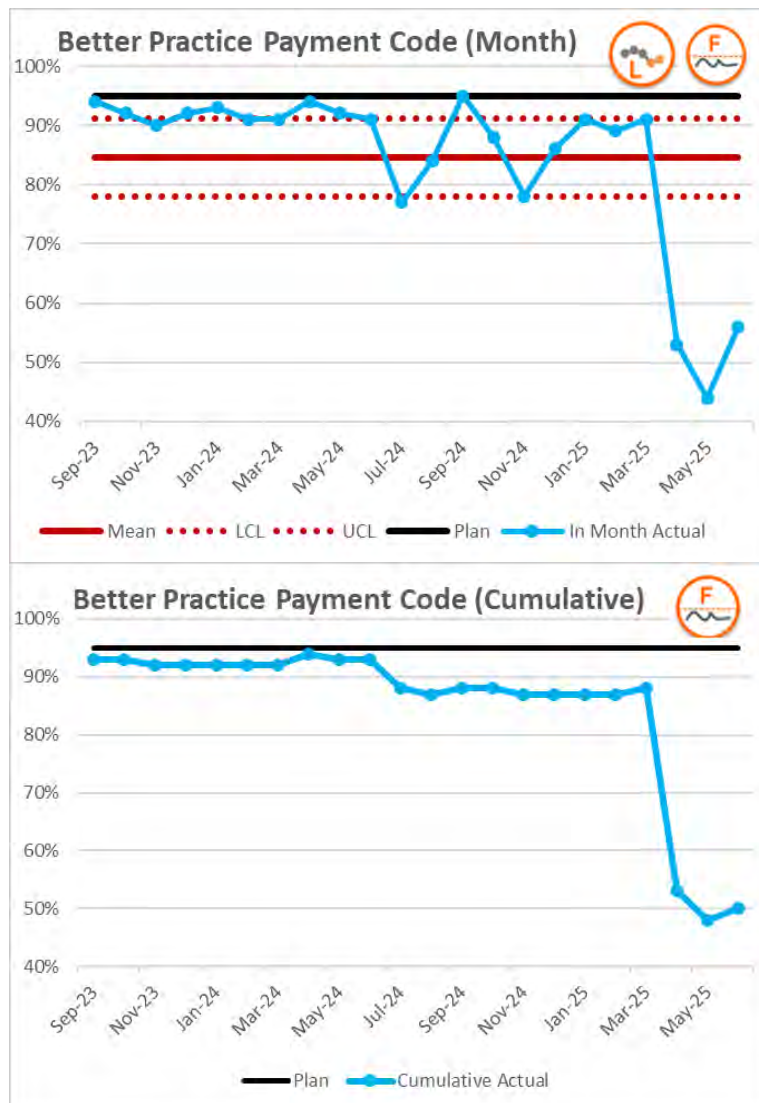
The risk associated with delivering the 2025/26 capital plan is being monitored at CPG and reported to FSC.

June 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. There has been a small improvement since 31 May 2025 due to a smaller volume and value of invoices requiring payment in June 2025 meaning that a higher percentage of invoices could be paid compared to the previous month.

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.

June 2025 IPR by Exception – Finance



**Warrington and Halton
Teaching Hospitals**
NHS Foundation Trust

61. CIP – % delivery against plan (recurrent)



£1.6m CIP has been delivered recurrently against the target of £2.5m.

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. The full year effect of schemes delivering later in the year mitigates the non-recurrent schemes into 2026/27.

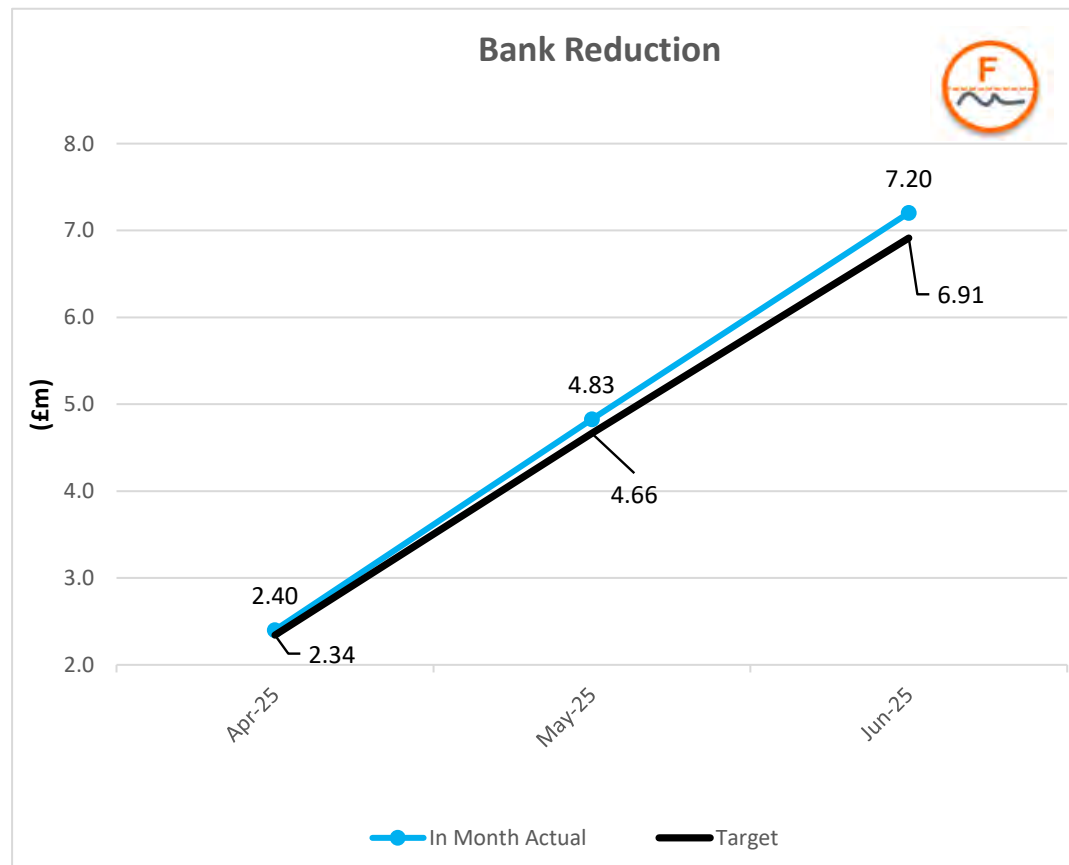
For 2025/26 a delivery unit has been established to support delivery of the CIP programme. This will include ensuring CIPs are recurrent and quality impact assessed.

June 2025 IPR by Exception – Finance



**Warrington and Halton
Teaching Hospitals**
NHS Foundation Trust

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



Bank expenditure is £7.2m at month 3 compared to a plan of £6.9m.

In line with operational planning guidance the bank reduction requirement is 10% of the 2024/25 plan which is the same as the annual budget (£27.6m). At month 3 bank expenditure is overspent by £0.3m.

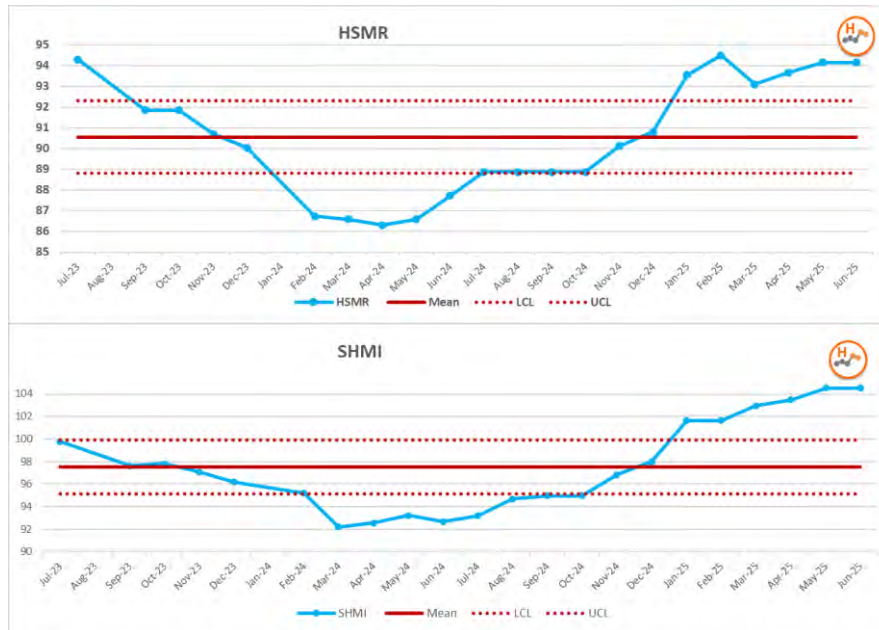
Actions have been taken to reduce bank spend and nursing bank spend is £0.3m behind plan at month 3. Medical bank spend is overspent by £0.6m due to vacancies. Substantive recruitment into medical posts has taken place and is expected to continue which will reduce the medical bank spend.

April 2025 IPR by Exception - Quality



**Warrington and Halton
Teaching Hospitals**
NHS Foundation Trust

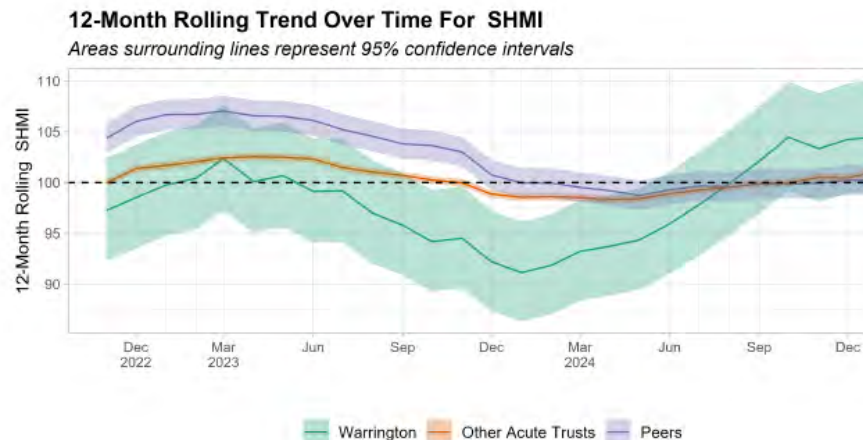
13,14. Mortality ratio – HSMR and SHMI



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.

Recommendation

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



Integrated Performance Report

National League Tables – 4hr, 12hr, RTT.

Chief Operating Officer & Deputy CEO



Working
Together



Excellence



Inclusive



Kind



Embracing
Change

National Lens – 12 hours

Table 1

Trust	Apr-May '25 combined
Blackpool Teaching Hospitals NHS Foundation Trust	26.7%
Countess of Chester Hospital NHS Foundation Trust	26.0%
The Shrewsbury and Telford Hospital NHS Trust	25.0%
Wirral University Teaching Hospital NHS Foundation Trust	21.9%
East Kent Hospitals University NHS Foundation Trust	20.8%
Warrington and Halton Teaching Hospitals NHS Foundation Trust	20.6%
Wrightington, Wigan and Leigh NHS Foundation Trust	20.2%
Mid Cheshire Hospitals NHS Foundation Trust	17.7%
Great Western Hospitals NHS Foundation Trust	17.6%
Northern Lincolnshire and Goole NHS Foundation Trust	17.6%

Table 2

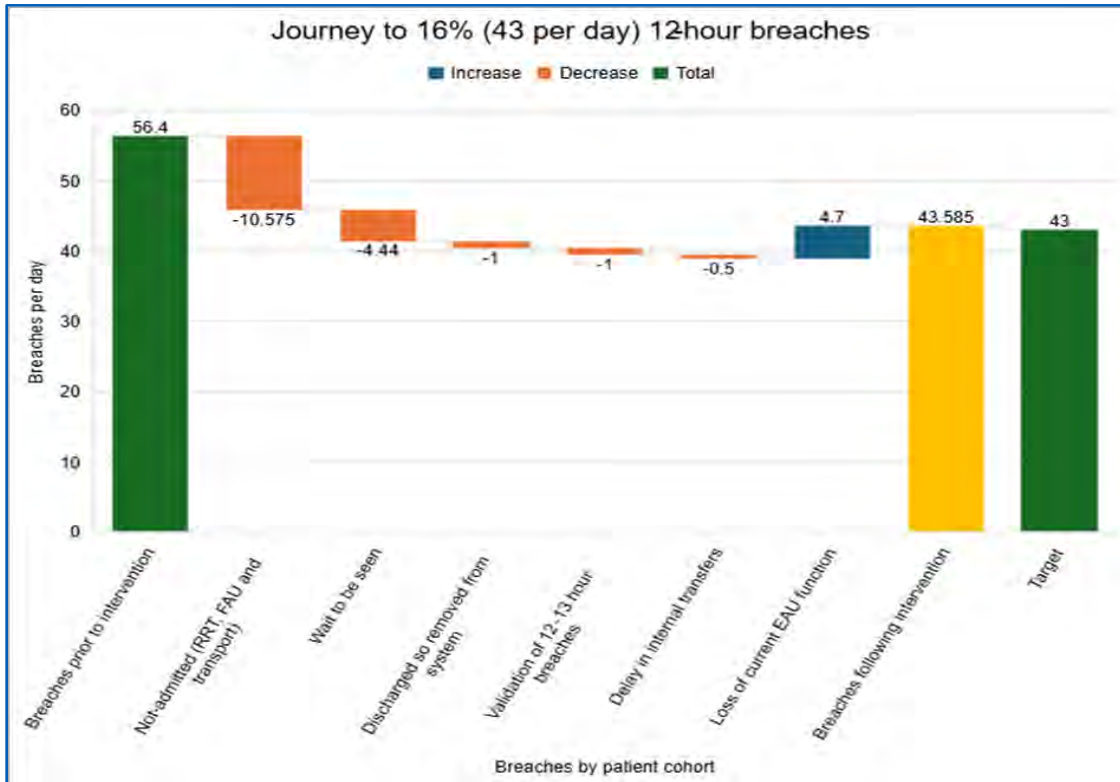
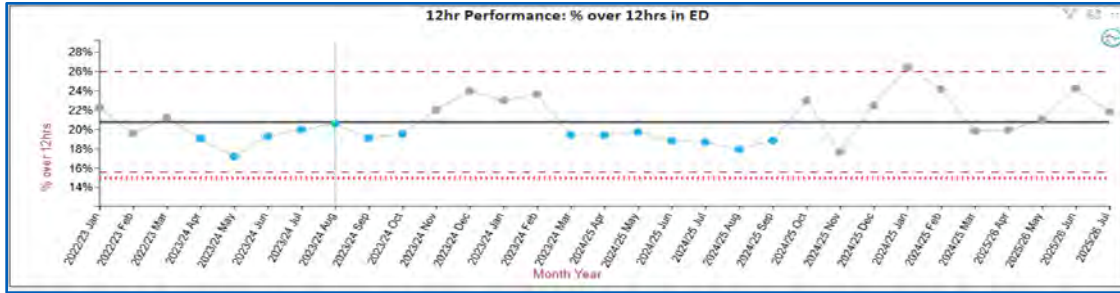
Acute provider	Percentage waiting within 18 weeks for elective treatment		Percentage waiting more than 52 weeks for elective treatment		Cancer Faster Diagnostic Standard *		Cancer 62 Day Combined Performance *		Diagnostics proportion waiting over 6 weeks		A&E 4 hour performance		A&E 12 hour performance *	
	May-25 (Rank out of 134)		May-25 (Rank out of 134)		May-25 (Rank out of 122)		May-25 (Rank out of 122)		May-25 (Rank out of 134)		Jun-25 (Rank out of 124)		Jun-25 (Rank out of 111)	
	Latest	Rank	Latest	Rank	Latest	Rank	Latest	Rank	Latest	Rank	Latest	Rank	Latest	Rank
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	54.3%	116	4.5%	122	71.1%	97	71.4%	57	7.7%	29	68.6%	92	15.2%	99
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	64.7%	41	2.8%	85	65.6%	112	79.9%	15	14.7%	56	73.9%	61	16.8%	102
COUNTRESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	47.9%	133	7.6%	134	75.6%	69	77.9%	22	19.0%	75	63.7%	108	22.1%	108
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	63.0%	49	2.8%	84	67.3%	106	75.8%	34	12.0%	45	61.5%	114	22.3%	109
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	56.5%	102	4.6%	125	72.0%	90	80.8%	12	3.7%	17	64.8%	105	24.3%	111
EAST CHESHIRE NHS TRUST	60.6%	65	1.0%	30	74.9%	75	72.0%	52	7.2%	28	46.7%	124		
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	56.5%	99	4.7%	126	77.0%	49	65.4%	88	19.0%	74	59.1%	118		

Table 3

A&E Metrics		
Provider	A&E 4 hour performance	A&E 12 hour performance (type 1 and 2)
	(7-day rolling average, week ending 30 Jul 2025)	(7-day rolling average, week ending 27 Jul 2025)
Warrington & Halton Teaching H	63.90% (Rank: 116 / 124)	17.50% (Rank: 107 / 115)

- ❖ 12 hour performance the driver for WHH being placed in Tier 1 in 2023.
- ❖ On the 9th of July CEO's of the 10 lowest ranked performing providers for 12 hour ED performance were invited to a meeting with the National team/CEO NHS England.
 - Based on April & May data
 - Increased intervention
 - An expectation to improve and explain plans.
 - Failure to improve could impact NOF scoring
- ❖ On the 10th July the Acute Provider League tables published
 - Based on June data
 - Focus on Constitutional Standard performance
 - Worst performing 111/111 – Not all trusts had a submitted figures eg Mid Cheshire and East had no performance or ranking score
 - o 14-20 winter beds closed (not all sites have)
 - o WBC closed its ICAHT service
 - 4 hour performance/Ranking - 105/134
- ❖ On the 5th August – weekly, unvalidated data to be released to CEO /Chairs.
 - There will be a difference with this and the final published statistics eg, WHH 4 hour performance doesn't include WUTC activity which would slightly improve the ranking to 110, instead of 116.

12 hours – Improving Patient Experience and Quality of Care



Background and current position:

- UEC System Improvement Group established May 2024 – prehospital, in hospital and post hospital workstreams
- Significant worsened position in June - closure of winter pressure beds (16 beds) and reduction in Warrington ICAHT capacity which contributed to an increase in NEL LoS

12-hour time in department (TiD):

- 62% of 12-hour breaches relate to admitted patients (Q1)
- 38% of 12- hours relate to non-admitted patients (Q1)

What have we done/are doing?

- Planned launch of Decisions discharge unit (DDU) - 28th July to provide a ward area for patients requiring a period of observation prior to a decision being made on their treatment plan
- Review of ECIST workforce modelling underway to improve medical staffing profile alignment with patient demand profile
- Exploring deflection 'bring back' clinics to be implemented to support with long waits overnight (East Lancs/Blackburn model)
- Additional twilight/overnight staffing cover being explored to ensure protected support for ED overnight
- Continuous Flow relaunch to support earlier flow from ED

Risks and challenges

- WTBS further challenged by recent mandated changes to Physician Assistant working practices
- High NCTR numbers is driving high bed occupancy compromising flow out of ED

Expected improvement

- **12-hour waterfall to improvement-** reduction to 43 breaches per day which will equate to approx. 16% performance
- Improvement in Patient experience and Quality of Care

National Lens –RTT

RTT Metrics		
Provider	Percentage waiting within 18 weeks for elective treatment (week ending 27 Jul 2025)	Percentage waiting more than 52 weeks for elective treatment (week ending 27 Jul 2025)
Warrington & Halton Teaching H	56.50% (Rank: 100 / 134)	5.06% (Rank: 125 / 134)

Acute provider	Percentage waiting within 18 weeks for elective treatment		Percentage waiting more than 52 weeks for elective treatment		Cancer Faster Diagnostic Standard *		Cancer 62 Day Combined Performance *		Diagnostics proportion waiting over 6 weeks		A&E 4 hour performance		A&E 12 hour performance *	
	May-25 (Rank out of 134)		May-25 (Rank out of 134)		May-25 (Rank out of 122)		May-25 (Rank out of 122)		May-25 (Rank out of 134)		Jun-25 (Rank out of 124)		Jun-25 (Rank out of 111)	
	Latest	Rank	Latest	Rank	Latest	Rank	Latest	Rank	Latest	Rank	Latest	Rank	Latest	Rank
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	64.7%	41	2.8%	85	65.6%	112	79.9%	15	14.7%	56	73.9%	61	16.8%	102
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	63.0%	49	2.8%	84	67.3%	106	75.8%	34	12.0%	45	61.5%	114	22.3%	109
EAST CHESHIRE NHS TRUST	60.6%	65	1.0%	30	74.9%	75	72.0%	52	7.2%	28	46.7%	124		
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	56.5%	99	4.7%	126	77.0%	49	65.4%	88	19.0%	74	59.1%	118		
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	56.5%	102	4.6%	125	72.0%	90	80.8%	12	3.7%	17	64.8%	105	24.3%	111
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	54.3%	116	4.5%	122	71.1%	97	71.4%	57	7.7%	29	68.6%	92	15.2%	99
COUNTS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	47.9%	133	7.6%	134	75.6%	69	77.9%	22	19.0%	75	63.7%	108	22.1%	108

- ❖ The RTT performance for WHH is ranked 102/134 in the monthly Acute Provider League table.
 - 100/134 in the new unvalidated weekly.
 - The Operational Plan is to deliver 65% by March 26.
- The Trust RTT trajectory for July is 60% - expected to close the position at 57%.
- Participation in the Q1 and Q2 validation sprint is actively worsening performance by c2.7%
 - This is because we are validating patients 0-14 weeks.

This means, that without the sprint validation activity, the Trust would be on RTT plan for July.

RTT performance is expected to improve in Q3 once the sprint validation has finished.

Speciality	Week Ending 29/06/25	Week Ending 6/7/25	Week Ending 13/07/25	Week Ending 20/7/25	Week Ending 27/07/25 - Month End	Month End July	Week Ending 3/8/2025	Week Ending 10/08/25	Week Ending 17/8/25	Week Ending 24/8/25	Week Ending 31/8/25 - Month end
Total	154	135	133	117	98	61	88	108	100	88	47
Actual	154	135	130	114	91	57	70	92			

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/08/59a (i)	Meeting	Trust Board	Date Of Meeting	6 August 2025

Date of Meeting	10 June 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/25/06/053	Deep Dive – Typing Backlog	The Committee received a presentation noting - Backlog of circa 12,000 letters (May2025), 9000 are overdue. - Noted on all Clinical Business Units Risk Registers - Outsourcing and overtime payments utilised to support backlog reduction - Monitoring of harm ongoing - Trajectories to be presented to Executive team by end June 2025	Moderate The committee noted although actions in place significant backlog to recover, limited assurance at this time on harm reviews- further assurance required	Substantial: Review via Patient Experience and Inclusion Sub Committee/ Quality Assurance Committee	Review via Patient Experience and Inclusion Sub Committee July 2025 Update to QAC August 2025 Trajectories to Executive Team by end June 2025.
QAC/25/06/55	Quality Account – Final Document	The Committee received the final version of Quality Account noting - Feedback had been received and collated from external partners in line with requirements - The Quality Account will be submitted for final approval at Audit Committee June 2025	Substantial Will require final approval at Audit Committee June 2025	Substantial: Approved at Quality Assurance Committee (QAC) as per requirements.	Audit Committee June 2025

		The Quality Account will be uploaded to the organisation's website by 30 June 2025			
QAC/25/06/057	Patient Safety and clinical Effectiveness Sub Committee Report.	An update from Patient Safety and Clinical Effectiveness Sub-Committee (PSCESC) was provided to the committee. Key areas to note - ENT De-escalated from Fragile Services - Neck of Femur- Adjusted mortality above expected range for the first time – improvement plan for Theatre waiting times and time to mobilise post Theatre to be presented to the Executive Team. - Cardiology – concerns re diagnostic delays – improvement plans requested – no harm to date. Awaiting Standard Operating Procedure finalising to provide assurance on mechanisms for the management of patients. - Urology – improved waiting list position. However, service remains fragile relating to staffing.	Moderate Assurance received – regarding Fragile Services – further improvements required.	Substantial Monthly oversight at QAC Executive oversight monthly of all fragile services via PSCESC	QAC July 2025
QAC/25/06/058	MIAA Theatre Safety Audit and update from Directors visits	The Committee received a presentation including - Overview of external review commissioned following a series of GP concerns Points to note include 15/17 actions complete, remaining actions remain on track	Moderate Evidence of MDT working required Service specification needs review	Substantive Oversight at QAC Bimonthly Fragile Service – Monthly reporting to Patient Safety	Fragile Service Report to PSCESC next July 2025

		- Observational audits are 99% compliant with WHO checklist - No immediate intervention required for safety - Positive feedback from Director/Non-Executive Director observational visits	SOPs and standardised letter to be reviewed and developed Improvements noted, sustainability required.	and Clinical Effectiveness Sub Committee.	
QAC/25/06/065	PSIRF Annual Report	The Committee received a presentation overview of PSIRF noting - PSIRF Policy and Plan reviewed and endorsed by the ICB Patient Safety Team - Local Priorities will remain unchanged for forthcoming year. - Overview of learning responses and PSIs for 2024/35 - Overview of PSIRF training and plan - Level 1 97%, Level 2 86% compliance 4 patient Safety Specialists in place, further 4 to commence training in September 2025 - MIAA review noted substantive assurance for PSIRF- May 2025	Substantive MIAA review noted substantive assurance Strong systems and processes in place for PSIRF and learning	Substantive Weekly Executive oversight at Safety Oversight Meeting. Quarterly Oversight at PSIRF Executive Led Group and Patient Safety and Clinical Effectiveness	Patient Safety Clinical Effectiveness Quarter 2

The Committee also received the following items.

Patient Story

QAC/25/06/056 Quality IPR metrics

QAC/25/06/059 Quarterly Compliance Report

QAC/25/06/060 Maternity update

QAC/25/06/061 Learning from Experience Report

QAC/25/06/063 Quality Priorities

QAC/25/06/064 ED Improvement

QAC/25/06/066 Enabling Strategy Alignment

QAC/25/06/067 Medicines Management Annual Report

QAC/25/06/068 Controlled Drugs Annual Report
QAC/25/06/069 Update on proposed Risk Management Process

Assurance Key

Delivery Assurance: Assurance in achieving outcomes.

Governance Assurance: Assurance in the internal controls in place

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

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

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/08/59a	Meeting	Trust Board	Date Of Meeting	6 August 2025

Date of Meeting	8 July 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	Deep Dive – Maternity cardiotocography	The Committee received a presentation noting - The current position of Saving Babies' Lives Care Bundle was noted - A strong training programme was noted to be in place. - Training compliance is generally good, though dips are observed during periods of staff turnover or doctor changeovers. - Specialist Midwife roles are in place - Review of a more effective CTG training tool is underway - Issues with escalation were explored – it was noted cultural barriers to escalation have been addressed	Moderate The committee noted although actions in place. Further assurance required on clinical escalation	Substantial: Review via Quality Assurance Committee monthly in Maternity Paper.	Update to QAC August 2025
QAC/25/07/079	National Hip Fracture Mortality	The Committee received a presentation noting - Metrics remain below national averages - Mortality rates remained within expected limits until Q4 2024/25, when both crude and case-mix adjusted mortality exceeded control limits	Limited Need to improve time to Theatre position and receive assurance escalation	Substantial: Oversight at Quality Assurance Committee (QAC)	Quality Assurance Committee monthly until greater assurance received 2025

		- As of 4 July 2025, both mortality metrics had improved but remained close to the upper control limits - Improvement plan in place - Core issue identified as delay in surgery	processes are effective		
QAC/25/07/081	Patient Safety and clinical Effectiveness Sub Committee Report.	An update from Patient Safety and Clinical Effectiveness Sub-Committee (PSCESC) was provided to the Committee. Key areas to note - ENT removed from Fragile Services - Cardiology have 3 remaining actions to be completed prior to step down - Urology – Waiting list position improving. Remains a Fragile Service due to staffing and capacity. Harm Reviews - Clinical validation of the AI tool used for Outpatient Clinic follow-up risk scoring has shown that the model is not reliable in this setting	Moderate Assurance received – regarding Fragile Services – further improvements required.	Substantial Monthly oversight at QAC Executive oversight monthly of all fragile services via PSCESC	QAC August 2025
QAC/25/07/084	Mortuary Licenced Activity Biannual Report	The Committee received a report noting 17 recommendations were now fully complaint, It was agreed Ali Kennah Chief Nurse will present this at Trust Board in August 2025. - Human Tissue Authority (HTA) made an unannounced inspection on 16 April 2025. All actions complete and responses have been returned to HTA	Moderate An update in relation to timeframes was requested	Substantive Oversight at QAC Biannually	Update to QAC August 2025

The Committee also received the following items.

QAC/25/07/077 Patient Story

QAC/25/07/080 Board Assurance Framework (BAF)

QAC/25/07/082 Mortality (SHMI)

QAC/25/07/083 Maternity Update
 QAC/25/07/085 QI mental Health Update
 QAC/25/07/086 Infection Prevention and control BAF – Biannual Report
 QAC/25/07/087 Safeguarding Annual Report
 QAC/25/07/088 ED improvement Update
 QAC/25/07/089 Quality Impact Assessment
 QAC/25/07/090 High level enquiries and external assessment/inspections
 QAC/25/07/091 Committees Chairs Annual Report including BAF Annual Review

Assurance Key

Delivery Assurance: Assurance in achieving outcomes.

Governance Assurance: Assurance in the internal controls in place

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

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

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/08/59b (i)	Meeting	Trust Board	Date of Meeting	6 August 2025

Date of Meeting	Wednesday 18 June 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/25/06/048	Hot Topic – Job Planning	Paul Fitzsimmons, Executive Medical Director The Committee received an update on job planning for the Trust, noting that this was a key area of focus for 2025/26 following the launch of the NHSE Medical Job Planning Improvement Programme in September 2024 and letter from the National Medical Director in May 2025. The Committee noted the actions that were required from the letter and the Trust's position on this, including historic job plans across specialities and the work which has been undertaken to ensure compliance. Members noted that once work has been completed to resolve historic job plans, delivery of the targets were achievable and a cultural change to being prospective for job planning was essential.	The Committee received moderate assurance on the delivery of job planning with a positive trajectory to move towards the targets prior to April 2026.	The Committee received substantial assurance on the governance of job planning.	Annual review
SPCIC/25/06/052	Better Care Together Integration Update	Hayley Heard, Deputy Director of Strategy and Partnerships, Michelle Cloney, Chief People Officer, Adam Harrison-Moran, Head of Strategic Workforce Development & Culture	The Committee received substantial assurance on the	The Committee received substantial assurance on the	July 2025

	(Workforce and Corporate Services)	The Committee received an update on the workforce and corporate service integration for the Better Care Together programme. The Committee noted the positive work to enable partnership working with Trade Union representatives across both Trusts and progress to introduce a combined organisational change framework. In addition, the Committee noted progress for the Corporate Services workstream, with a lens on national corporate benchmarking and establishing corporate services for the future organisation. The Committee approved the Better Care Together: Culture Plan, focused on building the culture which brings the workforce across both Trusts together. Members welcomed the work undertaken to date and noted progress would be updated at a future point in the cycle of business.	delivery of the Better Care Together integration programme.	governance of the Better Care Together integration programme.	
SPCIC/25/06/053	Safe Staffing Assurance Report	Ali Kennah, Chief Nurse The Committee received an updated format of the monthly safer staffing report. Members noted the bank rate reductions and support which was being put in place for staff as a result. Members noted regular temperature checks were in place to monitor the impact of the bank rate reduction. The Committee highlighted that the new format allowed for increased triangulation of issues which was positively received.	The Committee received substantial assurance on delivery of the Safe Staffing Assurance Report.	The Committee received substantial assurance on the governance of the Safe Staffing Assurance Report..	July 2025
SPCIC/25/06/055	Report on the Impact of Flexible Working	Adam Harrison-Moran, Head of Strategic Workforce Development & Culture The Committee received a report on the impact of projects which have been focused on improving flexible working and the experience of staff across the Trust. The report noted that there has been an improvement in the WHH Staff Survey results for	The Committee received high assurance on delivery of the flexible working programme.	The Committee received substantial assurance on the governance of the flexible working programme.	Q4 2025/26

		flexible working, with two e-preference rostering pilots commenced in 2025/26. The Committee noted that a review of metrics through a quality, people and sustainability lens had been completed to assess the impact on flexible working and this was demonstrating a positive trajectory. <u>The Committee observed improved staff wellbeing but recognised that limited rostering resources could delay the programme's broader implementation. The Committee noted that discussions were underway to assess and support the rollout, with resourcing needs being scoped.</u>			

Other reports received by the Committee:

- SPCIC/25/06/050 – Chief People Officer Report
- SPCIC/25/06/051 – Workforce Brief on National, Regional, ICB or Local Workforce Issues
- SPCIC/25/06/056 – Health and Wellbeing Update (including the Health and Wellbeing Guardian Report)
- SPCIC/25/06/057 – Improving People Practices Bi-Annual Report (including Employee Relations Data)
- SPCIC/25/06/059 – WHH Committee Chairs Annual Report to Trust Board

Chairs Logs received by the Committee:

- SPCIC/25/06/060 – Workforce Inclusion and Culture Sub-Committee
- SPCIC/25/06/061 – Workforce Review Group

Assurance Key:

Delivery Assurance: Assurance in achieving outcomes

Governance Assurance: Assurance in the internal controls in place

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

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

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/08/59b (ii)	Meeting	Trust Board	Date of Meeting	6 August 2025

Date of Meeting	Wednesday 16 July 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/25/07/071(ii)	Chief People Officer Report	Michelle Cloney, Chief People Officer The Committee received a full update on several workforce priorities including: • WHH as a Placement Provider to the new Chester Medical School • Industrial Action • Delivery Unit (Workforce) Members noted that Resident Doctors will take industrial action from 25 July to 30 July 2025 following a successful ballot. An update was provided to the Committee that steps were being put in place to ensure the effective running of services during this period and a review of risk was being completed. Additionally, members noted that a further update on Physical Associates would be brought to the August 2025 Committee following the release of the	The Committee received moderate assurance on the delivery of industrial action.	The Committee received substantial assurance on the governance of industrial action.	August 2025

		Independent Review of Physician Associates and Anaesthesia Associates (the Leng Review).			
SPCIC/25/07/075	Better Care Together Integration Update (Workforce and Corporate Services)	Hayley Heard, Deputy Director of Strategy and Partnerships, Michelle Cloney, Chief People Officer, Adam Harrison-Moran, Head of Strategic Workforce Development & Culture The Committee received an update on the workforce and corporate services delivery of the Better Care Together integration programme. Notably, the Committee were provided an update on the implementation of the Culture Plan following prior approval at the Committee. The Committee noted that staff networks 'in common' are moving forward with a unified governance arrangement involving Bridgewater Community Healthcare. The Organisational Change Framework is currently undergoing final ratification with staff side partners and is scheduled to be presented to the Committee in August 2025. The Committee noted that a deeper dive into the corporate services workstream will be provided at a future date.	The Committee received substantial assurance on the delivery of the Better Care Together integration programme.	The Committee received substantial assurance on the governance of the Better Care Together integration programme.	August 2025

SPCIC/25/07/076	Safe Staffing Assurance Report	Ali Kennah, Chief Nurse The Committee received the report and discussed the data for April 2025. Members noted that there were key workforce metrics including turnover and sickness rates which remained high for Healthcare Support Workers whilst Nursing sickness had slightly reduced. Members discussed the NHSP bank rate reductions which were further reduced in May 2025 and were provided assurance that this is monitored regularly with escalations via the Workforce Review Group. Discussions focused on the triangulation of intelligence within the report by ward with a deeper dive to be included in the August 2025 paper on Neonatal fill rates.	The Committee received substantial assurance on delivery of the Safe Staffing Assurance Report.	The Committee received substantial assurance on the governance of the Safe Staffing Assurance Report.	August 2025
SPCIC/25/07/077	Bi-Annual Review of Obstetric, Anaesthetic, Neonatal and Q4 Midwifery Staffing	Laura James, CBU Manager The Committee received the paper as part of the bi-annual reporting cycle. The Committee noted the assurance provided in the review with relation to workforce within the maternity and neonatal services. In addition, the members reviewed the outcome of the 2024 Birthrate Plus assessment with assurance that ongoing monitoring of safe staffing levels is in place as per the safety action requirements. The Committee discussed and noted the report, recognising it will be submitted to the Trust Board.	The Committee received substantial assurance on delivery of the Bi-Annual Review of Obstetric, Anaesthetic, Neonatal and Q4 Midwifery Staffing report.	The Committee received substantial assurance on the governance of the Bi-Annual Review of Obstetric, Anaesthetic, Neonatal and Q4 Midwifery Staffing report.	6 Monthly

Other reports received by the Committee:

- SPCIC/25/07/070(ii) – Board Assurance Framework and Corporate Risk Register
- SPCIC/25/07/072 – Workforce Brief on National, Regional, ICB or Local Workforce Issues
- SPCIC/25/07/073(ii) – Workforce Integrated Performance Report
- SPCIC/25/07/078 – Guardian of Safe Working Annual Report

- SPCIC/25/07/080 – Facilities Time Off Annual Report – **approved by the Strategic People Committee in Common**

Chairs Logs received by the Committee:

- SPCIC/25/07/082 – Operational People Committee
- SPCIC/25/07/083 – Workforce Review Group

Assurance Key:

Delivery Assurance: Assurance in achieving outcomes

Governance Assurance: Assurance in the internal controls in place

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

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

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/08/59c (i)	Meeting	Trust Board	Date Of Meeting	6 August 2025

Date of Meeting	23 June 2025
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by John Somers
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up / Review date
FSC/25/06/057	Hot Topic – UEC Improvement and Non-Elective Length of Stay	The Committee received the presentation noting:- • Opportunity of £5.9m based on total non-elective cost multiplied by increased length of stay percentage • Review of specialities undertaken and adjusted for NCTR. Targeted schemes identified which will focus on 5,139 bed days (equates to 14 beds), costed as £2.2m of the £5.9m opportunity • The opportunity is only cash releasing if enough beds can be closed, no CIP recognised in month 1 and month 2 • Older Persons Short Stay Unit (OPSSU) is an area of focus, discharges increasing since opening on 2 June • Key risks include NCTR, cash releasing opportunity, capacity to deliver, system approach requirements and culture change required	The Committee received limited assurance based on progress against plans	The Committee noted and discussed the report receiving substantial assurance around level of detail reported	
FSC/25/06/058	Deep Dive – CBU CIPs	The Committee received the presentation noting:- • £1.7m CIP delivered at month 2 in line with plan, however £0.6m delivered non-recurrently • Planned and Unplanned Care not delivering YTD, forecast delivery not all identified by all Care Groups • The Unplanned Care Group have a gap in terms of WTE reduction and corresponding CIP reduction whereas Planned Care have identified WTE, however the value is below plan.	The Committee received limited assurance based on delivery of CIP plan in particular the level of high risk	The Committee noted and discussed the report receiving moderate assurance given recurrent plans in place are not	

		This is due to WTE being lower banded as well as posts only coming out later in the year - Clinical Support Services have identified WTE and the corresponding value however there is a significant number of non-recurrent posts included with additional review being undertaken to determine if any can be made recurrent - Workforce schemes currently included in the central schemes until identified, then moved to Care Groups, estimates to be included against Care Groups from next month - Productivity schemes are forecasting a lower delivery (£4.8m) compared to the plan (£10m), which is being mitigated by central schemes		delivering to expectations	
FSC/25/06/059	Corporate Performance Report	The Committee received the report noting:- - ED performance, 4 and 12 hours remain a concern - DM01 performance achieved the national standard for the fourth consecutive month (96.24%) - RTT on track to deliver in 2025/26	The Committee received moderate assurance given some metrics are not achieving	The Committee noted the report receiving substantial assurance around level of detail reported	FSC July 2025
FSC/25/06/061	Monthly Productivity Improvement Update	The Committee received the report noting:- - Theatres – Late starts and session utilisation negatively affecting the position - Outpatients improvement – good progress on clinic template work. Endoscopy risk, shortfall in delivery being reviewed by Delivery Unit	The Committee received moderate assurance given the progress that has been made	The Committee received substantial assurance given the plans in place	FSC July 2025
FSC/25/06/063	Cost Pressures	The Committee received the report noting:- - Medical staffing cost pressures (£1.1m) reduces to £0.3m once revenue requests written and approved, Planned Care expected to clear pressures in the next two months, Unplanned Care meetings in place with Medical Director to review overspending areas - Nursing staffing cost pressures (£0.4m) would be mitigated once revenue requests written and approved, mostly enhanced care driving the overspending areas.	The Committee received limited assurance based on the continued overspend on cost pressures	The Committee noted and discussed the report receiving moderate assurance of the ongoing review	FSC July 2025

FSC/25/06/066	Cash Position Update	The Committee received the report noting:- • Cash support required from September 2025 • Correspondence received from ICB that deficit support funding not to be received for Q2, cash support still only required from September 2025, expected that more cash will now be required later in the year • Actions have been taken to maintain cash position leading to negative impact on BPPC • Cash management measures continues to be in place	The Committee received moderate assurance due to the Trust financial position and inevitable requirement of cash support.	The Committee noted the paper receiving substantial assurance	FSC July 2025
FSC/25/06/067	Monthly Finance position – month 2	The Committee received the report noting:- • Month 2 deficit position is on plan at £9.3m (before deficit support) • CIP delivered in month 2 although £0.6m is non recurrent • Activity income plan in month 2 was not achieved • The process and timetable associated with the National Cost Collection (NCC) which will be reported to Trust Board for approval • PwC feedback not yet received • BPPC low due to cash management measures in place	The Committee received limited assurance recognising achievement of plan to date but risk of overall plan delivery	The Committee noted the paper receiving substantial assurance	FSC July 2025
FSC/25/06/069	Capital Position Month 2 Schemes over £500k	The Committee received the report noting:- • M2 spend of £0.39m, broadly in line with the Trust plan. • Movement in capital contingency, removal of the oversubscription and Ward A8 prioritised in the 2026/27 capital plan was approved • Risk highlighted that backlog maintenance has been brought forward to mitigate underspend of the Ward A8 scheme, which limits the ability to do this later in the financial year • TIF – there is a delay in the theatre 3 scheme, completion now expected mid September, however recovery area hand back delayed by 6 weeks. Mitigation of delay to be achieved via 7 day working at no additional cost.	The Committee received moderate assurance due to spend being behind plan.	The Committee noted the position receiving substantial assurance, approved the contingency and oversubscription changes and ringfenced Ward A8 in the 2026/27 programme	FSC July 2025

Items for noting

FSC/25/06/060 Monthly CIP Update

FSC/25/06/062 Recovery Update
 FSC/25/06/064 Pay Assurance
 FSC/25/06/065 Integration Update
 FSC/25/06/068 Revenue request – none this month
 FSC/25/06/070 Digital Strategy Group Update
 FSC/25/06/071 EPRR Group minutes

Assurance Key:

Delivery Assurance: Assurance in achieving outcomes

Governance Assurance: Assurance in the internal controls in place

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

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

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/08/59c (ii)	Meeting	Trust Board	Date Of Meeting	6 August 2025

Date of Meeting	28 July 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/2 5/ 07/06	Deep Dive – 65 Weeks and UEC	The Committee in Common received the presentation noting:- 4 key metrics are being tracked No-criteria to reside (NCTR) - Looking at the East Lancs nurse led electronic triage tool which uses an algorithm system that directs patients to the right service. A bid has been submitted to North West Regional Transformational Fund for the electronic triage tool. - WBC Intermediate Care At Home Service (ICAHT) was suspended for July 25 due to sickness and quality improvement work within the team and negatively impacting increasing NCTR. - Requirement to re-establish System Sustainability Group to manage system wide issues. AED 12 hour performance – 62% are waiting to be admitted to the bed base. Decisions Discharge Unit (DDU) launched on 28th July. All actions expected to lead to a reduction of 43 breaches per day (16% performance improvement). Ambulance handover time – Significant improvements through refocus with NWS colleagues including 45 minute handover project which will officially launch on 1st August. Time to Triage - implementing Manchester Triage System since April 2024 – average is now 23.36 minutes	The Committee in Common received moderate assurance based on progress against plans	The Committee in Common noted and discussed the report receiving substantial assurance around level of detail reported	FSPCiC August 2025

		65 week wait – C&M ICB target of zero by the end of August. Forecast to be 47 at the end of August as best case or 67 in worst case depending on the impact of industrial action. Continue to use mutual aid and insourcing to mitigate risks in particular Max Fac and T&O.			
FSPCiC/2 5/ 07/07	Monthly CIP Updates – Month 3	The Committee in Common received the report noting:- £2.5m CIP delivered at month 3 in line with plan, however £0.9m delivered non-recurrently. FYE of these schemes will ensure recurrent delivery - Progress has been made in regard to CIP plans maturity with 59% submitted on 10 July which has increased to 64% at the last submission. This was a focus at the PwC meeting and a target of 75% by next week has been set. This target is expected to be achieved. - Income performance at month 3 is 97% at flex position, therefore, no cash releasing efficiencies have yet been realised in relation to the elective improvement productivity schemes. £12m stretch target – ICS still expects the Trust to fully deliver. A list of suggested schemes has been provided by ICS. The list will be reviewed by the Executive Team. - The Delivery Unit is holding people to account to deliver actions in a timely manner.	The Committee in Common received limited assurance based on delivery of CIP plan in particular the level of high risk	The Committee in Common noted and discussed the report receiving moderate assurance given recurrent plans in place are not delivering to expectations	FSPCiC August 2025
FSPCiC/2 5/ 07/09	Cash Support Update	The Committee in Common received the report noting:- - Q2 deficit support funding of £4.8m has been withheld - Support for cash support request of up to £5.087m for September acknowledging the risk that NHSE may not approve the cash support request - Support for the Cash Preservation MOU issued by ICB - Support for mitigation option 1 (delay payment to NHS Supply Chain and NHS Professionals) and mitigation option 2 (delay payment to HMRC) if required.	The Committee in Common received moderate assurance due to the Trust financial position and requirement for cash support.	The Committee in Common noted the paper receiving substantial assurance and supported both the cash support request and the cash preservation MOU for Trust Board approval.	Trust Board August 2025
FSPCiC/2 5/ 07/10	Finance Report	The Committee in Common received the report noting:- Month 3 deficit position is on plan at £13.5m (before deficit support).	The Committee in Common received limited assurance	The Committee in Common noted the paper receiving	FSPCiC August 2025

		- Agency spend is below plan, however bank spend is above plan due to medical vacancies. - Risk adjusted forecast excluding deficit support funding has been submitted at a £46.8m deficit. Included £10.8m level 3 CIP, risk assessed CIP delivery based on PFR percentages of £6.0m, £0.5m PDC dividend increase and £0.8m estimated industrial action costs.	recognising achievement of plan to date but risk of overall plan delivery	substantial assurance	
FSPCiC/2 5/ 07/16	Capital Expenditure	The Committee in Common received the report noting:- - Increase in CDEL of £2m for UEC capital however there is a risk as it is not cash backed and would require capital cash support. - M3 spend of £0.63m, £1.1m behind the Trust plan – expected to catch up later in the year. - Supported and approved the movement in capital contingency.	The Committee in Common received moderate assurance due to spend being behind plan.	The Committee in Common noted the position receiving substantial assurance, approved the contingency changes	FSPCiC August 2025
FSPCiC/2 5/ 07/17	Corporate Performance Report	The Committee in Common received the report noting:- - ED performance, 4 and 12 hours remain a concern - DM01 performance achieved the national standard for the fifth consecutive month (96.14%). - RTT has a slight improvement from last month. - Cancer 62 day – improvement to 80.8%. 28 day Faster Diagnosis has worsened slightly to 72%	The Committee in Common received moderate assurance given some metrics are not achieving	The Committee in Common noted the report receiving substantial assurance around level of detail reported	FSPCiC August 2025

Items for noting

<i>FSPCiC/25/07/08</i>	<i>Cost Pressures</i>
<i>FSPCiC/25/07/11</i>	<i>WHH Pathology Hub financial business case (supported for approval by Trust Board)</i>
<i>FSPCiC/25/07/12</i>	<i>WHH UTC (supported for approval by Trust Board)</i>
<i>FSPCiC/25/07/13</i>	<i>WHH CDC Phase 4 (supported for approval by Trust Board)</i>
<i>FSPCiC/25/07/14</i>	<i>WHH Revenue Requests – none this month</i>
<i>FSPCiC/25/07/15</i>	<i>Emergency Preparedness Annual Report (EPRR) and Bi-Annual Update</i>
<i>FSPCiC/25/07/16</i>	<i>Schemes over £500k and CPG Annual Report</i>
<i>FSPCiC/25/07/19</i>	<i>Monthly Productivity Update</i>
<i>FSPCiC/25/07/20</i>	<i>WHH Elective Recovery Update</i>
<i>FSPCiC/25/07/21</i>	<i>Reports / minutes from the Delivery Unit</i>
<i>FSPCiC/25/07/26</i>	<i>EPRR Group minutes</i>
<i>FSPCiC/25/07/27</i>	<i>FSC Chairs Annual Report</i>
<i>FSPCiC/25/07/28</i>	<i>Board Assurance Framework and Corporate Risk Register</i>

Assurance Key:

Delivery Assurance: Assurance in achieving outcomes

Governance Assurance: Assurance in the internal controls in place

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

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

Trust Board: Committee Assurance Report

Agenda Reference	BM/25//08/59(d)	Meeting	Trust Board	Date Of Meeting	6 August 2025

Date of Meeting	12 June 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/25/06/004	Charity Impact Story	The committee heard an impact story from Laurence Barrow of Barrow Electrical Ltd, a long-standing corporate charity supporter and former ICU patient who has benefited from WHH Charity.	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	Sept 2025
CFC/25/06/005	Fundraising Report and Quarterly Workplan	CFC noted the quarterly fundraising report, including updates on key campaigns, a £65k donation to the Willow Tree Hub Appeal, discussions with community and corporate partners, and progress against the charity's three-year strategy. Lead: Kate Henry	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 the Charity leadership team meets regularly	Sept 2025
CFC/25/06/006	Finance Report Q4 Update	CFC noted the financial position for The financial position for quarter 4 (1 January to 31 March 2025) and the year ending 31 March 2025 is as follows: Income is £33k below plan in quarter 4 and £56k above plan for the year ending 31 March 2025.	The Committee received substantial assurance as	The Committee received high assurance as sufficient processes and	Sept 2025

		- Expenditure (overheads) is £4k below plan in quarter 4 and £2k below plan for the year ending 31 March 2025. - Expenditure (disbursements of funds) is £29k in quarter 4 and £134k for the year ending 31 March 2025. - The net fund balance is £609k. - The balance after commitments for purchases, reserves and overheads is £243k, this has increased from £160k as at 31 March 2024. Lead: Tina Littler	income is above plan	reporting are in place	
CFC/25/06/007	Bridgewater Charitable Funds Agreement	CFC approved a service specification setting out the agreement between WHH Charity and BCH. It explains that the Trust will manage one 'community fund' on behalf of BCH, in accordance with existing charity governing arrangements and policies. Lead: Heather Farrington	The Committee received substantial assurance that arrangements will be sufficient until WHH/BCH become one organisation	The Committee received high assurance as the agreement is proportionate and in line with existing governance arrangements	March 2026
CFC/25/06/008	Bid Applications	Two bids were approved by CFC linked to previously approved campaigns: £200k for the Willow Tree Hub appeal £20k for the Ophthalmology Sensory Garden appeal Both bids were to ringfence funds as they are generated for these campaigns, to allow project implementation to commence. Funds will only be spent up to the value that income has been generated for these appeals. An update was provided on bids under £5k approved since the last committee meeting, either by the director of communications and engagement (up to £1k) or by EMT (up to £5k). Lead: Kate Henry	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	Sept 2025

No additional reports were received at the June Committee meeting, in line with the cycle of business.

Assurance Key:

Delivery Assurance: Assurance in achieving outcomes

Governance Assurance: Assurance in the internal controls in place

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

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

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/08/059e	Meeting	Trust Board	Date Of Meeting	6 August 2025

Date of Meeting	23 June 2025
Name of Meeting & Chair	Audit Committee (YEAR END), 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/25/06/27 & AC/25/06/28	External Auditor's Findings Report 2024/25 & Annual Report	The Committee received the report, which summarised the key findings and other matters arising from the statutory audit of the Trust and the preparation of the Trust's financial statements for the year ended 31 March 2025 for those charged with governance. The committee also received the Auditor's Annual Report for the year ended 31st March 2025 - The Committee received and discussed the report which highlighted on key recommendation.	Substantial – The Committee received substantial assurance	Substantial – it was evidenced that the Trust had substantial Governance systems and processes in place	Lay before Parliament – July 2025
AC/25/06/29	Annual Report	The Committee received final audited version of the WHH Annual Report & Accounts for 2024/25	High – the Committee approved the Annual Report to be laid before Parliament	High - the Committee received high assurance on the completion of the Annual Report	Annual Members Meeting
AC/25/06/30	Quality Account	The Committee received report, it was explained that In line with legal requirements, Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce and publish their Quality Accounts for the 2024/25 by 30 June 2024.	High – the Committee approved the Quality Account for publication on the Trust's website	High - the Committee received high assurance on the completion of the Quality Account	n/a

AC/25/06/31	Final Audited Accounts & Financial Statements	The committee received the Accounts & Financial Statements, and it was noted that the Audit had not yet concluded. The Committee were advised of the amendments made since the presentation of the draft versions in April 2024. The Committee agreed that should there be any additional changes that do not impact on the draft audit opinion, the Audit Committee would be asked to support approval of any further amendments on the committee's behalf by the Chair of the Audit Committee and disclosed to the committee by email.	Substantial – the Committee approved the Annual Accounts pending any significant findings.	High - the Committee received high assurance on the completion of the Annual Accounts	Annual Members Meeting

Other agenda items:

AC/25/06/33 – Code of Governance Compliance & Licence Annual Return

AC/25/06/34 – Fit & Proper Persons Test 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

REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/25/08/60																																						
SUBJECT:	Fragile Clinical Services																																						
DATE OF MEETING:	6 August 25																																						
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	<i>Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</i> <table border="1"> <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>			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:			
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 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		
PURPOSE: (please select as appropriate)	Approval	To note ✓	Decision
RECOMMENDATION:	Trust board is asked to: • Note the current list of Fragile Services, associated clinical risk and high-level progress updates • Note 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 • Note the improving position in Cardiology with an intention to deescalate from fragile services oversight in the coming weeks • Receive further Fragile Service Oversight reports		
PREVIOUSLY CONSIDERED BY:	Committee	Choose an item.	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: (if relevant)	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Fragile Services Oversight	AGENDA REF:	BM/25/08/60

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

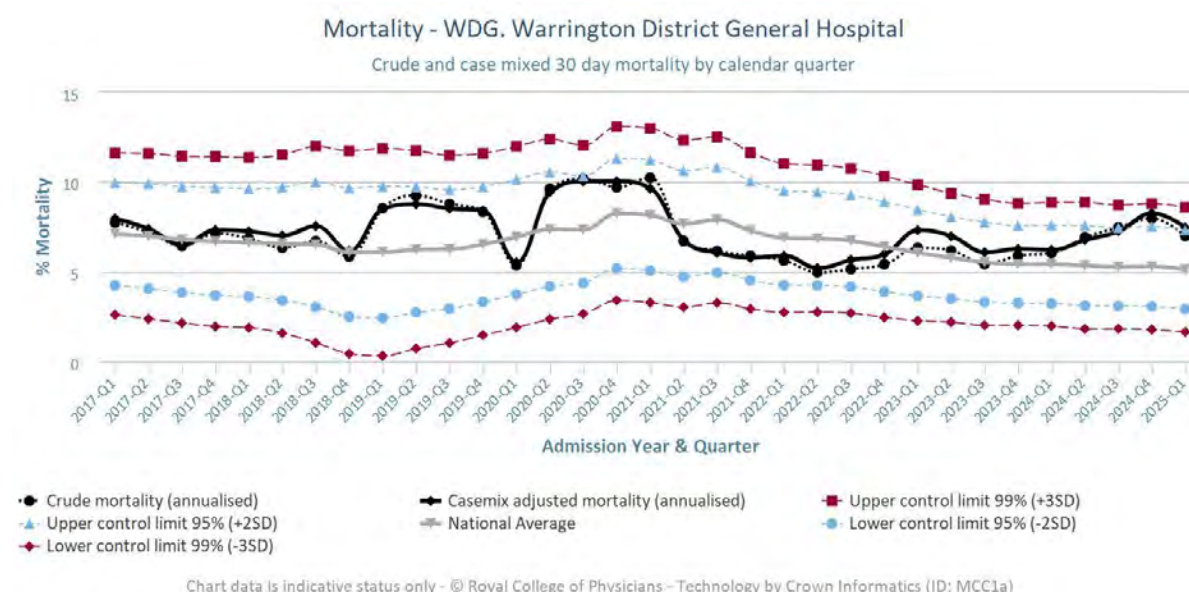
Prompt surgery and prompt mobilisation remain an unresolved quality and performance issue. Emergent risk around Orthogeriatric review and medical support now resolved

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

Latest data reported (Q1 2025) shows 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.

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 likely 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 remains static
- P3 & P4 waiting lists show an overall positive reducing trend – however recent increases in both have been noted
- Transperineal prostate biopsy position shows sustained improvement, with (sustained reduction in undated waiting list patients from >120 to <10)
- Surveillance cystoscopy position very significantly improved from peak, with waiting list now fewer than 25 patients (from a peak >200)
- Tier 2 doctor staffing issues remain a significant challenge

Completed Actions

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

Current mitigations

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

Ongoing improvement plan actions:

- o Urology Cancer Deep Dive output – MDT and surveillance improvement work required – underway as part of cancer improvement plan
- o Urology Specialty/Tier 2 Doctor requires additional support to move to independent practice – plan in place
- o Discussion with Chester regarding future of PCNL list
- o CD and AMD to develop sustainability plan

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

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

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
- Automated referrals/upgrades of malignancy identified via histology results

Ongoing improvement plan actions:

- Complete standardisation of Cancer MDTs across Trust
- Assurance audits of cancer escalation and cancer tracking effectiveness
- Scoping for automation of referrals/upgrades from radiology reports
- Mapping and baseline assessment of each tumour site specific cancer surveillance pathway
- 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 plan for management of ‘Awaiting Results’ patient access plan backlog**

- 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
 - o Task and finish group established
 - o Fixed term consultant appointed to vacant post
 - o Job planning process completed – supported by MD
 - o Band 7 physiologist post recruited to
 - o WatchPat device introduction has reduced formal sleep study demand and workload
 - o Revenue request for additional consultant completed – funded by job planning efficiencies and WLI reduction – delivers CIP
 - o ‘Awaiting Results’ access plan management SOP developed and progressing through governance to ratification
- Current mitigations
 - o Cardiology vacancy recruited to
 - o Successful recruitment into the Assistant Technical Officer posts resulting in a reduction in spirometry wait
- Ongoing improvement plan actions:
 - o Complete 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
- Note the improving position in Cardiology with an intention to deescalate from fragile services oversight in the coming weeks
- Receive further Fragile Service Oversight reports

REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/25/08/61	
SUBJECT:	Mortuary Licensed Activity Bi-Annual Report (Including Fuller update)	
DATE OF MEETING:	6 August 2025	
AUTHOR(S):	Gemma Jenkins, Histopathology Manager and Hilary Stennings, Associate Director for CSS	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse	
LINK TO STRATEGIC OBJECTIVE: <i>(Please select as appropriate)</i>	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): <i>(Please DELETE as appropriate)</i>	224 If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival resulting in an overcrowded Emergency Department. 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. 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. 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	<i>Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</i>			
	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 outlines HTA related recommendations and actions, which Mortuaries must be compliant for, from the previous 2 years. Report was previous submitted in January 2025. This report is an update to include HTA inspection non-conformances, both now closed, awaiting further HTA feedback. There has been significant improvement on last report with a total of 7/94 partially compliant actions remaining. No major concerns raised. Details of compliance summary in the key elements and full details in the appendices. Appendices are not included in this report and are available to board members on request. These appendices were presented to the Quality Assurance Committee in detail for assurance on – 8 July 2025.			
PURPOSE: (please select as appropriate)	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.	BM/25/08/61		
	Date of meeting	8 July 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	Mortuary Licensed Activity Report (Including Fuller update)	AGENDA REF:	BM/25/08/61

1. BACKGROUND/CONTEXT

On 28 November 2023, Sir Jonathan Michael, Chair of the Independent Inquiry into the issues raised by the actions of David Fuller, published the Phase 1 Report. This phase of the Inquiry was to establish what happened in the Maidstone and Tunbridge Wells NHS Trust to allow Fuller to commit such awful crimes and to understand how his offending remained undetected for so long. The national regulatory framework and its effectiveness will be reviewed in Phase 2 of the Inquiry.

Following the report there were 17 recommendations made to Maidstone and Tunbridge Wells NHS Trust, anticipated to be actioned by NHS organisations with Mortuary or body store facilities with the aim to prevent this happening again.

A regular update of our compliance will be presented to trust board via this committee.

November 2023, a gap analysis was conducted against the report recommendations, of the 17 recommendations WHH required 8 corrective action to provide compliance.

Since January 2024 monthly Mortuary Meetings have been held with Human Tissue Authority as a standing agenda item. Persons designated and the Trust Designated Individual attends the meetings to report/record on any findings. No major concerns have been raised to date. Mortuary monthly minutes or matters arising are also sent to Clinical Support Services (CSS) meeting for review.

13 August 2024 – HTA emailed to state inspections will be unannounced from Sept 24 and provided a list of 71 types of documents/evidence they may wish to see upon inspection. A gap analysis was performed, see update below.

14 August 2024 – HTA emailed in response to a security questionnaire which had been submitted prior with 4 security recommendations received, 1 compliant and 3 partially compliant. Please see update below.

15 October 2024 – Phase 2 interim report published, specifically for funeral sector – no further actions for the mortuary. Awaiting further publications.

10 December 2024 – Confirmation that all new licence holders now registered accordingly with the HTA.

16 April 2025 – Unannounced inspection conducted. Report issued 16 May 2025. Generally, very positive feedback, 2 minor non-conformances found to do with consent See appendix 4. Corrective action to be submitted by 30 June 2025 by Gemma Jenkins.

2. KEY ELEMENTS

On 3 October 24, a meeting took place between Ali Kennah (Chief Nurse) Paul Fitzsimmons (Medical Director), Hilary Stennings (Associate Director for CSS) and Gemma Jenkins (Histopathology Manager) to discuss mortuary compliance matters –

Update as follows

HTA inspection May 2022, licence maintained.

- All findings now compliant and closed.

Fuller enquiry, Phase 1 recommendations WHH compliance (Appendix 1, updated Jan 25):

- 17/17 Compliant, still awaiting phase 2 report for any further recommendations.

Unannounced inspections gap analysis findings (Appendix 2, reviewed 19/6/25):

Progress of 17 actions now compliant, reduction from 21 to 6 partial compliances still remain. No longer any non-compliances.

- 66/71 Compliant,
- 6/71 Partially compliant – mostly involve audits/minor modifications to documentation all in progress. 1 is a repeat of the partial compliance for security below.

Security recommendations (Appendix 3, last reviewed 19/6/25)

Progress with 3 /4 now compliant.

- 1 Partially complaint - involving lone worker device activation.

HTA unannounced inspection performed 16 April 2025 (Appendix 4, update 23/6/25)

All procedures and documentation listed in the gap analysis were reviewed.

- 2 Non-conformances raised. Both now actioned and sent back to HTA for further feedback.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Trust Histopathology Manager and Mortuary Manager are making changes to documentation as required and regularly review progress of the gap analysis for unannounced inspections and the security recommendations.

Continue to monitor Fuller enquiry phase 2 report release and assets if any further action is required.

To reach further compliance against the Fuller recommendations, the Trust should consider how to proceed with:

- Periodic review of DBS checks for all staff who enter/work within the mortuary.

4. RECOMMENDATIONS

The Trust Board is asked:

- To note the current compliance of the Fuller Recommendations understanding they are recommendations and not covered to date by HTA requirements
- Continue with Biannual report to QAC for updates.
- To progress the report to Trust Board of Directors in order to demonstrate compliance of mortuary activity

Appendices available on request

REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/25/08/62			
SUBJECT:	Risk Management Strategy Annual Report 2024/25			
DATE OF MEETING:	6 August 2025			
ACTION REQUIRED:	The Borad of Directors are asked to note the contents of this paper.			
AUTHOR(S):	Catherine Umbers, Deputy Director of Integrated Governance, Nicola Edmondson, Associate Director of Governance			
EXECUTIVE DIRECTORS SPONSOR:	Ali Kennah, Chief Nurse			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	Patients	Workforce	Public
			✓	
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	Yes	No	N/A
				✓
	Further Information / Comments:			
EXECUTIVE SUMMARY:	Warrington and Halton Hospitals NHS Foundation Trust is committed to a Risk Management Strategy which aims to minimise risk to all its stakeholders, through a comprehensive system of internal control. Accordingly, the Trust takes an integrated approach to Risk Management across the organisation, which incorporates all risks. This report provides an overview of the Risk Management Strategy, which aims to minimise risk to all its stakeholders, through a comprehensive system of internal control. • Accordingly, the Trust takes an integrated approach to Risk Management across the organisation, which incorporates all risks. • Various levels of risk registers are in place and are actively managed and reviewed by identified leads, Care Groups and their associated Clinical Business Units. • A full review of all Clinical Business Units risk registers took place in 2024/25. • A full review of the Corporate Risk Register took place in 2024/25. • A full review of longstanding high risk took place in 2024/25			

- A monthly Risk Review Group Meeting takes place and is chaired by the Chief Nurse or Deputy Chief Nurse/Director of Governance.
- Risk awareness sessions held
- Strengthened oversight at the monthly Risk Review Group Meetings
- Updated risk module in Datix, enabling process improvements
- Updated Risk Management Policy and Procedure
- Updated Risk Management Strategy

The revised Risk Management Strategy details the framework which defines the Trust's governance arrangements in terms of the way the Trust leads, directs and controls risks to its key functions, to support the Trust strategic objectives and comply with Health and Safety legislation, its Provider License, CQC regulations and NHS Constitution commitments, all of which are interlocked.

The revised Trusts Risk Management Policy and Procedure aligns with the Risk Management Strategy, with the aim to minimise risk to all stakeholders through a comprehensive system of internal control. This policy and procedure provides practical guidance on process and procedure for managing risk within the Trust.

The Trust accepts that it carries risks that have the potential to cause harm to patients, staff and the public or loss of its assets and reputation if not effectively managed and controlled. The Trust further accepts that the nature of health care services means that some risks cannot be eliminated entirely. Fundamentally it is essential that the Trust has good risk management systems and processes in place, which eliminate risk where possible and reduce the impact of those risks that cannot be eliminated to a tolerable level.

The Trust is committed to understanding the causes of risks that may impact on the organisation's achievement of its stated strategic objectives and addressing the issues to prevent risk from occurring, thereby improving the quality, safety, and effectiveness of the services we provide. To achieve this, we will apply a proactive risk-based approach to all aspects of our undertakings, activities, and condition of our estate. This will be achieved using the Trust's risk assessment methodology as a tool to identify potential hazards and any associated risks to ensure appropriate control measures are identified and implemented, to either eliminate or mitigate risks as far as is reasonably practicable.

PURPOSE: (please select as appropriate)	Approval √	To note	Decision
RECOMMENDATION:	The Board of Directors are asked to note the contents of this paper.		
PREVIOUSLY CONSIDERED BY:	Committee	Quality Committee	
	Agenda Ref.	QAC/25/03/262	
	Date of meeting	31 July 2025	
	Summary of Outcome	Approved	
NEXT STEPS: <i>State whether this report needs to be referred to at another meeting or requires additional monitoring</i>	Submit to Trust Board		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: <i>(if relevant)</i>	Section 41 – confidentiality		

REPORT TO TRUST BOARD

SUBJECT	Risk Management Strategy	AGENDA REF	QAC/25/08/62

1. KEY ELEMENTS

2.1 Introduction

The management of risk is achieved by ensuring an effective Governance Framework is in place and embedded fully across the organisation.

WHH acknowledges, a robust risk management system will have a positive impact on service delivery and therefore ensure the safety of all patients, visitors and staff.

The Trust has made improvements to strengthen this process over the past 12 months by:

- A full review of all Clinical Business Units risk registers took place in 2024/25.
- A full review of the Corporate Risk Register took place in 2024/25.
- A full review of longstanding high risk took place in 2024/25.
- A monthly Risk Review Group Meeting takes place and is chaired by the Chief Nurse or Deputy Chief Nurse/Director of Governance.
- Strengthened oversight at the monthly Risk Review Group Meetings.
- Risk awareness sessions held.
- Updated Risk Management Policy and Procedure.
- Updated Risk Management Strategy.
- The DATIX risk module has been updated to enable the following improvements.
 - Notification emails sent out to relevant people when high risks are logged.
 - Changes to the initial risk form to enable the risk gradings to be undertaken in first instance rather than on review.
 - Risks now have a risk owner as well as a risk manager.
 - All high Risks have an accountable executive.
 - Enhanced oversight. Risk reports with open actions are circulated monthly. to Care Groups leads with an overview of current risks open.

2.2 Risk Management Strategy

The Risk Management Strategy has been revised, this details the framework which defines the Trust's governance arrangements in terms of the way the Trust leads, directs and controls risks to its key functions, in order to support the Trust strategic objectives and comply with Health and Safety legislation, its Provider License, CQC regulations and NHS Constitution commitments, all of which are interlocked.

The Trust accepts that it carries risks that have the potential to cause harm to patients, staff and the public or loss of its assets and reputation if not effectively managed and controlled. The Trust further accepts that the nature of health care services means that some risks cannot be eliminated entirely. Fundamentally it is essential that the Trust

has good Risk Management systems and processes in place, which eliminate risk where possible and reduce the impact of those risks that cannot be eliminated to a 'tolerable' level.

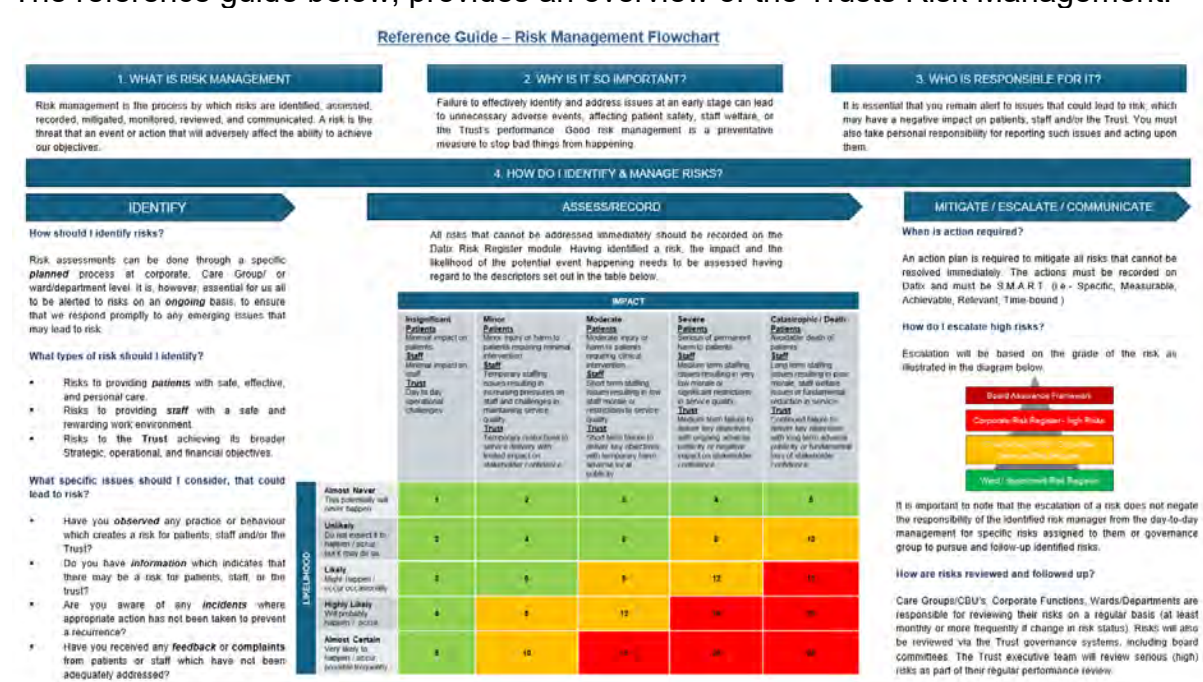
The Trust is committed to understanding the causes of risks that may impact on the organisation's achievement of its stated strategic objectives and addressing the issues to prevent risk from occurring, thereby improving the quality, safety, and effectiveness of the services we provide. To achieve this, we will apply a proactive risk-based approach to all aspects of our undertakings, activities, and condition of our estate. This will be achieved using the Trust's risk assessment methodology as a tool to identify potential hazards and any associated risks to ensure appropriate control measures are identified and implemented, to either eliminate or mitigate risks as far as is reasonably practicable.

2.3 Risk Management Process

There is a clear risk management process embedded across the Trust. The Risk Management Policy and procedure has been updated and aligns with the Risk Management Strategy, with the aim to minimise risk to all stakeholders through a comprehensive system of internal control.

The policy and procedure provide practical guidance on the process and procedure for managing risk within the Trust.

The reference guide below, provides an overview of the Trusts Risk Management.



2.4 Risk Registers

Wards/department, Care Groups and Corporate Service Risk Registers (repository of risks) are in place and reflect 'live' records that support safety and sound risk

management. They contain all unresolved risks identified to services (both clinical and non-clinical). Reported risks on Datix contain:

- Date risk first identified
- Date of last review
- Trust objective
- CQC domain
- Risk cause
- Risk description
- Risk impact/consequences
- Current controls in place
- Current gaps
- S.M.A.R.T actions to address gaps
- Initial risk rating
- Current risk rating
- Target risk rating
- Expected review date
- Risk manager
- Risk owner
- Assurance

Risks are described clearly to ensure there is a common understanding by stakeholders of the risk.

2.5 Assurance

- Risks are managed and reviewed to assure both operational and strategic objectives are being met.
- The Board Assurance Framework (BAF) is submitted to the Trust Board of Directors at each Board Meeting, bi-monthly and has additional monitoring via Board Assurance Committee
- Any risk scoring 15 or above is escalated to the Corporate Risk Register and with agreement of relevant executives would be recommended as appropriate these risks being added to the BAF.
- The Trust Executive Team reviews high risks as part of their regular performance reviews.
- The Trust can be assured that risks are being mitigated and/or escalated when required with oversight of this taking place at the Risk Review Group.
- The Trust has sight of all levels of risk which are monitored and reviewed through the appropriate structures in place.
- There is an escalation process in place to ensure that risks are placed on the most appropriate risk register. Any risks escalated or de-escalated from the BAF or Corporate Risk Register is done so via the recommendation of the appropriate Committee.

2.6 Risk Review Group

The Risk Review Group takes place monthly to oversees the recording and monitoring of risk registers within the Trust. The meeting and attendance representation has been

reviewed with all Care Groups and Corporate Services attending the meeting on a 12-month rolling programme. The Risk Review Group scrutinises risks scoring 12 and above.

The Corporate Risk Register reports are presented at each meeting. The Board Assurance Framework is presented at the meeting on a bi-monthly basis.

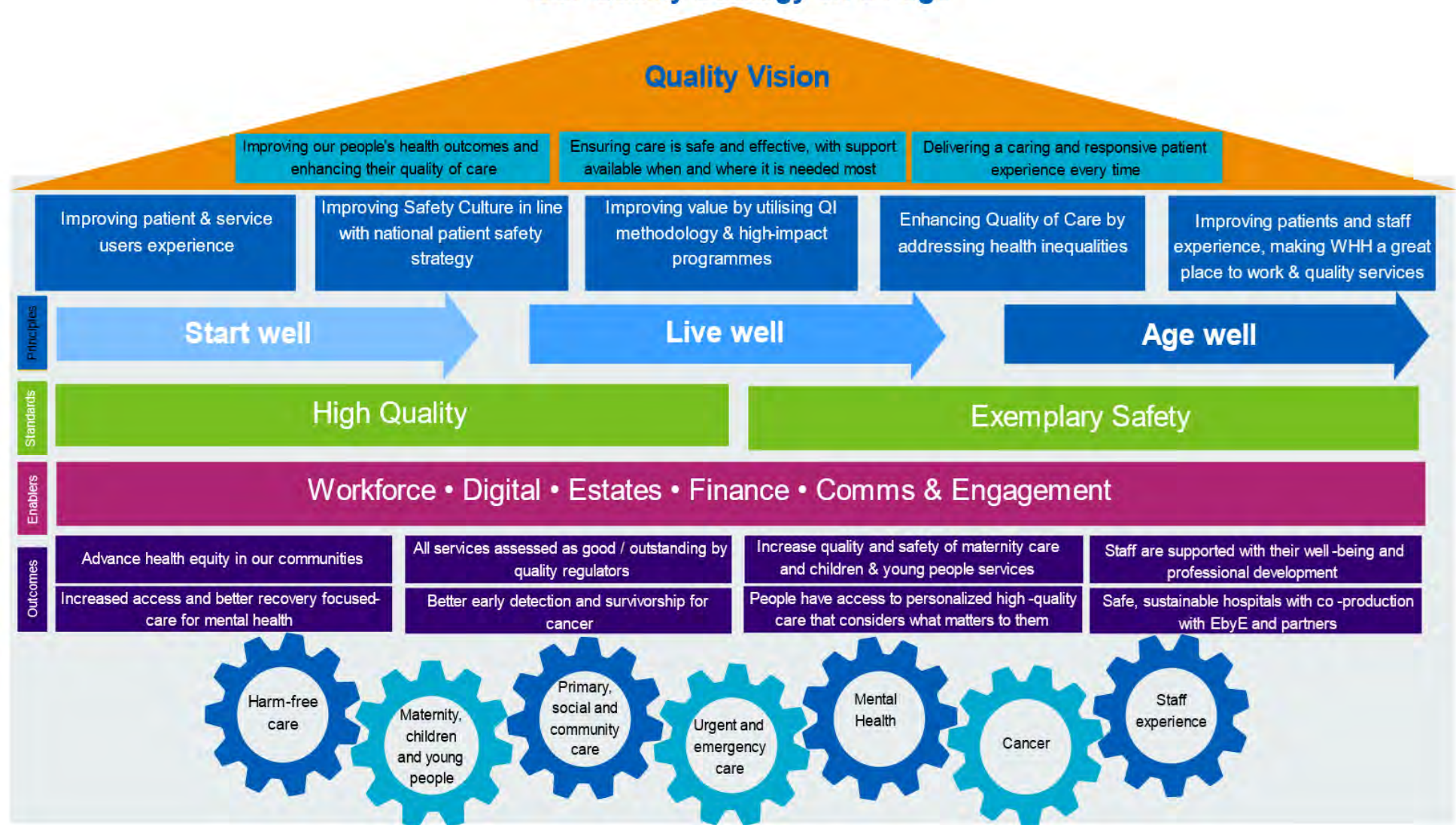
3 Actions for 2024/25

- Embed the revised Risk Management Strategy and Policy
- Executive Led Risk Summit to be held in Q2.
- Risk Training Needs Analysis and associated training programme to be developed.
- Full review of all risk registers with the Care Group and Corporate Heads of Services
- Further review of the Datix Risk Module, enabling risks to be aligned with the CQC domains, this supporting enhanced focus on areas of risk.

4 RECOMMENDATIONS

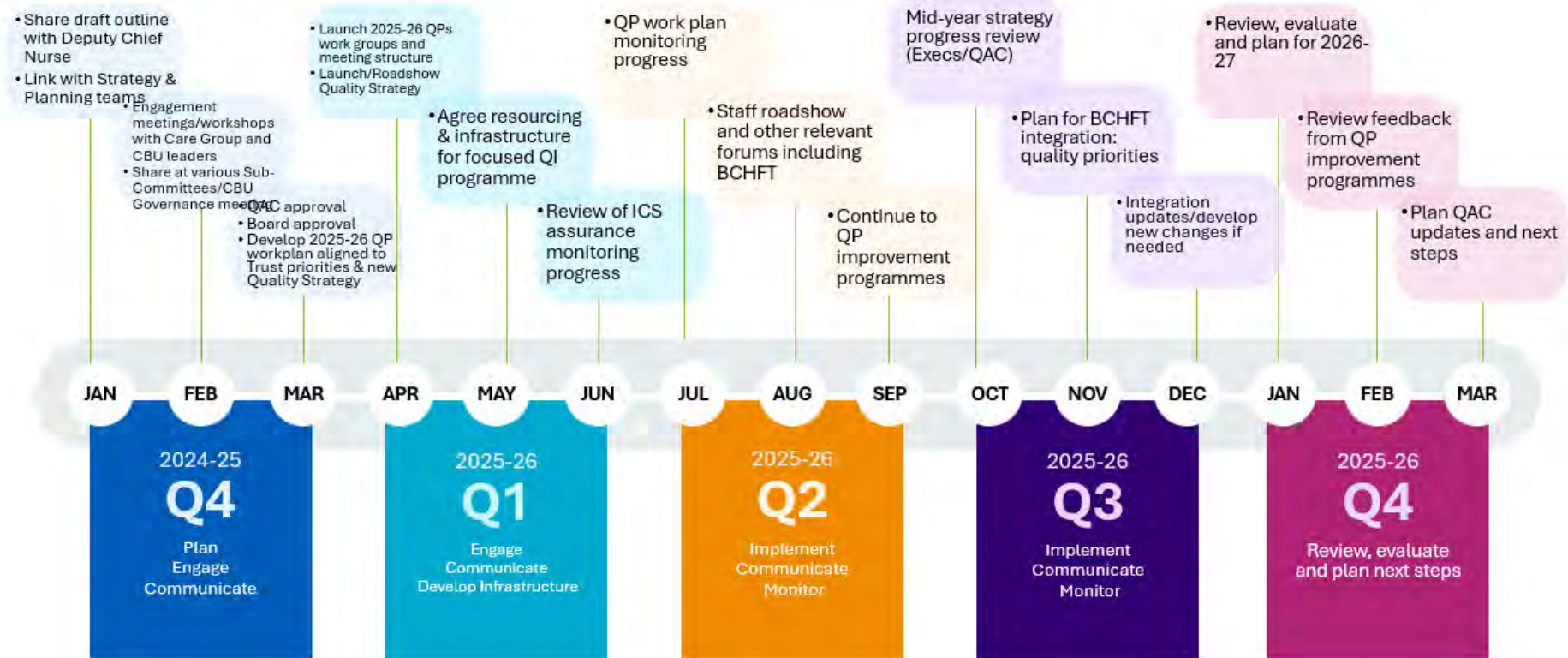
The Board of Directors are asked to receive, note the information contained in this paper and approve the approach to the Quality Strategy and the Quality Priorities.

Our Quality Strategy on a Page



Delivering Quality Strategy:

Quality Strategy engagement High Level Plan



Risk Management Strategy			
Lead Executive	Chief Nurse		
Author's Details	Catherine Umbers, Deputy Director of Integrated Governance		
Type of Document	Strategy		
Target Audience	All Trust staff		
Document Purpose	The purpose of this strategy is to detail the framework which defines the Trust's governance arrangements in terms of the way the Trust leads, directs and controls risks to its key functions, in order to support the achievement of its strategic objectives and comply with Health and Safety legislation, its Provider License, CQC regulations and NHS Constitution commitments, all of which are interlocked.		
Ratification Meeting		Date of Mtg	
Approval Meeting	Quality Assurance Committee	Date of Mtg	
Implementation Date		Review Date	
WHH documents to be read in conjunction with all Trust			
Risk Management Policy and Procedure (linked to Risk Management Strategy)			
All Trust Policy Documents			
Document change history			
Version	2		
What is different?	Complete rewrite		
Appendices/electronic forms	Appendix 1 Committee and Groups Governance Structure Appendix 2 Board Assurance Committees Appendix 3 Risk Appetite for NHS Organisations – Matrix to support better sensitivity in decision making. Appendix 4 Equality Analysis Impact Assessment		
What is the impact of change?	This Strategy and supporting risk management policy and procedure supports effective strategic and operation management of risk. It establishes a framework and approach for identifying, assessing, and mitigating risks to ensure the delivery of safe, high-quality patient care and the achievement of organisational objectives. It aims to integrate risk management into all levels of the organisation, fostering a culture where risk awareness informs decision-making and accountability and responsibility is clear.		
Training Requirements	Refer to section 11 p12		
Does your document contain any medicine information? Please indicate what	No		

pharmacist you have liaised with?			
Keywords			
Taxonomy	Type	Policy Category non-clinical	Policy Category clinical
	Non-Clinical	Integrated Governance & Risk	Choose an item.

Statement of Purpose

The Trust Board is committed to ensuring Risk Management is an integral component of the Trust Board, its associated committees, Care Groups, associated Clinical Business Units and Corporate Support Functions so that all Corporate, Clinical, Operational and Financial risks are eliminated or reduced to an acceptable level with appropriate control measures in place.

The Trust mission is that we will be outstanding for our patients, our communities and each other, with the associated vision that the organisation will be a great place to receive health care, work and learn. Implementation of the Risk Management Strategy and associated Policy is critical to delivery of the Trust mission/vision. Therefore, commitment and engagement from all members of staff is required to ensure our patients receive high quality, safe, effective care within a culture that values honesty and openness at all levels of the organisation. The Trust Risk Management system will ensure that

- Risks that have the potential to adversely affect the quality of care, safety, and wellbeing of people (patients, staff, and the public) and on the business, performance, and reputation of the Trust, are proactively identified and effectively managed.
- Anticipate opportunities or threats and adapt a response through the Trust's explicit Risk Management process.
- Priorities are identified, expressed through objectives, understood and owned by staff and are under continuous review.
- Controls are in place which are effective in their design and application to manage risk at the level of the Trust risk appetite.
- Risk treatment is implemented effectively by risk owners and managers.
- Gaps in controls are identified and treated effectively to mitigate risks.
- Risk owners and managers are held to account for the effective implementation of controls.
- Assurances are reviewed and acted on where deficits are identified in line with this framework and associated policy.
- The escalation process is followed in line with this framework and associated policy.
- Risk Management systems and processes are embedded at all levels of the organisation including Care Groups and their associated Clinical Business Units (CBU's) Corporate Support Services, education and development, business planning cycles, service development, financial planning, project, and programme management.

The strategic approach reflected in this document strongly supports the requirements of the 'Well Led' Care Quality Commission (CQC) domain underpinned through the defined governance model, ensuring clear accountabilities at all levels of the organisation and effective processes to measure performance and address concerns in a timely manner.

1. Contents

Section	Page
Statement of Purpose	3
Contents	4
1. Introduction & Purpose	5
2. Scope	5
4. Risk Management and Corporate Governance	6
5. Trust Objectives	6
6. Risk Appetite	7
7. Risk Management Maturity Model	7
8. The Risk Management Process	8
9. Duties, Accountabilities and Responsibilities	8
10. Communication, Training and Awareness	13
11. Monitoring, Implementation and Review	13
12. References	13
13. Definitions	13
14. Appendix's	15 - 45
Appendix 1 Committee and Groups Governance Structure	
Appendix 2 Board Assurance Committees	
Appendix 3 Risk Appetite for NHS Organisations – Matrix to support better sensitivity in decision making.	
Appendix 4 Equality Analysis Impact Assessment	

1. Introduction

Warrington and Halton Hospitals NHS Foundation Trust is committed to a Risk Management Strategy which aims to minimise risk to all its stakeholders, through a comprehensive system of internal control. Accordingly, the Trust takes an integrated approach to Risk Management across the organisation, which incorporates all risks.

The purpose of this strategy is to detail the framework which defines the Trust's governance arrangements in terms of the way the Trust leads, directs and controls risks to its key functions, in order to support the Trust strategic objectives and comply with Health and Safety legislation, its Provider License, CQC regulations and NHS Constitution commitments, all of which are interlocked.

The Trust accepts that it carries risks that have the potential to cause harm to patients, staff and the public or loss of its assets and reputation if not effectively managed and controlled. The Trust further accepts that the nature of health care services means that some risks cannot be eliminated entirely. Fundamentally it is essential that the Trust has good Risk Management systems and processes in place, which eliminate risk where possible and reduce the impact of those risks that cannot be eliminated to a 'tolerable' level.

The Trust is committed to understanding the causes of risks that may impact on the organisation's achievement of its stated strategic objectives and addressing the issues to prevent risk from occurring, thereby improving the quality, safety, and effectiveness of the services we provide. To achieve this, we will apply a proactive risk-based approach to all aspects of our undertakings, activities, and condition of our estate. This will be achieved using the Trust's risk assessment methodology as a tool to identify potential hazards and any associated risks to ensure appropriate control measures are identified and implemented, to either eliminate or mitigate risks as far as is reasonably practicable.

The Trust recognises that effective risk management must actively consider equality, diversity, and inclusion, and ensure that no individual or community is disproportionately affected by risks or their mitigation. We are committed to complying with the Equality Act 2010 and the Public Sector Equality Duty by eliminating discrimination, advancing equality of opportunity, and fostering good relations between different groups. This Strategy underpins the Trust's aim to ensure that our risk management approach considers the potential for disproportionate impacts on individuals or groups who may be more vulnerable.

2. Scope

Everyone employed by the Trust or acting on behalf of the Trust is responsible for Risk Management in the Trust. In practice this means that everyone is responsible for making sure that risks associated with the activities and assets they are responsible for are identified, assessed for hazards, and associated risk and managed accordingly.

3. Risk Management and Corporate Governance

Corporate Governance is the system whereby the Trust is directed and controlled at its most senior level to achieve the Trust's strategic objectives and meet its standards of accountability and probity. The Trust has adopted an integrated approach to risk management, meaning it has systems, processes and behaviours by which it leads, directs and controls its functions in order to achieve organisational objectives and the safety, quality and value for money of services as they relate to patients, carers, staff, the wider community and partner organisations.

The Trust is required to demonstrate that it is "doing its reasonable best" to manage risks. This is accomplished by ensuring that Corporate Governance and Risk Management are aligned and integrated.

In practice this means having systems and processes in place to identify, access, mitigate, evaluate, and assign responsibility to manage risks at all levels of the organisation, monitor and aggregate the findings at corporate level. To achieve this the Trust will carry out the following:

- ✓ Integrate Risk Management into all decision-making processes.
- ✓ Integrate Risk Management into all functions including patient safety, health and safety, incidents, complaints, claims, inquests, safeguarding, business continuity and quality improvement.
- ✓ Integrate Risk Management with service developments and clinical governance activities to improve patient safety.
- ✓ Implement a consistent approach to the investigation of risks, incidents and complaints and litigation.

4. Trust Objectives

The Trust Board recognises that the implementation of an effective Risk Management Strategy and associated Risk Management processes is essential to the delivery of the Trust's objectives, the development of a positive learning environment and risk aware culture. The tool the Board uses to facilitate this is the Board Assurance Framework (BAF). The BAF contains those principal/strategic risks that without mitigation have the potential to fundamentally impact on the achievement of the strategic objectives. They are agreed annually by the Trust Board and are reviewed at each Board meeting. The BAF underpins the Annual Governance Statement (AGS) and is the subject of annual review by both internal and external audit.

The strategic risks are monitored by the Board's Assurance Committees and reviewed on a bi-monthly basis by the Trust Board of Directors, or more frequently if there are any changes in month and updated on the Datix Risk Management system, to provide assurance that the risks are being managed and mitigated.

The corporate risk register reporting details the high-level operational risks which may impact on the BAF risks, and these are monitored by the Trust Executive led Risk Review Group and the relevant Board committees. The terms of reference for these committees are detailed at **appendix 2**. The Audit committee ensures that the Trust

Risk Management Strategy remains effective and as such reviews and monitors the BAF, and other high risks as appropriate.

5. Risk Appetite

The Trust recognises that it is not always possible to eliminate risks, nor is it always appropriate. Systems of control need to be balanced in order that innovation and use of resources are supported when applied to healthcare. Therefore, the Trust may be willing to accept a certain level of risk when the cost of mitigating the risk is high when compared to the potential severity of the risk and the likelihood of it occurring.

The Board will set the risk appetite, including tolerance annually, for the risks identified on the BAF. The annual review will be informed by an assessment of the Trust's risk maturity, which in turn enables the Board to determine the Trust's capacity to control risk. The risk appetite statement will be communicated via governance processes to all staff and stakeholders to formalise and clarify the Trust's overall approach to risk. Additionally, all Trust corporate risks going forward will be linked to the Trust strategic objectives and by association with the relevant BAF risks on the Datix Risk Management system, risk register module, which will enable staff to identify Trust risk appetite and tolerance for individual risks when they apply the linked BAF risk.

In practice the Trust risk appetite should address several dimensions including the nature of the risks to be assumed, the amount of risk to be taken (tolerance), on the desired balance of risk versus reward.

The Board has completed the annual assessment for the Trust Risk appetite 2025/26 and this will be available for staff to access on the Trust intranet.

The model risk appetite matrix used by the Board to support the development of the Trust risk appetite statement for NHS organisations is located at **appendix 3**.

6. Risk Management Maturity Model

The value of the Risk Maturity Model is that it provides an assessment tool for the organisation to use in order to understand its current Risk Management maturity level. The results together with key performance indicators can then be used to create an improvement plan which will guide the organisation to reach our target maturity level. The more mature the Risk Management system, the better the decision making, with better outcomes for the Trust. Full details of the model are available at **appendix 4**. The Trust will consider undertaking a risk maturity assessment in 2025/26 and develop and implement a plan according to the findings from that assessment.

7. The Risk Management Process

The Trust's governance structure has systems in place to identify, assess, manage, evaluate, and control risk throughout the organisation. This system provides the Trust with assurance that the risks which the Trust could be exposed to are controlled and escalated at the appropriate level. The Trust Risk Management Policy and Procedure

is aligned with this Strategy and is available for all staff to access via policy section on the Trust intranet.

8. Duties, Accountabilities and Responsibilities

11.1. Statutory

Health and Social Care Act; The Trust is legally required to register with the Care Quality Commission under the Health and Social Care Act 2008 and as a legal requirement of the Trust's registration, must protect patients, workers, and others.

Management of Health and Safety at Work Regulations (1999): The Trust is required to undertake a suitable and sufficient assessment of risks to the health and safety of all employees and persons not in its employ to which they are exposed to while at work and arising out of or as a result of Trust activities.

Health and Safety at work Act 1972 (HASWA): Section 2 of the act places a duty on the Trust to ensure as far as is reasonably practicable the health, safety and welfare of all employees and anyone who may be affected by its work activities.

9. Regulation and Assurance

The Care Quality Commission (CQC): is the independent regulator of health and social care services in England. The Trust is required to provide robust assurance to the CQC of its compliance against the essential quality and safety standards which include the five domains of safe, effective, caring, responsive and well-led.

NHS England (NHSE) and NHS Improvement (NHSI): From 1 April 2019 both organisations joined to form one body to help improve care for patients and provide leadership and support to the wider NHS. NHS Improvement is the sector regulator for health services in England. It currently authorises and regulates NHS Foundation Trusts, ensuring they are well-led (governance) and run efficiently (financial) in order that they deliver good quality services for patients. NHSI has created a risk-based system of regulation, which determines the intensity of the monitoring it undertakes. The Trust is required to demonstrate compliance with its licence and Oversight Framework. The expectation is that this regulator will be absorbed into the Department of Health and Social Care (DHSC) by 2027.

NHS Improvement established the Oversight Framework to ensure there is a clear compliance framework that all Integrated Care Boards (ICB's) and NHS Trusts and Foundation Trusts can provide assurance that they are operating within their provider license. Therefore, it is essential that the Trust identifies any risks that may impact on its ability to adhere to that framework. The framework will be reviewed in 2026/27 to implement the ICB operating model and to take account of the ambitions and priorities of the 10-year Health Plan

Mersey Internal Audit (MIAA): is the Trust's independent internal auditor who develop and deliver an annual internal audit programme for the Trust. This includes verifying

that the Trust has suitable and effective systems of internal control in terms of Risk Management and that it is effective.

Grant Thornton UK is the Trust's independent external auditor appointed by the Council of Governors. The external auditors provide an unbiased and independent opinion on the annual report and accounts, which includes the Annual Governance Statement.

10. Organisation

The Trust manages risk proactively through a number of individuals, specific committees, and groups working together to integrate Risk Management activity across the organisation. The roles and responsibilities of specific individuals and functions are described, including specific Trust Board Assurance Committees

A key component of an effective and mature Risk Management organisation is a culture of knowledge and understanding of Risk Management and leadership. This means that roles and responsibilities need to be clearly defined so that Risk Management is owned by appropriate members of staff and that all staff are encouraged and supported to be risk-aware through the promotion of openness and support at every level of the organisation.

Individuals

Chief Executive Officer: has overall accountability for Risk Management and as such has responsibility for maintaining a sound system of internal control that supports the achievement of the Trust objectives. The Chief Executive is also responsible for ensuring the Trust is administered prudently and economically and that resources are applied efficiently and effectively. The Chief Executive has delegated responsibility for risk within the management structure to the executive directors for their respective portfolios.

Deputy Chief Executive/Chief Operating Officer: is accountable to the Board of Directors and the Chief Executive for the management of operational risks and risks relating to estates and facilities services.

Chief Nurse: is the executive lead for Risk Management and is accountable to the Board and the Chief Executive for the Trust's Risk Management activities. In addition, they are jointly accountable with the Medical Director to the Board of Directors and the Chief Executive for clinical Risk Management and Clinical Governance via governance reporting mechanisms. The Chief Nurse is also responsible for embedding compliance with CQC standards across the organisation with the support of their executive colleagues. The Chief Nurse has professional responsibility for nursing and allied health practice within the Trust.

Medical Director/Chief Digital Officer/Caldicott Guardian: is jointly accountable with the Chief Nurse for Clinical Governance including clinical risks via governance reporting mechanisms. The Medical Director has executive responsibility for Digital

and as such is accountable to the Board of Directors and the Chief Executive for the management of Digital risks. They are also accountable to the CEO and the Trust Board for ensuring adherence to the Caldicott principles. The Medical Director has professional responsibility for medical practice within the Trust.

Director of Finance is responsible for ensuring that the Trust carries out its business within sound financial governance arrangements that are controlled and monitored through effective audit and accounting systems and associated risk.

Chief People Officer and Organisational Development: Is responsible for the development and delivery of the Trust's People Plan and Organisational Development Strategy, staff training and management of risk relating to the Trust's workforce and associated policies and as such is accountable to the Board of Directors and the Chief Executive for risks associated with the activities therein.

Chief Information Officer: is responsible for Information Governance and is the nominated Senior Information Risk Owner. They are accountable to the Medical Director

Non-Executive Directors: The Chairperson and Non-Executive Director has responsibility for the promotion of Risk Management through their participation in the Trust Board and its Assurance Committees. They have responsibility for scrutinising systems of governance and hold executives to account for their Risk Management responsibilities.

The Trust Secretary reports directly to the Chief Executive and is accountable to the Trust Chairperson. They function as an independent advisor and primary governance liaison among Board members. They are responsible for steering the Trust governance evaluation and development programs ensuring Board members and governors are supported, well prepared and fully compliant with Fit and Proper Persons regulations. As such they play a key role in steering and supporting the Trust in the achievement of its stated strategic objectives via the BAF and associated Risk Management processes.

The Deputy Director of Nursing/Director of Clinical Governance is the Trust operational lead for Risk Management, and governance and is accountable to the Chief Nurse. They are responsible for ensuring that the Trust's operational governance and Risk Management systems and processes are effective and delivered in accordance with best practice. In addition to their Deputy Director of Nursing supports the Chief Nurse in delivering their professional nursing responsibilities.

The Deputy Director of Governance is responsible for the management of Trust policies including updating and overseeing the Risk Management strategy and associated policy/procedure, ensuring it is in line with best practice Risk Management standards. They are accountable to the Chief Nurse and responsible to the Deputy Director of Nursing/Director of Governance to support delivery of the integrated governance agenda. They are also responsible for line management of the Governance department staff, ensuring they operate and deliver the required

assurance in line with the expected Trust governance and associated Risk Management standards.

Care Group Triumvirates (The Associate Chief Operating Officers, Associate Chief Nurses, Associate Medical Directors) are responsible for ensuring that Risk Management systems within the Care Groups and associated Clinical Business Units (CBU's) are effectively meeting the objectives outlined within the Risk Management Strategy and associated Policy and Procedure and holding their staff to account in meeting their risk management responsibilities. They are responsible for providing assurance to the Trust Board through their integrated governance assurance groups via the corporate committee structure (**Appendix 1**) that they are effectively managing risks in all their services, including regular scrutiny and validation of their care group and associated CBU's risk registers.

Medical Governance leads and lead Nurses are responsible to the Care Group Triumvirates for ensuring risk assessments, incidents, claims & inquests and complaints are managed in line with Trust policy and ensuring that agreed actions for improvement are carried out to completion, ensuring feedback is disseminated to staff and provide assurance of compliance via care group governance and integrated risk-based systems.

The Head of Health and Safety is the Trust operational lead for Health and Safety, accountable to the Deputy Director of Nursing/ Director of Governance and responsible to the Deputy Director of Integrated Governance for the management of operational risk relating to Health and Safety. They are responsible for providing assurance that the Trust's Health and Safety systems and processes are effective and operate in accordance with statutory requirements.

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

Assurance Committees & Groups

The Trust Board along with the **Council of Governors** sets the Strategic goals and objectives for the organisation. They monitor how the Trust performs against these objectives and make sure appropriate action is taken where necessary. The Board is structured in line with the Trusts constitution which enables it to comply with its terms of authorisation.

Audit Committee is responsible for providing the Board with a means of independent and objective review of financial and corporate governance, assurance processes for Risk Management and the control environment across the whole of the Trust's activities. It commissions an annual audit of the board assurance framework and strategic risk register, as part of the internal audit plan, to satisfy itself that the system of internal control is effective. It examines the assurances on the effectiveness of controls for all strategic risks received from the Chairpersons of the committees, and

from internal and external auditors. The Audit Committee monitors and tracks all material governance activity to ensure that the system of internal control, Risk Management and governance is fit for purpose and compliant with regulatory requirements.

Quality Assurance Committee is accountable to the Board of Directors (the Board) for providing oversight and assurance on all aspects of clinical quality, including strategy, improvement, delivery, clinical governance, clinical audit and the regulatory standards relevant to quality and safety. They are also accountable to the Board for providing assurance that controls are in place to identify, prioritise and manage risks arising from clinical care and assurance to the Board on specific clinical risks identified on the BAF and that these are managed appropriately in line with professional and regulatory standards.

Strategic People Committee is accountable to the Board for providing assurance that the Trusts' people organisational development strategies to enhance patient care, operational efficiency, and resource use, are aligned with NHS regulations and local priorities. They are also accountable to the Board for providing assurance that controls are in place to identify, prioritise and manage risks arising from organisational development strategies and assurance to the Board on specific people risks identified on the BAF and that these are managed appropriately in line with national and local priorities.

Risk Management Review Group is responsible for providing assurance to Patient Safety and Clinical Effectiveness Sub Committee that the Risk Management Strategy and operational management of risks held on the Trust risk registers are being managed effectively and where there are deficits these are addressed effectively.

Patient Safety and Clinical Effectiveness Sub Committee: is responsible for providing assurance to the Quality Assurance Committee for clinical quality including patient safety, clinical effectiveness and patient experience. They will also provide assurance that controls are in place to identify, prioritise and manage risks arising from clinical care in line with their work plan responsibilities.

Information Governance Group: is responsible for providing assurance that effective arrangements are in place to manage the processing of and control risks to information and data through the Information Governance framework based on legal requirements and Department of Health guidelines.

Care Groups and Corporate Functions - Governance and Quality Assurance groups: are responsible for providing assurance for local implementation of the Risk Management Strategy and associated policy and procedure and provide formal assurance on progress to the Board Assurance Committees demonstrating that systems and controls are in place to ensure clinical business units and associated wards and departments and services, are proactively reviewing risks and implementing appropriate mitigating actions.

11. Communication, Training and Awareness

The strategy will be widely shared across the organisation utilising electronic means, governance structures, and training sessions. It will form part of the Trust training sessions, and the Trust Induction package. Additional bespoke Risk Management training sessions will be provided, which all staff are invited to attend.

The Trust will work collaboratively with other local organisations and stakeholders in relation to Risk Management. This will include participating in local and regional forums related to risk management, working closely with the relevant, Health & Safety Executive, Care Quality Commission, and NHS Improvement/England (NHSI/e) representatives, and working with other local agencies including Clinical Commissioning Groups to identify risks, learn lessons and share good practice.

12. Monitoring, Implementation and Review

The Chief Nurse with the support of the Executive Team will oversee the implementation and monitoring of this strategy.

Monitoring will be overseen via the Trust Board Assurance Committees and reported to the Audit committee on behalf of the Trust Board. Implementation of this Strategy will also be formally monitored by the Trust's Internal Auditors (Mersey Internal Audit Agency), as well as external regulators such as CQC, NHSI and HSE.

Annual review of effectiveness of Board Assurance Committees and groups with responsibility for risk management.

Trust Board annual review of the Board Assurance framework content and process.

This strategy will be reviewed annually or earlier in response to any significant organisational changes.

14. References

- NHS Oversight Framework 2025/26. [NHS England » NHS Oversight Framework 2025/26](#)
- The Management of Health and Safety at Work Regulations 1999. [The Management of Health and Safety at Work Regulations 1999](#)
- HSE. Managing Risks and Risk Assessment at Work. [Managing risks and risk assessment at work: Overview - HSE](#)
- The Health and Safety at Work Act 1974. [Health and Safety at Work Act 1974 - HSE](#)
- ISO 31000: 2009 – Risk Management– Principles and Guidelines
- The NHS Constitution January 2022. [NHS Constitution for England: resources - GOV.UK](#)
- Corporate Governance Manual. December 2023. [Corporate Governance Manual](#)

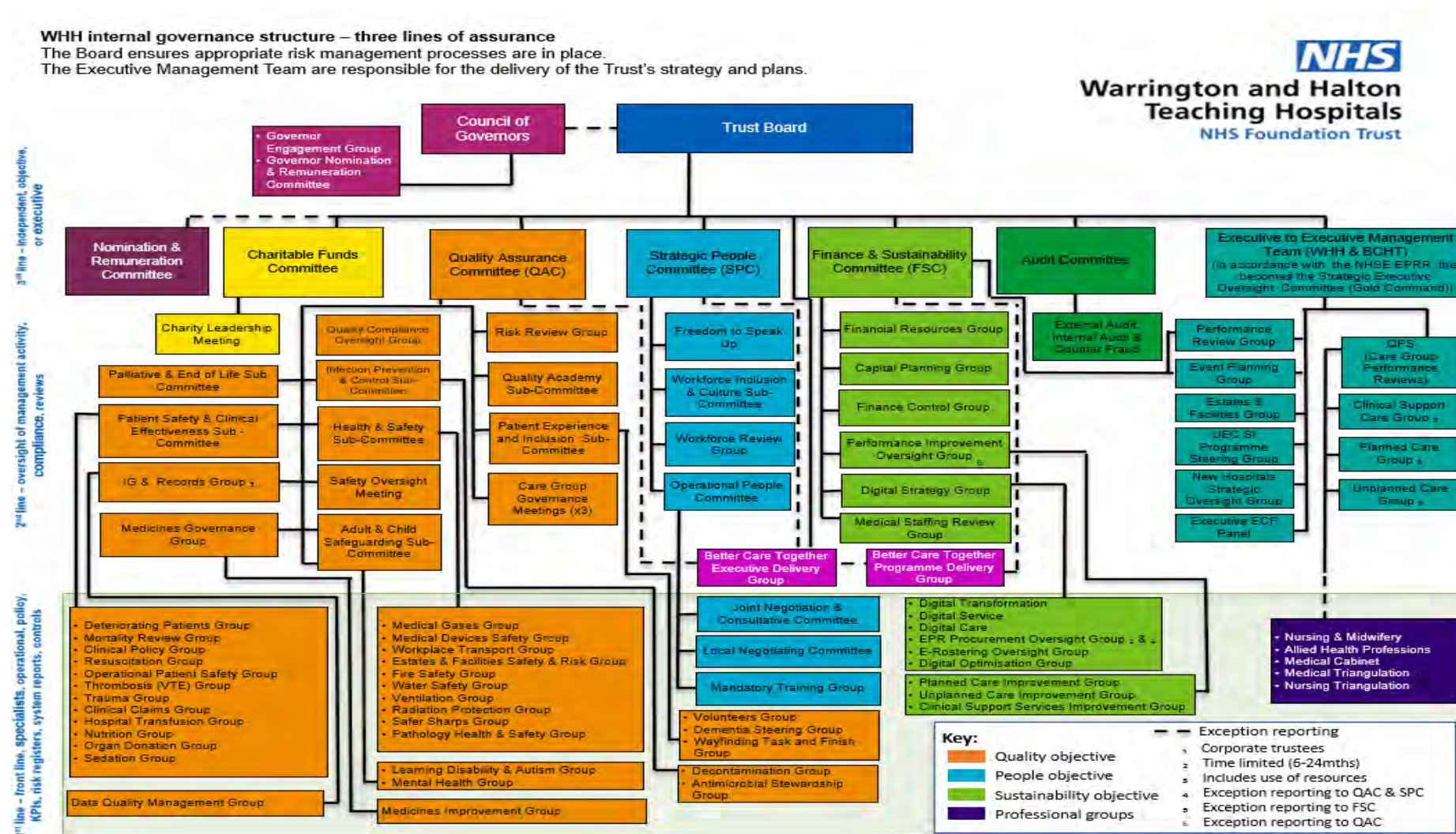
- Fit for the Future, the 10-year Health Plan for England. July 2025. [10 Year Health Plan for England: fit for the future - GOV.UK](#)

15. Definitions

Refer to Trust Risk Management Policy and Procedure - **Appendix 4**

17. Appendices

Committees & Groups Governance Assurance Structure



Board of Assurance Committees

TERMS OF REFERENCE AUDIT COMMITTEE

1. PURPOSE

The Audit Committee has primary responsibility for monitoring and reviewing the establishment and maintenance of an effective system of integrated governance, Risk Management, and internal control, across the whole of the organization's activities (clinical and non-clinical), that supports the achievement of the organization's objectives.

The Audit Committee shall provide the Board of Directors with a means of independent and objective review of assurance processes and Risk Management across the whole of the Trust's activities (clinical and non-clinical), both generally and in support of the Annual Governance Statement. In addition, the Audit Committee shall:

- provide assurance of independence for external and internal audit.
- ensure that appropriate standards are set and compliance with them monitored in all areas that fall within the remit of the Audit Committee; and
- monitor compliance with corporate governance requirements (e.g., compliance with the terms of the Licence; Constitution; codes of conduct; standing financial instructions; maintenance of registers of interest).

2. FREQUENCY OF MEETINGS

Meetings shall be held at least five times per year with additional meetings where necessary.

The internal auditor and external auditor shall be afforded the opportunity at least once per year to meet with the Audit Committee without the Executive Directors present.

3. QUORUM

The quorum necessary for the transaction of business shall be two members.

4. MEMBERSHIP

The Committee shall be composed of all (7) the Trust's independent non-executive directors, at least one of whom should have recent and relevant financial experience (Monitor Code C.3.1), as follows:

- at least one member of the Trust's Quality Assurance Committee will be a member of the Trust's Audit Committee
- the Chair of the Trust shall not be a member.

The Board will appoint one of the Non-Executive Director members of the Committee to be Chair of the Committee. Should the Chair be absent from the meeting the committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.

Members can participate in meetings by two-way audio link including telephone, video, or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval from all the members of the Committee, such written approval may be by email from the members Trust email account.

The Trust Chair may be invited to attend meetings of the Audit committee if required.

The Lead Governor (or nominated deputy) may be invited to attend meetings of the Audit committee where items of specific interest or concern raised by Governors are being addressed.

Only members of the Audit Committee have the right to attend meetings, but the following individuals shall normally be in attendance:

- Chief Finance Officer
- Director of Integrated Governance and Quality
- Representative(s) of the external audit service provider
- Representative(s) of internal audit service provider
- Representative(s) of counter fraud service provider
- Company Secretary & Associate Director of Corporate Governance
- Head of Financial Services
- Governor Observer
- Associate Director of Finance – Operational

The Chief Executive may also be invited to attend and should in any case, attend at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

The Audit Committee may require individual Trust Directors to attend in respect of specific agenda items and, in addition, will normally extend an open invitation to all Trust Directors to attend all meetings.

5. AUTHORITY

The Audit Committee is constituted as a standing committee of the Trust's Board of Directors. Its constitution and terms of reference shall be as set out, subject to amendment at future Board of Directors meetings. The Audit Committee shall not have any executive powers in addition to those delegated in these terms of reference.

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff, and all members of staff are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice on any matter within its Terms of Reference and to request the attendance of individuals and authorities from outside the Trust with

relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

6. REPORTING

The Committee shall report to the Board of Directors and Council of Governors annually on how it discharges its responsibilities; specifically on its work in support of the annual governance statement, commenting on:

- The fitness for purpose of the assurance framework
- The completeness and 'embeddedness' of Risk Management in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements.
- The robustness of the processes behind the quality account

This annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

The minutes of the Committee meetings will be formally recorded. The Chair of the Audit Committee shall draw to the attention of the Board any issues that require disclosure or require executive action via a Committee Assurance Report.

7. DUTIES & RESPONSIBILITIES

The Committee's responsibilities fall broadly into the following areas:

Integrated Governance, Risk Management, and Internal Control

Be the Trust Board of Directors delegated Committee responsible for risk management, ensuring there is scrutiny and oversight of the Strategic Risk Register and Board Assurance Framework

The Audit Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the governance statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances, prior to submission to the governing body.
- The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.
- The policies and procedures for all work related to counter fraud and security as required by NHS Counter Fraud Authority

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit, and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, Risk Management, and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees (for example, the Quality Assurance Committee) so that it understands processes and linkages. However, these other committees must not usurp the Audit Committee's role.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector Internal Audit Standards, 2017* and provides appropriate independent assurance to the Committee, Accountable (or Accounting) Officer and governing body. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved
- Liaising with the Committee Chairs and the Trust's Executive Team to plan and approve the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation, including areas identified in the assurance framework.
- Considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Monitoring the effectiveness of internal audit and carrying out an annual review.

External Audit

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the governing body when appropriate)
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.

- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- Reviewing all external audit reports, including the report to those charged with governance (before its submission to the governing body) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non audit services.

Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Counter Fraud standards and shall review the outcomes of work in these areas.

Management

The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, Risk Management, and internal control.

The Committee may also request specific reports from individual functions within the organisation after taking briefings from Committee Chairs or the Executive Team

The Committee will also periodically review the Trust's Standing Orders, Standing Financial Instructions, Scheme of Delegation and Standards of Business Conduct (Managing Conflicts of Interest) and examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension.

Financial Reporting

The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the governing body, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The Committee shall review the annual report and financial statements before submission to the governing body, focusing particularly on:

- The wording in the annual governance statement and other disclosures relevant to the terms of reference to the Committee
- Changes in, and compliance with, accounting policies, practices, and estimation techniques
- Unadjusted misstatements in the financial statements
- Significant adjustments resulting from the audit.
- Letters of representation
- Explanations for significant variances.

Other

Review performance indicators relevant to the remit of the Audit committee.

Examine any other matter referred to the Audit Committee by the Board of Directors, the Chairs of the Committees of the Board or the Executive Team and initiate investigation as agreed with the members of the Audit Committee.

Develop and use an effective assurance framework to guide the Audit Committee's work. This will include utilising and reviewing the work of the internal audit, external audit, and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as to fulfil its functions in connection with these terms of reference.

Consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health [and social care] sector and professional bodies with responsibilities that relate to staff performance and functions.

8. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reached with the Chair of the Committee, Agenda and Papers will be sent out 5 working days before the date of the meeting. No papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board and the Trust Secretary.

9. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements and report on this to the Trust Board.

These terms of reference will be reviewed every two years by the Council of Governors and the Trust Board.

TERMS OF REFERENCE QUALITY ASSURANCE COMMITTEE

1. PURPOSE

The purpose of the Quality Assurance Committee (the Committee) is to be accountable to the Board of Directors (the Board) for providing oversight and assurance on all aspects of quality, including strategy, improvement, delivery, clinical Risk Management and governance, clinical audit and the regulatory standards relevant to quality and safety.

The Quality Assurance Committee is accountable to the Board for ensuring that the integrated quality governance framework is implemented throughout the organisation and that organisational risks in relation to Quality are managed appropriately in line with professional and regulatory standards.

2. FREQUENCY OF MEETINGS

Meetings shall be held monthly.

3. QUORUM

Quorum shall be seven members, of which at least one should be a Non-Executive Director.

4. MEMBERSHIP

The Committee shall be composed of two Non-Executive Directors, one of whom is the Maternity Board Safety Champion, and one of whom shall be appointed by the Board to be Chair of the Committee

Core Members

- Chief Nurse
- Executive Medical Director
- Chief Operating Officer
- Chief Finance Officer
- Director of Strategy & Partnerships
- Chief People Officer
- Deputy Chief Nurse & Director of Clinical Governance
- Deputy Medical Director
- Company Secretary
- Chief Pharmacist
- Director of Midwifery & Associate Chief Nurse /Midwifery Safety Champion Lead
- Associate Director of Quality

Attendees

- Chief Executive

- Obstetrics/Obstetrics Safety Champion Lead & Governance Lead
- Associate Chief Nurse (Planned Care)
- Associate Chief of Nursing (Unplanned Care)
- Head of Therapy / Lead AHP
- Associate Medical Director - Patient Safety
- Associate Medical Director - Clinical Effectiveness
- Associate Chief Nurse/Associate DIPC
- Senior Information Risk Owner

Observers

- Governor

Members can participate in meetings by two-way audio link including telephone, video, or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval.

5. AUTHORITY

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of people external to the Trust, with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

6. REPORTING

The Committee will have the following reporting responsibilities:

- The minutes of the Committee meetings will be formally recorded. The Chair of the Committee shall draw to the attention of the Board and Audit Committee any issues that require disclosure to it or require executive action.
- The Chair of the Committee will provide a written committee assurance report to the Board bi-monthly following each meeting providing assurance of the quality governance arrangements in place within the Trust and provide an annual report to be presented to the Board meeting on its work and performance in the preceding year.

The sub committees listed below are required to submit high level briefing papers to the Committee.

- Patient Safety & Clinical Effectiveness Sub-Committee
- Patient Experience and Inclusion Sub-Committee
- Health & Safety Sub-Committee
- Information Governance and Corporate Records Group

- Adult & Child Safeguarding Sub Committee
- Risk Review Group
- Quality Academy Sub-Committee
- Infection Prevention and Control Sub Committee
- Palliative Care and End of Life Sub Committee
- Medicines Governance Group
- IG & Records Group
- Compliance Oversight Group

7. DUTIES & RESPONSIBILITIES

The Committee will undertake the following duties:

- Monitor the quality objectives as set out in the Trust Strategy on the agreed success/KPIs for each objective and the underpinning priorities.
- Oversee the development and implementation of the Trust's enabling strategies aligned to integrated governance and quality, including the overarching Quality Strategy, Risk Management Strategy, Clinical Effectiveness Strategy, Patient Experience Strategy, Quality Improvement Strategy, with a clear focus on upholding the tenants of quality and integrated governance and avoiding harm, ensuring that all strategies and performance indicators are consistent with the Trust's Mission, Vision and strategic objectives;
- Overseeing 'Deep Dive Reviews' of risks to quality identified by the Board or the Committee, particularly "Serious Incidents Requiring Investigation" and how well any recommended actions have been implemented.
- The Committee may also initiate such reviews based on its own tracking and analysis of quality trends flagged up through the regular performance reporting to the Board.
- Review the quality dashboard and information presented to the Committee, with regard to ensuring assurance is received on all quality and safety of patient care matters, which fulfils the Trust's strategic goals regarding quality and assurance, as well as statutory, regulatory, and contractual requirements.
- To consider all appropriate matters of clinical and non-clinical, quality governance including patient care, patient experience and patient and staff safety, via a planned integrated quality governance assurance system, giving assurance either directly to the Committee or indirectly via its reporting Sub Committees, and all risks are appropriately escalated.
- Ensure there is an appropriate investigations framework within the Trust i.e. ensure all incidents and complaints are appropriately investigated, ensure that the Trust's Mortality Review process aligns to the Royal College of Physicians Standard Judgment Review process, and that people have the skills and expertise to undertake these investigations.
- Ensure there is an appropriate policy development and review framework within the Trust, and that staff education strategy and organisational development is aligned to policy development within the Trust.

- Ensure there is an action planning framework in place within the Trust, so that actions from investigations, risk assessments and internal and external reviews are implemented, monitored appropriately, and escalated when off track.
- Ensure that there is a learning framework in place within the Trust, so that aggregate learning from incidents, Serious Incidents, complaints, claims, audit, and assessments are communicated appropriately and changes in practice are facilitated.
- Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery.
- Ensure all external accreditations are monitored within the Trust, so that the Board of Directors has assurance that the Trust is meeting external quality requirements, and where there is variance or risk, actions are put in place appropriately.
- Obtain assurance of the Trust's on-going compliance with the Care Quality Commission registration through appropriate systems of control.
- Ensure that the Trust has effective communication channels in place forward to Board monitoring and that the Clinical Business Unit, directorate, speciality, ward and department governance and quality assurance structures are robust.
- Monitor the process for the production of the Trust's year end quality (Quality Accounts) reports before they are presented to the Trust Audit Committee and Board for formal approval.
- Ensure all reporting Sub Committees have effective reporting structures in place and that planned assurance reports are scrutinised through a business and assurance cycle.
- To inform the Board where it has concerns about standards of care or safety.

8. ATTENDANCE

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

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

Other Executive Directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Officers who are unable to attend a meeting of the Committee may appoint a deputy who will attend. It is the responsibility of the core member to inform the Chair of the Committee if they are unable to attend and who will attend as their deputy.

9. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reached with the Chair of the Committee the Agenda and Papers will be sent out 5 working days before the date of the meeting. No Papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board.

- The ToR will be reviewed annually by Trust Board
- A Cycle of Business will be established.

Papers to this Committee must be submitted for inclusion one week in advance of the meeting. Papers will be distributed by 5pm on the Tuesday preceding the Quality and Assurance Committee.

10. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed every 12 months by the Committee.

The Cycle of Business will be reviewed by the Committee every 12 month.

TERMS OF REFERENCE STRATEGIC PEOPLE COMMITTEE

1. PURPOSE

The Strategic People Committee in Common (the "Committee") is established to enable collaboration, strategic alignment, and efficient decision-making between Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCHT).

It oversees the Trusts' people and organisational development strategies to enhance patient care, operational efficiency, and resource use, aligning with NHS regulations and local priorities.

The Committee Supports:

WHH's 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* the Committee will ensure that there are arrangements in place to enable staff to have a voice, through the development of a just and learning culture which values diversity, inclusion, compassionate leadership and equity for all.

BCHT's Strategic Objective 3, 5 and 6:

- *We will... Ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.*
- *We will... Ensure that equity, diversity, and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.*
- *We will... Work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.*

The Committee provides assurance to both sovereign Trust Boards that people strategies align with quality aims, overseeing the development and implementation of a joint People Strategy, Workforce Equality, Diversity and Inclusion Strategy, and Culture Plan as the Trusts progress toward integration by April 2027.

2. FREQUENCY OF MEETINGS

Meetings shall be held monthly at either the Warrington Hospital site or Spencer House.

3. MEMBERSHIP

a. Membership of the WHH Committee will comprise of:

- Two Non-Executive Directors (including Committee Chair for meeting held at Warrington)
- Chief People Officer (WHH)
- Deputy Chief People Officer (WHH)
- Chief Finance Officer (WHH)
- Chief Nurse (WHH)
- Joint Chief Operating Officer and (Deputy Chief Executive WHH)
- Joint Executive Medical Director
- Chief Strategy & Partnerships Officer
- Director of Communications & Engagement
- Company Secretary
- Head of Strategic Workforce Development & Culture

3.2. Membership of the BCHT Committee will comprise of:

- Two Non-Executive Directors (to include Committee Chair for meeting held at Bridgewater)
- Director of People and Organisational Development (BCHT)
- Deputy Director of People and Organisational Development
- Director of Finance (BCHT)
- Chief Nurse and (Deputy Chief Executive BCHT)
- Joint Chief Operating Officer and (Deputy Chief Executive WHH)
- Joint Executive Medical Director
- Director of Corporate Governance (BCH)

The Joint Chief Executive and other staff members may also be invited/ expected to attend for appropriate agenda items; however, there is no requirement to attend the whole meeting.

3.3. Observers:

- Council of Governors' representative from WHH and BCHT
- Other staff members may also observe the meeting with prior permission of the Committee Chairs.

Members can participate in meetings by two-way audio link including telephone, video, or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. However, attendance in person at the meeting is strongly encouraged to facilitate more effective collaboration, engagement, and decision-making. Should the need arise, the Committee in Common may approve a matter in writing by receiving

written approval from the quorate membership of the Committee, such written approval may be by email from the members NHS email account.

4. QUORUM

A quorum requires four members: two from each Trust, including one Non-Executive Director per Trust and the Chief People Officer/ Director of People and Organisational Development (or nominated Deputy) If a Non-Executive Director is unavailable, a substitute Non-Executive Director from the respective Trust may attend and count toward the quorum.

The Committee shall be quorate provided each Trust each Trust's Committee is quorate; however, if a single Committee of one Trust is quorate, it can undertake business exclusive to that Trust. Each single Committee will reserve the right during a committee meeting to unilaterally decide matters pertaining only to their Trust, should agreement on the matter not be possible across both Committees.

For the avoidance of doubt, a person can count as a member of both committees provided, they hold a related in common role.

5. AUTHORITY

The Committee in Common is authorised by both sovereign Trust Boards to investigate matters within its remit, request information from employees (who must comply), and escalate issues requiring further assurance to either Trust's Audit Committee.

The Committee in Common may also receive a specific request to provide further assurance on a defined area of work from the Audit Committee at WHH or BCHT.

The Committee in Common must comply with the provisions of the respective Trust's Schemes of Reservation & Delegations and Standing Financial Instructions, including the declarations concerning conflicts of interest.

The CiC does not inherently make joint decisions that legally bind the sovereign boards of both organisations. It a governance arrangement where separate statutory bodies meet together to coordinate decision-making. Each committee remains accountable to its own sovereign board, and decisions made within a CiC are technically separate but synchronised to achieve a unified outcome.

6. REPORTING

The Committee will have the following reporting responsibilities:

- The minutes of the Committee meetings will be formally recorded.
- The Chair(s) of the Committee will provide a written Committee assurance report to the Board bi-monthly following each meeting to draw to the attention of the Board and Audit Committee (at BCHT or WHH) any issues that require disclosure to it, approval or require executive action.

The Committee will report to the Trust Boards at WHH and BCHT annually on its work and performance in the preceding year.

7. DUTIES & RESPONSIBILITIES

Duties – decision making:

- To provide overview and scrutiny in areas of workforce performance referred to the Committee by the Trust Boards.
- Receive and consider the workforce plans and make recommendations as appropriate to the Trust Boards.
- To provide overview and scrutiny to the development of the WHH and BCHT People Strategies.
- To ensure the WHH and BCHT People Strategies are designed, developed, delivered, managed, and monitored appropriately.
- To ensure the WHH and BCHT Workforce Equality, Diversity and Inclusion Strategies are designed, developed, delivered, managed, and monitored appropriately.
- To ensure that appropriate clinical advice and involvement in the WHH and BCHT People Strategies are provided.
- To receive, agree and monitor progress on the WHH and BCHT People Strategies through receipt of exception reports and updates.
- To ensure that the Trusts attract and retain their workforce using the principles of Model Employer to become the employers of choice.
- To review the consultation, negotiation, and approval of all employment policies on an annual basis, including:
 - Details of any delays in consultation timeframes which impact on the maintenance of the current valid policy,
 - Details of any employee relations negotiations delaying policy approval,
 - Details of extensions to policy dates,
 - Details of any risks identified by the extension to policies versions and the management of these risks as a consequence of delays, and,
 - Details of any trends or employment issues associated with external factors influencing policy content.
- To receive the annual National Staff Survey results and to provide a set of recommendations for action by the Trusts.
- To receive, agree and monitor the staff engagement activity at both Trusts, including reward and recognition programmes. Ensuring the effectiveness of these activities on improved morale, increased Quarterly People Pulse scores and subsequent impact on patient experience.
- To ensure that all statutory and regulatory obligations are met in relation to equality, diversity, and inclusion. The Committee holds the delegated responsibility on behalf of the Trust Board at BCHT and WHH for the approval of all equality, diversity and inclusion regulated reporting where the Committee is quorate.
- To receive, agree and monitor the Health and Wellbeing activity in both Trusts to be assured of the effectiveness of these activities on improving staff experience.

Duties – advisory:

- Consider any relevant 'people' risks within both Board Assurance Frameworks and corporate level risk registers as they relate to the remit of the Committee, as part of the reporting requirements,
- To ensure that there is a framework in place for Education Governance to support the management of risks associated with our people and the quality of care provided to our patients.

Duties – monitoring:

- To monitor both Trusts' performance against national standards so far as they relate to employment.
- To monitor the effectiveness of both Trusts' workforce performance reporting systems, ensuring that the Trust Boards are assured of continued compliance through their annual reporting, reporting by exception where required.
- To review the Integrated Performance Indicators relevant to the remit of the Committee.
- To report any areas of significant concern to the Trust Boards as appropriate via the Committee Assurance Report.
- To monitor the implementation of Improving People Practices principles for WHH and BCHT through the adoption of a Just and Restorative Culture, including.
 - o Details of Employee Relations Cases in respect of numbers,
 - o Summary of workforce demographics,
 - o Analysis and impact assessment of emerging themes,
 - o Identification of any risks associated with complex case work such as Employment Tribunal cases, Subject Access Requests, and costs,
 - o Overview of lessons learned, and actions taken to address these,
 - o Specific information on those cases where suspension/exclusion is involved, including any Supporting Attendance dismissals/appeals.
- To monitor the progress with Internal Audit recommendations where there is limited or no assurance identified.
- To monitor the delivery of staff engagement reports, including the NHS Staff Survey results and action plans.
- Monitor ward and maternity staffing data.

Duties of members:

Ensuring, through agreed communication strategies, that key decisions and requirements are appropriately disseminated and that appropriate responses are implemented.

The following Sub-Committees/ Groups will report directly to the Committee:

WHH:

- Operational People Sub Committee
- Workforce Inclusion and Culture Sub-Committee
- Workforce Review Group

BCHT:

- People Organisational Delivery Council (the "POD")
- Medical and Dental Professional Governance
- Flu Group

Each Sub-Committee will submit a Chair Log Report to their respective Boards detailing any items of escalation or items requiring decision or action rather than minutes.

8. ATTENDANCE

A record of attendance will be kept, attendance of 75% per year is expected. Members unable to attend must send a nominated deputy who is able to make decisions on their behalf.

9. ADMINISTRATIVE ARRANGEMENTS

- The Committee will be supported by a member of the Corporate Governance Team from either WHH or BCHT
- The Terms of Reference will be reviewed annually by Trust Board
- A Cycle of Business will be established.

Papers to this Committee must be submitted for inclusion one week in advance of the meeting. Papers will be distributed by 5pm one week preceding the Committee.

Papers are to be submitted in the following format:

1. Front sheet – with FOI exemptions duly applied if appropriate and equality and diversity considerations included.
2. Sub-Committees – Chairs key issues reports using the prescribed template.
3. Members / People Professional Service leads – reporting via the prescribed template.
4. An Action Log will be maintained and distributed between meetings to enable members to respond.
5. Presentations must be sent to the Administrator ahead of the meeting unless otherwise agreed with the Chair of the Committee
6. No tabled papers will be accepted unless in an emergency and with permission of the Chair(s) of the Committee.

10. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. By standard, these Terms of Reference will be reviewed annually by the Committee. From April 2025, these Terms of Reference will be reviewed within three months.

TERMS OF REFERENCE FINANCE & SUSTAINABILITY COMMITTEE

1. PURPOSE

The Finance and Sustainability Committee (“the Committee”) is accountable to the Board of Directors (the Board) and will operate under the broad aims of reviewing financial and operational planning, performance, and strategic & business development.

2. FREQUENCY OF MEETINGS

Meetings shall be held monthly.

3. QUORUM

A quorum shall be two (2) members, one of who must be a Non-Executive Director. In the event that two Non-Executive Directors cannot attend a meeting of the Committee, one of the Non-Executives Directors not normally members of the Committee may attend in substitution and be counted in the quorum.

4. MEMBERSHIP

The Committee shall be composed of two (2) Non-Executive Directors, at least one of whom shall have recent and relevant financial experience.

The Board will appoint one of the Non-Executive Director members of the Committee to be Chair of the Committee. Should the Chair be absent from the meeting the committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.

Core Members

The following individuals, or their nominated Deputy, shall normally be in attendance at the meetings:

- a. Non-Executive Director (Chair)
- b. Non-Executive Director (Deputy Chair)
- c. Chief Finance Officer
- d. Chief Nurse
- e. Chief Operating Officer & Deputy CEO
- f. Executive Medical Director
- g. Chief People Officer
- h. Chief Strategy & Partnerships Officer
- i. Director of Communications & Engagement
- j. Deputy Chief Finance Officer

- k. Company Secretary & Associate Director of Corporate Governance
- l. Associate Director of Estates and Facilities Management
- m. Chief Information Officer

Other Directors including the Chief Executive or staff members may also be invited / expected to attend from time to time for appropriate agenda items; however, there is no requirement to attend the whole meeting.

Observer

- n. Governor

Members can participate in meetings by two-way audio link including telephone, video, or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. Should the need arise, the Committee may approve a matter in writing by receiving written approval.

5. AUTHORITY

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain external assurance; legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

6. REPORTING

The Committee will have the following reporting responsibilities:

- a. The minutes of the Committee meetings will be formally recorded. The Chair of the Committee shall draw to the attention of the Board and Audit Committee any issues that require disclosure to it or require executive action.
- b. The Chair of the Committee will report to the Board annually on its work and performance in the preceding year. The Trust's Standing Orders of Reservation and Delegation and Standing Financial Instructions apply to the operation of the Committee.

The groups listed in the next paragraph are required to submit the following information to the Committee:

- the formally recorded minutes of their meeting; and/or
- separate reports to support the working of the Committee or address areas of concern these Reporting Groups may have; and/or
- An Annual Report setting out the progress they have made and future developments. The following groups will report directly to the Committee:

- Capital Planning Group
- Financial Resources Group
- Digital Strategy Group
- Medical Staffing Review Group
- Strategy & A Greener WHH Sub-Committee
- GIRFT/Clinical Productivity Group
- Improvement & Productivity Group

7. DUTIES & RESPONSIBILITIES

The Committee's responsibilities fall broadly into the following two areas:

Finance and performance.

- a. To provide overview and scrutiny in areas of financial performance referred to the Committee by the Trust Board particularly with regard to any regulatory breaches of the NHS Provider License
- b. Receive and consider the financial and operational plans and make recommendations as appropriate to the Board.
- c. To monitor the effectiveness of the Trust's financial performance reporting systems, ensuring that the Board is assured of continued compliance through its annual reporting, reporting by exception where required.
- d. To review the Trust's performance against its annual financial plan and budgets.
- e. Review the service line reports for the Trust and seek assurance that service improvements are being implemented.
- f. To review the Trust's operational performance against its annual plan and to monitor any necessary corrective planning and action.
- g. Overseeing the development and subsequent monitoring of an operational plan including activity, workforce, finance, annual budget, annual capital programme and cashflow for approval by the Trust board.
- h. To ensure that appropriate triangulation across portfolios in the medium- and long-term financial models is provided.
- i. To review and monitor the in-year delivery of annual efficiency savings programmes.
- j. Consider any relevant risks within the Board Assurance Framework and Corporate Risk Register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Audit Committee or the Board as appropriate via the Committee Assurance Report.

- k. To monitor compliance with NHSE requirements relating to pay policies.
- l. To review and monitor the Trust's overall pay bill.
- m. Benchmark financial and operational performance within the Integrated Care System, regionally and nationally.
- n. Approve capital expenditure up to £5m on behalf of the Trust Board
- o. To oversee the Trust's Emergency Preparedness and Response (EPRR) Framework

Strategy, planning and development.

- p. Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities by reporting to the Board on the nature of those risks and opportunities and their effective management.
- q. Advise the Board and maintain an oversight on all major investments and business developments.
- r. Advise the Board on all proposals for major capital expenditure over £5m or such capital expenditure of lower levels that have a material impact on the Trust's operation.
- s. Oversee the development of the Trust's Commercial Strategy for approval by the Board and oversee implementation of that strategy.
- t. Receive a monthly Digital Services report and maintain oversight of digital investments in line with the Digital Strategy.

8. ATTENDANCE

A record of attendance will be kept, attendance of 75% per year is expected. Members unable to attend must send a nominated deputy who is able to make decisions on their behalf.

9. ADMINISTRATIVE ARRANGEMENTS

Unless prior agreement is reached with the Chair of the Committee, Agenda and Papers will be sent 3 working days before the date of the meeting. No papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board.

- a. The ToR will be reviewed annually by the Trust Board.
- b. A Cycle of Business will be established.

10. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. These terms of reference will be reviewed every 12 months by the Committee.

7.3. Appendix 3



RISK APPETITE FOR NHS ORGANISATIONS

A MATRIX TO SUPPORT BETTER RISK SENSITIVITY IN DECISION TAKING

TO USE THE MATRIX IDENTIFY WITH A CIRCLE THE LEVEL YOU BELIEVE YOUR ORGANISATION HAS REACHED AND THEN DRAW AN ARROW TO THE RIGHT TO THE LEVEL YOU INTEND TO REACH IN THE NEXT 12 MONTHS. 0-5

Risk levels	0	1	2	3	4	5
Key elements	Avoid Avoidance of risk and uncertainty is a Key Organisational objective	Minimal (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only have limited reward potential	Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VFM)	Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	Mature Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VFM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VFM is the primary concern.	Prepared to accept possibility of some limited financial loss. VFM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focused on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliance.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo. Innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery. Responsibility for non-optimal decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisations reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	

'Good is only good until you find better' – Maturity Matrices are produced under license from the Benchmarking Institute. Published by and © GGI Limited Old Woking, Surrey, UK. Tel: 01483 899 979-1407910-11

www.good-governance.org.uk

17.4. Appendix 4 - Risk Management Maturity Model: Assessment Criteria

[illegible]

[illegible]

[illegible]

[illegible]

Specific Key Characteristics : Monitoring and Feedback					
Measurement and monitoring	No measurement framework is in place to assess Risk Management practices.	Number of internal and external reviews provide a range of opinions but no one overall framework to evaluate progress	Risk Management Improvement Plan (RMIP) developed, updated and progress reported via Risk Review Group with assurance report to Board committees	RM Maturity Model developed to provide cross Trust measurement and monitoring of the effectiveness of the embedding of Risk Management in each Care Groups, Service, and programme. Key Performance Indicators established for each Care Group/ programme on risk and governance matters.	Performance against indicators is measured, and results are tracked over time. Action plans are developed to improve performance, and action is taken as required. Performance indicators and benchmarks are refined and updated.
Managers provide assurance on the effectiveness of their risk management.	No but typically not asked for either.	Risk Manager reports to operational Risk Management Review Group on activity within the year.	Central governance/risk team and risk leads take forward actions from the RMIP and provide feedback to risk review committee with assurance reports to Board and Audit Committee.	Risk Leads report to their Care Groups, Service, programme /Governance meeting on the effectiveness of the Risk Management processes within their Care Group, Service, programme	For all risks there is a clear reporting structure for responsible officers to assure Board via governance structures that risks are being managed as agreed.
Assurances are received regarding the effectiveness of the Trusts Risk Management system.	No effective assurance processes in place, nor are any sought from Executives or the Board.	Internal assurances on Risk Management process are received via the central governance/risk team and operational Risk Management committee.	The Trust receives regular assurance both internally and externally regarding the effectiveness of its Risk Management system.	Action plans and feedback from internal and external reviews are formally documented and progress monitored.	The Trust has clear mechanisms in place to proactively seek assurance in respect of risk management. Assurances are identified, monitor and reviewed with feedback used to further enhance the arrangements in place. The Board would typically be challenging Executives as appropriate on all risk matters .

Appendix 4 – Equality Analysis

Impact Assessment (EHIA)

This analysis is being undertaken to prevent your policy, guidance, or standard operating procedure from adversely affecting people with different protected characteristics or at a known disadvantage. This analysis is referred to as 'proposal' throughout the document.

1.1. This section asks you to consider a few questions relating to your proposal:

Who does your proposal affect? (Please put an x in the relevant group)

Patients/ service users	Workforce	Public
*	X	

1.2. Please state if you have completed any engagement as part of this proposal:

Please include any engagement or consultation groups below (e.g. Staff Networks/ Partners).

Patients/ service users	Workforce	Public
	X	

2.1. Does your proposal impact positively, negatively, or neutrally on any of the below characteristics/groups?

2.1.1. Protected characteristics.

Protected characteristics	Scale (select by an x)			Comments / Rationale:
	Positive	Neutral	Negative	
Age	x			This Strategy supports people of all ages to ensure risks are managed equitably
Disability, including learning disabilities/difficulties, physical/hidden disability, sensory impairment, and mental health condition		x		This Strategy sets out clear plans ensuring no disproportionate impact on people who share a protected characteristic and those who do not, aligning with the Trust commitment to equality, diversity and inclusion
Gender reassignment (trans), include consideration for non-binary people		x		

Race (ethnicity)		x		
Religion or belief		x		
Sex		x		
Sexual orientation including lesbian, gay and bisexual people		x		
Marriage and civil partnership, including same sex relationships		x		
Pregnancy and maternity/paternity		x		
Armed Forces and Military Veterans		x		

Does your proposal support positive action for protected characteristic groups?	☒ Yes ☐ No ☐ N/A neutral

2.1.2. Groups who face health inequalities

Groups who face health inequalities	Scale (select by an x)			Comments / Rationale:
	Positive	Neutral	Negative	
Looked after children and young people		x		This Strategy sets out clear plans ensuring no disproportionate impact on people who share a protected characteristic and those who do not, aligning with the Trust commitment to equality, diversity and inclusion
Unpaid carers, e.g. family members		x		
Social factors: • People or families on a low income • People with poor literacy or health literacy • People living in deprived areas and poorer communities. • People living in remote, rural and island locations		x		
Homeless people		x		
People involved in the criminal justice system		x		
Refugees, asylum seekers or those experiencing modern slavery		x		
Other groups experiencing health inequalities (please describe)		x		

2.2. Is the impact of the proposal likely to be negative?	☐ Yes	☒ No

2.3. If yes, please summarise if the impact can be avoided or are there any alternatives?	

3. Link to legal duties:

Does your proposal support compliance with the Public Sector Equality Duty (Equality Act 2010), consider the Armed Forces Act 2021 and Human Rights Act 1998? Please add an x to the relevant box below:

	Tackling discrimination	Advancing equality of opportunity	Fostering good relations
The proposal will support?	x	x	x
The proposal may support?			
Uncertain whether the proposal will support?			

Does your proposal support reducing health inequalities faced by the patients/communities we serve? Please add an x to the relevant box below:

	Reducing inequalities in access to health care	Reducing inequalities in health outcomes through outputs
The proposal will support?		
The proposal may support?	x	x
Uncertain whether the proposal will support?		

Does your proposal support the Trusts commitment to being an anti-racist organisation - neutral ☒	☐ Yes ☒ No

Please provide a rationale / summary for your decision making:

This policy supports an equitable service for people of all protected characteristics.

4. Sign Off – *This should be completed by a Senior Responsible Officer for the proposal (e.g., Director, CBU Manager, Lead Nurse, policy author)*

Name:	Catherine Umbers	Business Unit:	Governance

Signature		Date:	22/7/2025

A copy of this EHIA should be sent to whh.equalityimpactassessments@nhs.net once completed.

You will need to complete a full EHIA if your summary EHIA has identified:

- A negative impact which cannot be mitigated, for both protected characteristics and/or groups who face health inequalities.
- You are unsure about the impact on specific groups.
- You do not have sufficient data or evidence.
- You are completing a public consultation or full-service review / redesign.

Support can be provided in identifying impact / next steps by contacting whh.equalityimpactassessments@nhs.net

The full EHIA can be found [here](#).

Document Version History

Version Number	What has changed
	Complete rewrite Equality and Health Inequality Impact Assessment considered and updated

Risk Management Policy and Procedure

Lead Executive	Ali Kennah, Chief Nurse		
Author's Details	Catherine Umbers, Deputy Director of Integrated Governance		
Type of Document	Policy and Procedure		
Target Audience	All Trust staff		
Document Purpose	Warrington and Halton hospitals NHS Foundation Trust is committed to creating a culture of good risk management through simple processes that will identify, analyse, control, evaluate and monitor risks, with the overall aim of delivering safe, high quality effective care to our patients and create a safe environment for patient's staff and the organisation. This risk management policy and procedure is aligned to the Risk Management Strategy, with the aim to minimise risk to all stakeholders through a comprehensive system of internal control. This policy and procedure provide practical guidance on process and procedure for managing risk within the Trust.		
Ratification Meeting		Date of Mtg	
Approval Meeting		Date of Mtg	
Implementation Date		Review Date	
WHH documents to be read in conjunction with the following documents (note the list below is not exhaustive as this policy and procedure document is linked to all clinical and non-clinical policy documents) Risk Management Strategy Risk Assessment Policy Health and Safety Policy			
Document change history			
Version	1		
What is different?	New Policy		
Appendices/electronic forms	Appendix 1: Risk Identification Wheel Appendix 2: Risk Matrix Appendix 3: Bow Tie Tool Appendix 4: Definitions Appendix 5: Equality Analysis		
What is the impact of change?	Refer to Risk Management Strategy		
Training Requirements	Trust Induction and as required		
Does your document contain any medicine information? Please indicate what	No		

pharmacist you have liaised with?			
Keywords	risk management, registers, identification assessment, analysis, monitoring, SMART actions, controls, gaps, escalation, impact, likelihood, responsibility, culture.		
Taxonomy	Type	Policy Category non-clinical	Policy Category clinical
	Non-Clinical	Integrated Governance & Risk	Choose an item.

[Contents](#)

Section	Page
1. Risk Management on a page - reference guide	3
2. Introduction & Purpose	4
3. Scope	5
4. Duties & Responsibilities	5
5. The Trust Risk Management Process	6
5.1 Establishing the context	6
5.2. Risk Identification	6
5.3. Risk Assessment	7
5.4. Risk Registers	7
5.5. Risk Analysis	8
5.6. The escalation process	9
5.7. Action planning	9
5.8. Monitoring and closure	10
6. Management of Trust wide risks	10
7. Monitoring, implementation and review	10
8. Communication	10
9. References	11
10. Associated Documents	11
11. Appendices	
11.1. Appendix 1 – Risk Identification Wheel	12
11.2. Appendix 2 – Risk Matrix	14
11.3. Appendix 3 – Bow Tie Tool	16
11.5. Appendix 5 – Definitions	17
11.6. Appendix 6 – Equality Analysis	19

1 RISK MANAGEMENT ON A PAGE

Reference Guide – Risk Management Flowchart

1. WHAT IS RISK MANAGEMENT

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

2. WHY IS IT SO IMPORTANT?

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

3. WHO IS RESPONSIBLE FOR IT?

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

4. HOW DO I IDENTIFY & MANAGE RISKS?

IDENTIFY

How should I identify risks?

Risk assessments can be done through a specific **planned** process at corporate, Care Group/ or ward/department level. It is, however, essential for us all to be alerted to risks on an **ongoing** basis, to ensure that we respond promptly to any emerging issues that may lead to risk.

What types of risk should I identify?

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

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

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

ASSESS/RECORD

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

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

MITIGATE / ESCALATE / COMMUNICATE

When is action required?

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

How do I escalate high risks?

Escalation will be based on the grade of the risk as illustrated in the diagram below.



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

How are risks reviewed and followed up?

Care Groups/CBU's, Corporate Functions, Wards/Departments are responsible for reviewing their risks on a regular basis (at least monthly or more frequently if change in risk status). Risks will also be reviewed via the Trust governance systems, including board committees. The Trust executive team will review serious (high) risks as part of their regular performance review.

2. Introduction & Purpose

Warrington and Halton hospitals NHS Foundation Trust is committed to creating a culture of good risk management through simple processes that will identify, analyse, control, evaluate and monitor risks, with the overall aim of delivering safe, high quality effective care to our patients and create a safe environment for patient's staff and the organisation.

This risk management policy and procedure is aligned to the Risk Management Strategy, with the aim to minimise risk to all stakeholders through a comprehensive system of internal control.

This policy and procedure provide practical guidance on process and procedure for managing risk within the Trust.

Risk management is about continually asking and answering the following questions

Context – What is the objective or goal we wish to achieve?

Identify - What is the risk(s) associated with that objective or goal?

Analyse – What would be the impact (consequences if the risk was realised and what would be the likelihood of the risk occurring at that impact?

Evaluate – What is the capacity, appetite and tolerance of the Trust for the identified risk(s)?

Treat – How should we respond to the risk?

Escalate – What is our escalation process (ward to board)?

Monitor – How do we assure ourselves we are managing our risks effectively?

Communicate – Are we communicating our risks via the right channels?

3. Scope

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

4. Duties and Responsibilities

Risk Owner

Risks will be assigned to a named individual, who is responsible for ensuring the risk is managed effectively, including ensuring controls and actions are in place to mitigate the risks and reporting on the risk. High/extreme risks will be overseen by executive directors and will be discussed and agreed with the relevant executive director via the risk owner for there agreement of the level of risk proposed.

Risk Manager

The risk manager is assigned to manage a risk by the risk owner, following discussion and agreement. The risk manager is responsible for completing the risk assessment, with relevant expert support. They report to the risk owner and are responsible for ensuring the risk is identified on the register, reviewed and updated in a timely way, ensuring actions are progressing and inform the risk owner of any change in status of

the risk. Changes to risk manager during the lifetime of the risk will be discussed and agreed with the new proposed risk manager.

Risk Action Owner.

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

Note: Refer to Risk Management Strategy for duties and responsibilities of individual staff and committees/groups.

5. The Risk Management Process

5.1. Establishing the Context

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

5.2. Risk Identification

Risk assessments can be taken through a specific planned process at corporate, care groups, ward/department level, for example Health and Safety. However, it is essential for us all to be alerted to risks on an ongoing basis, to ensure that we respond promptly to any emerging issues. The risk identification wheel at **Appendix 1** will support the identification of different sources through which risk can arise in the organisation.

The types of risks that should be identified are:

Risks to providing patient services which do not meet national and local quality standards, as identified by the Care Quality Commission (CQC) five domains of safe, effective, caring, responsive to people's needs and well-led.

- Risks to providing patients with a safe environment
- Risks to providing staff with a safe working environment
- Risks to the Trust achieving its broader operational and financial objectives and managing the Trust reputation.

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

5.3. Risk Assessment

It is essential all risks are assessed in an objective and consistent manner, if they are to be managed effectively and to guide operational, project and programme planning and resource allocation.

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

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

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

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

The assessment is completed by scoring the impact multiplied by the likelihood. In addition, to the matrix in the quick reference guide at the beginning of this document, an additional more detailed 5x 5 matrix is available at **Appendix 2**. The risk score will inform the risk owner at what level of the organisation and to whom the risk needs to be escalated.

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

5.4. Risk Registers

Wards/department, care groups and corporate service risk registers (repository of risks) are 'live' records that support safety and sound risk management. They contain all unresolved risks identified to services (both clinical and non-clinical) Also as a minimum when reporting a risk onto Datix the risk will contain:

- Date risk first identified
- Date of last review
- Trust objective
- CQC domain

- Risk cause
- Risk description
- Risk impact/consequences
- Current controls in place
- Current gaps
- S.M.A.R.T actions to address gaps
- Initial risk rating
- Current risk rating
- Target risk rating
- Expected review date
- Risk manager
- Risk owner
- Assurance

The risk needs to be described clearly to ensure there is a common understanding by stakeholders of the risk. The recommended format for risk descriptions is to identify the event, the cause and the effect. The Bow Tie tool identified at **Appendix 3** can be used to describe the risk and structure statements. When wording the risk, it is helpful to think about it in three parts, event, cause, effect. If the event (e.g. sickness and absence above safe target -) then this will cause (resulting in staff shortages) resulting in effect/impact (unable to meet service delivery safely)

5.5. Risk Analysis (Scoring)

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

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

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

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

Inherent (gross) risk score	Is the level of risk score when the risk is first identified and reported before the effect of the mitigation
Current risk score	Is the score at the time of the last review taking into consideration the controls place? The minimum review timescale for risks on the register is monthly or more frequently if there is any change in the risk status, for example if mitigating actions completed and identified as controls that will mitigate the risk, or the

	environment has changed resulting in an increase in the risk score requiring further action to mitigate.
Target (mitigated) risk score	Is the estimated exposure arising from a specific risk after implementing the proposed controls and actions contained in the action plan

5.6. Escalation Process

The Board Assurance Framework (BAF) is submitted to the Trust board at each Board meeting, bi-monthly and has additional monitoring via Board Assurance Committees

Any risk scoring 15 or above is escalated to the corporate risk register and with agreement of relevant executives would be recommended as appropriate these risks being added to the BAF.

The Trust executive team will review high risks as part of their regular performance reviews.

Any risks 15 or above (corporate or care group) will be added to the corporate risk register and any risks that cannot be managed locally (above tolerance) at care groups or corporate function level will be escalated to the relevant Board sub-committee.

Risks scoring 8 and above that cannot be managed at ward/department level will be escalated to the care groups triumvirate or corporate function head of department and local governance assurance group for review and action as appropriate.

It is important to note that the escalation of a risk does not negate the responsibility of the individual risk manager for that risk, or the ward/department, care groups or corporate function to pursue or follow up identified risks including associated actions, where they have identified responsibility on Datix.

Refer to the Trust Risk Assessment Policy for further guidance on authority to manage risk and the escalation process.

5.7. Action Planning

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

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

The risk manager with the agreement of the risk owner will assign risk action owner(s) who understand the required action and is capable of delivering the required outcome.

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

- Review the progress of all mitigating actions
- Ensure completed actions are recorded as an existing control
- Record the review by entering the review date and amend current risk grading appropriately.

It is not always possible to identify and then fully implement actions that eliminate or minimise risk. Where this is the case, it is essential the significance of the remaining risk is understood, and the Trust confirms it is prepared to accept that level of residual risk. Acceptance of risk level is determined by the Trust risk appetite and tolerance.

Risk action plans are an important performance measure and are incorporated into performance management via the Trust executive team

5.8. Monitoring and Closure

Risks registers are expected to be a standing item at ward/department, care groups, corporate function and Trust governance committee's agenda. This ensures that risks are consistently identified, monitored and re-evaluated throughout the year. Once all possible actions have been completed and the risk is at the identified target or eliminated the risk on Datix will be closed.

6. Management of Trust Wide Risks

Trust wide risk is an integral part of the system of internal control and defines risks that cross a number of care groups and/or corporate functions, and which may impact on the Trusts ability to deliver its objectives. Ownership and management of Trust wide risks sits with the person who has primary organisational responsibility for the risk domain, this could either be at corporate function level or care groups level. Risks may be owned and managed in a care groups or corporate function but can have actions assigned to a number of staff in other care groups or corporate functions. It is important that when risk actions are assigned to action owners this is discussed and agreed with them before adding to the risk register.

7. Monitoring, Implementation and Review

The Deputy Director of Integrated Governance will oversee the implementation and monitoring of this policy.

Monitoring will be reported to the Executive Led Risk Review Group, and the relevant Board Assurance Committees on behalf of the Trust Board.

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

8. Communication

This Policy & Procedure will be communicated to staff via the following means

- Dissemination and sharing via representatives at approving group
- Care groups notification via relevant care group and corporate function governance processes.
- Available on the Trust intranet via policies on SharePoint

9. References

- Risk Management Strategy
- Risk Assessment Policy

10. Associated Documents

All Trust Policy documents including clinical and non-clinical documents.

11. Appendices

11.1. Appendix 1 – Risk Identification Wheel



Appendix 1

11.2. Appendix 2 - Risk Matrix

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

Consequence Score

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

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

Risk Management Policy

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

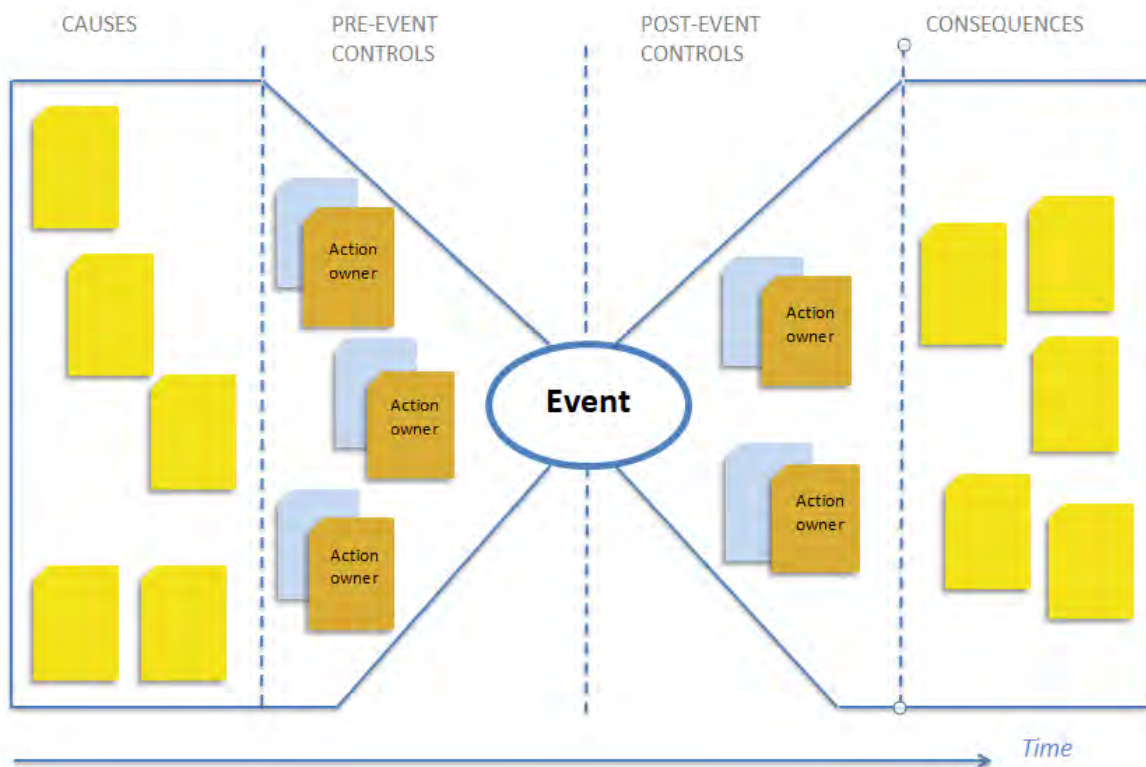
Likelihood score (L)

What is the likelihood of the risk being realised?

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

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

11.3. Appendix 3 Bow Tie Tool



1. Add Event in the centre box – State the risk and context for the risk
2. List causes in the left-hand section
3. List consequences in the right-hand section
4. Then think about the control measures – Proactive (Pre-event) and Reactive (Post-event) controls.
5. Then draw the links between the proactive controls and causes
6. Draw the links between the reactive controls and consequences
7. Look for causes or consequences with no controls – a control that has many causes
8. Decide which of the controls are in place (those are controls) and those that are not in place (those are actions)
9. Decide your level of confidence in the controls – Giving assurance to risk owner that the risk is manageable
10. Allocate action owners according to their expertise and put in place an agreed S.M.A.R.T. action plan to mitigate gaps in controls

11.4. Appendix 4 Definitions

Board Assurance Framework (BAF)	The BAF is the tool by which the Board corporately assured itself about the successful delivery of the Trusts strategic objectives. The BAF is designed to focus the Board on controlling principal risks threatening the delivery of those objectives. The BAF aligns principal risks, key controls and assurances on the operation of the controls.
Risk appetite	The level of risk the Trust is prepared to accept or be exposed to at any point in time
Cost	Activities, both direct or indirect, which result in a negative outcome or impact for an individual or the Trust. For example, cost could include money, labour, reputation, political and intangible losses.
Hazard	Potential source of harm or adverse health effect
Issue	Essentially a risk that has happened
Risk	The chance of something happening that will have an adverse impact on the achievement of the Trusts objectives and the delivery of high-quality care. It is measured in terms of consequences and likelihood.
Risk Management Process	Systematic application of management policies, procedures and practice to the tasks of establishing the context of risk, then identifying, analysing, evaluating, treating, monitoring and communicating risk.
Material risk	Most significant risks or those on which the Board and their assurance committee focuses
Risk assessment	Overall process of risk identification, risk analysis, risk action and risk evaluation. <i>Refer to Trust Risk Assessment Policy available on the Trust document management system (DMS)</i>
Risk analysis	A systematic use of the available information to determine how often specific events may occur and the magnitude of the consequences
Inherent risk	This is the score assigned to a risk if the controls in place are found to be ineffective or absent. <i>It involves the use of the 5x5 matrix at appendix 2.</i>
Residual risk	This is also known as the current risk score. It is the score assigned to any risk after the control measures in place are taken into account. It involves the use of the 5x5 matrix with impact and likelihood being adjusted following the inherent risk score. <i>The scoring 5x5 matrix is provided at appendix 2</i>
Target risk	This is the future risk score assigned to a risk after gaps in control measures have been addressed and outstanding actions implemented. This should reflect the risk tolerance.
Risk Tolerance	The boundaries of risk taking outside of which the organisation is not prepared to venture in the pursuit of its objectives,
Impact	The potential consequences if the adverse effect occurs as a result of the hazard.
Likelihood	A qualitative measure/description or probability of frequency
Probability	The likelihood of a specific event or outcome occurring. This is measured by the ratio of specific events or outcomes occurring to the total number of possible events or outcomes. Probability is expressed along a scale ranging from rare to almost certain. Refer to 5x5 risk matrix at appendix 2.
Risk Rating	The total score worked out by identifying the consequences and likelihood score and cross referencing with the risk matrix. <i>Refer 5x5 matrix at appendix 2</i>

Risk Control	That part of risk management which involves the development and implementation of policies, standards, procedures and/or physical changes to eliminate or minimise adverse events of risk.
Adverse events	Any event or circumstances leading to unintended harm and/or suffering which resulted in admission to hospital, prolonged stay, significant disability at discharge or death.
Gaps in controls	Processes or activities not yet in place in order to effectively manage the risk
Risk actions	A specific, measurable, achievable, relevant and time-specific piece of work that is to be completed, that will address an identified gap in control or assurance.
Secondary risks	risks caused by actions/treatment
monitor	To check, supervise, observe critically or record the progress of an activity, action or system on a regular basis in order to identify change
Controls Assurance	A process designed to provide evidence that the NHS in total (and its constituent parts) is doing its reasonable best to manage, direct and control itself so as to protect itself, its employees, patients and stakeholder's safety and interests against all types of risks.
Risk assurance	Evidence that supports the measurement of controls in place, to ensure they are operating effectively, and the desired outcome is being achieved.
Inadequate Assurance	When assurance or evidence is limited and cannot provide full assurance that controls are effectively managing the risk. Gaps should be identified and lists with actions to mitigate
Gaps in assurance	Lack of measures or evidence to support the measurement of controls
Internal assurance	Assurance provided by reviewers, auditors and inspectors who are part of the organisation such as clinical audit or management peer review
External Assurance	Independent assurance provided by reviewers, auditors and inspectors from outside the organisation for example the CQC, Commissioners, NHS Improvement.
System Failure	A non-conformance with malfunction or deviation from a defined management system. A system failure may also be defined as inadequate performance, non-participation in or non-application of a defined management system or process.

11.5. Appendix 5 – Equality Analysis

2. Impact Assessment (EHIA)

This analysis is being undertaken to prevent your policy, guidance, or standard operating procedure from adversely affecting people with different protected characteristics or at a known disadvantage. This analysis is referred to as 'proposal' throughout the document.

1.1. This section asks you to consider a few questions relating to your

2.1. proposal:

Who does your proposal affect? (Please put an x in the relevant group)

2.2.

Patients/ service users	Workforce	Public
*	X	

1.2. Please state if you have completed any engagement as part of this.

2.3. proposal:

Please include any engagement or consultation groups below (e.g. Staff Networks/ Partners).

2.4.

Patients/ service users	Workforce	Public
	X	

2.1. Does your proposal impact positively, negatively, or neutrally on any of the below characteristics/groups?

2.7.

2.1.1. Protected characteristics.

Protected characteristics	Scale (select by an x)			Comments / Rationale:
	Positive	Neutral	Negative	
Age	x			This Policy and Procedure supports people of all ages to ensure risks are managed equitably
Disability, including learning disabilities/difficulties, physical/hidden disability, sensory impairment, and mental health condition		x		This Policy and Procedure sets out clear plans ensuring no disproportionate impact on people who share a protected characteristic and those who do not, aligning with the Trust
Gender reassignment (trans), include		x		

consideration for non-binary people				commitment to equality, diversity and inclusion
Race (ethnicity)		x		
Religion or belief		x		
Sex		x		
Sexual orientation including lesbian, gay and bisexual people		x		
Marriage and civil partnership, including same sex relationships		x		
Pregnancy and maternity/paternity		x		
Armed Forces and Military Veterans		x		

Does your proposal support positive action for protected characteristic groups?

☒ **Yes** ☐ **No** ☐
N/A neutral

2.9.

2.1.2. Groups who face health inequalities

Groups who face health inequalities	Scale (select by an x)			Comments / Rationale:
	Positive	Neutral	Negative	
Looked after children and young people		x		This Policy and Procedure sets out clear plans ensuring no disproportionate impact on people who share a protected characteristic and those who do not, aligning with the Trust commitment to equality, diversity and inclusion
Unpaid carers, e.g. family members		x		
Social factors: • People or families on a low income • People with poor literacy or health literacy • People living in deprived areas and poorer communities. • People living in remote, rural and island locations		x		
Homeless people		x		
People involved in the criminal justice system		x		
Refugees, asylum seekers or those		x		

experiencing modern slavery				
Other groups experiencing health inequalities (please describe)		x		

2.2. Is the impact of the proposal likely to be negative?	☐ Yes	☒ No

2.3. If yes, please summarise if the impact can be avoided or are there any alternatives?	

3. Link to legal duties:

Does your proposal support compliance with the Public Sector Equality Duty (Equality Act 2010), consider the Armed Forces Act 2021 and Human Rights Act 1998? Please add an x to the relevant box below:

	Tackling discrimination	Advancing equality of opportunity	Fostering good relations
The proposal will support?	x	x	x
The proposal may support?			
Uncertain whether the proposal will support?			

Does your proposal support reducing health inequalities faced by the patients/communities we serve? Please add an x to the relevant box below:

	Reducing inequalities in access to health care	Reducing inequalities in health outcomes through outputs
The proposal will support?		
The proposal may support?	x	x
Uncertain whether the proposal will support?		

Does your proposal support the Trusts commitment to being an anti-racist organisation - neutral ☒	3. ☐ Yes ☒ No

Please provide a rationale / summary for your decision making:

This policy supports an equitable service for people of all protected characteristics.

4. Sign Off – This should be completed by a Senior Responsible Officer for the proposal (e.g., Director, CBU Manager, Lead Nurse, policy author)

Name:	Catherine Umbers	Business Unit:	Governance
Signature		Date:	22/7/2025

A copy of this EHIA should be sent to whh.equalityimpactassessments@nhs.net once completed.

You will need to complete a full EHIA if your summary EHIA has identified:

- A negative impact which cannot be mitigated, for both protected characteristics and/or groups who face health inequalities.
- You are unsure about the impact on specific groups.
- You do not have sufficient data or evidence.
- You are completing a public consultation or full-service review / redesign.

Support can be provided in identifying impact / next steps by contacting whh.equalityimpactassessments@nhs.net

The full EHIA can be found [here](#).

Document Version History

Version Number	What has changed
	New Policy & Procedure Linked to rewritten Risk Management Strategy

REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/25/08/71	
SUBJECT:	CQC Compliance Assurance Report Q4 2024/25	
DATE OF MEETING:	6 August 2025	
AUTHOR(S):	Felicia Swift, Head of Compliance	
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah, Chief Nurse	
LINK TO STRATEGIC OBJECTIVE: <i>(Please select as appropriate)</i>	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): <i>(Please DELETE as appropriate)</i>	224 If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival resulting in an overcrowded Emergency Department. 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. 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. 115 If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. 1134 If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low	

	levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	Yes	No	N/A
			✓	
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	Yes	No	N/A
			✓	
	Further Information:			
EXECUTIVE SUMMARY (KEY ISSUES):	3. Foster good relations between people who share a protected characteristic and those who do not	Yes	No	N/A
			✓	
	Further Information:			
	The purpose of this paper is to provide the Quality Assurance Committee with CQC standards compliance assurance and where deficits are identified actions for improvements are identified and implemented.			
	The report provides oversight to the committee about assurances provided to the following meetings			
	Quality Compliance Oversight Group (QCOG), - 15 January 2025 (Q4) Quality Compliance Oversight Group (QCOG), - 19 March 2025 (Q4) Quality Compliance Oversight Group (QCOG), - 19 May 2025 (Q1) CQC Engagement meeting - 31 March 2025			
	The report provides assurance about the CQC enquiries, both closed and ongoing.			
The report also provides assurance about the Health and Safety Executive inspection following the tuberculosis exposure incident in the Pathology laboratory				
PURPOSE: (please select as appropriate)	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.	
	Date of meeting	10 June 2025
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: (<i>if relevant</i>)	None	

REPORT TO TRUST BOARD

SUBJECT	CQC Compliance Assurance Report Q4 2024/25	AGENDA REF:	BM/25/08/63

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.

To monitor overall performance in relation to the Trust's compliance and assurance objectives, a Quality Compliance Oversight Group (QCOG) was formed. Meetings took place during Q4 on 15 January 2025 and 19 March 2025. The most recent meeting took place on 19 May (Q1 of 2025/26). Going forwards the frequency of the meetings has been changed. The Group will now meet monthly instead of bi-monthly.

2. QUALITY COMPLIANCE OVERSIGHT GROUP OVERVIEW

A QCOG Meeting, held on 15 January 2025, reflected the quality compliance and assurance work being undertaken, as well as outlining health and safety compliance visits from other agencies. The updates received related to the following:

- CQC General Update
- Update on Single Assessment Framework (SAF)
- Update on plans for scheduled mock assessments (Medicines Management and Safeguarding). Plans for a Well-Led Assessment (strategic and operational)
- Previous Inspection Must Do's and Should Do's
- CQC Enquiries
- Policy Progress Regulation 17 Update

A QCOG Meeting was held on 19 March 2025. Points covered:

- CQC General Update and outline of plans for the Engagement Meeting scheduled to take place on 31 March 2025

The proposed Engagement Meeting agenda that is prepared by the CQC, was outlined and an update was given regarding the preparation that was already underway for the meeting. The key presentation featured Specialist Surgeries. A visit to observe the Pharmacy Robot was also planned.

- Single Assessment progress update
The SAF guide is on the intranet and there is a communications plan to support development. Making a Difference” articles that feature in Weekly News will be aligned with Quality Statements and a submission structure for articles is to be implemented, to ensure there is a good stock of stories.
- CQC Enquiries
An overview of the current CQC enquiry position was presented, with reference to the enquiries that remained open, and why.
- Health and Safety Update
The update described the RIDDOR reported incident in Pathology.
- Infection Prevention and Control presentation
Position presentation and update relating to the increase in Clostridium Difficile cases and ongoing work that is place to reduce the incidence.
- Culture Plan and Staff Survey Headlines
A detailed overview was presented of both the recently publicised Staff Survey results and the WHH Culture Plan. The survey highlighted a high level of positive results both from a WHH perspective (when analysing against previous results), and when results were compared against other hospital Trusts.

The first Q1 meeting for QCOG took place on 19 May 2025. The headlines are listed below:

- CQC General Update (engagement Mtg feedback from 31 March 2025)
- Update on Single Assessment Framework (SAF)
- Presentation: Ionising Radiation (Medical Exposure) Regulations Inspection (IRMER)
- Previous Inspection Must Do's and Should Do's
- Health and Safety update
 - o The visit from the HSE, in connection with the RIDDOR reported incident in Pathology, was undertaken on Friday 2 May 2025. The visit went extremely well, with excellent feedback.
- CQC Enquiries
- Policy Progress Regulation 17 Update

The next QCOG Meeting is scheduled to take place on 18 June 2025.

2.1 CQC ENGAGEMENT MEETING OF 31 MARCH 2025 UPDATE

A CQC Engagement Meeting took place on 31 March 2025. The CQC provided an update on their national leadership changes, SAF methodology changes and procedural improvements.

Sir Mike Richards joined as Chair of the CQC from 1 April 2025. The service highlight discussion for the meeting featured Specialist Surgery. A Trust presentation was delivered which outlined areas of good practice, challenges and improvement goals for the Care Group. In addition to the standard agenda items, the CQC added more specific topics to their agenda, under the quality update sections.

Quality Assurance - Safe

- o IPC: Update on the WHH best practice campaign. Outcome of 23/24 deep dive.
- o NC2R: IPR notes 206 NC2Rs, representing more than a third of the Trust's total bed numbers. Daily discharge sitreps (below) identify high numbers delayed by care transfer hub processes. Discussion around action the Trust is taking and what support is being provided by partners to address NC2Rs.
- o Sepsis performance: Trust's screening performance in ED had dropped from 54% to 52%. Sepsis performance in inpatients was 60%. Antibiotics administered within the hour in ED was reported as 52%. The Trust's IPR notes that this was the third month of data under the new NG51 guidelines. WHH performance compared C&M Trusts was noted. Actions to improve were discussed.
- o Maternity including Stillbirth, Neonatal deaths and MNSI referrals: Noted CNST full compliance. An overview of Maternity performance was provided, including learning from themes from recent MNSI investigation outcomes.
- o It was noted there have been 3 PSII's since November 2024 and zero never events.
- o No regulation 28's have been received.

Quality Assurance - Effective

- o Mental Health Care in Acute Trusts: Recent assessment activity continues to highlight issues similar to those identified in our national report:
https://www.cqc.org.uk/sites/default/files/20201016b_AMSAT_report.pdf
Discussion were held around how WHH is assured patients with a mental health condition receive safe care. Due to time constraints, it was agreed to defer this item to the next Engagement Meeting.

Quality Assurance – Caring

- o Patient satisfaction analysis: CQC Maternity Survey results
 - Maternity Survey results show WHH to be in the top 8 in Trusts, rated better than expected. It was noted WHH is currently just one of two Trusts who were awarded this rating.
 - Hot spot surveys have been completed to check current position. There are dedicated resources, and an action plan has been created with one area around infant feeding.
 - The LMNS Partnership (Local Maternity and Neonatal System) came to visit WHH Maternity Services in December 2024, and the regional team provided positive feedback on the progress the service has made.

Quality Assurance – Responsive

- o Complaints & Compliments
- o Access and waiting times

Deferred until the next Engagement Meeting.

Quality Assurance – Well-Led

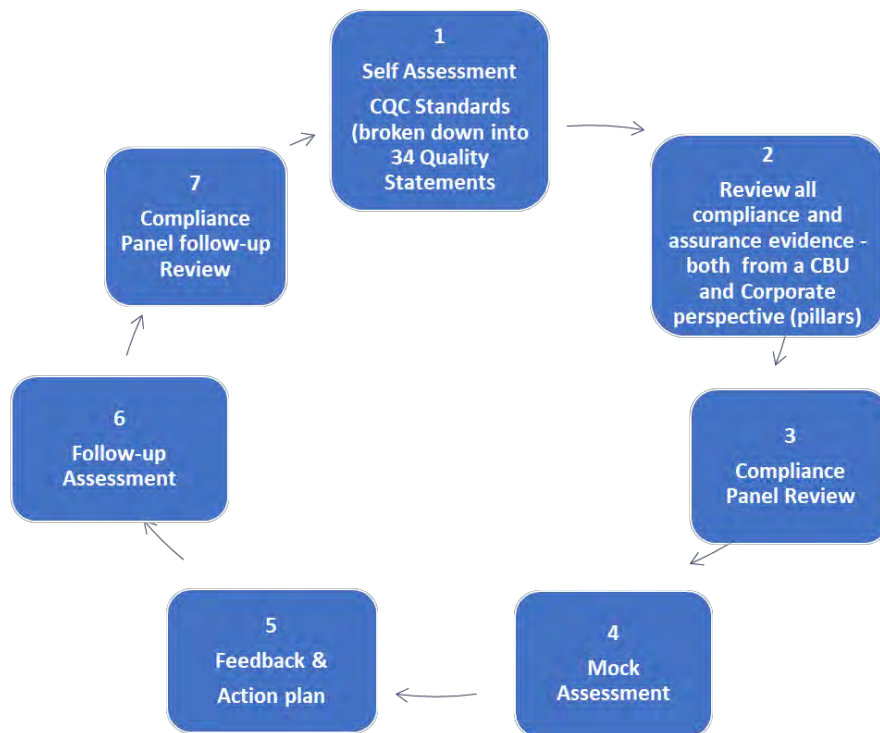
- o Culture deep dive: An overview of the WHH Culture Plan including drivers and work programme was positively received.
- o Fragile services update – included in the update was the fact that Chronic Pain would be added as a Fragile Service going forwards for additional support.

The next CQC Engagement Meeting is anticipated to take place on 17 July 2025. The venue will be at Halton Hospital, and it will provide an opportunity for CQC representatives to visit key areas on the site. There were several agenda items that had to be deferred from the last meeting and will feature in the next meeting. The up-to-date agenda will be drafted by the CQC and sent through to the Compliance Team early in July 2025, giving time for WHH assurances to be prepared.

2.2 UPDATE ON SINGLE ASSESSMENT FRAMEWORK AND COMPLIANCE FRAMEWORK OF ASSURANCE

WHH has Pillars of Assurance and collectively, all information gathered under each of the pillars, contributes to assessing whether the right systems, processes and evidence in place to assure ourselves and the Trust Board that we are a Safe, Effective, Caring, Responsive and Well-led organisation (CQC's 5 Key Questions).

A cycle of business has been implemented. The aim of the Cycle of Business is to constantly monitor, review and test all evidence found under each pillar of assurance. Compliance and Assurance is monitored through the Quality Compliance Oversight Group (QCOG).



Step 1

Updated SAF scores from the self-assessment work have been collated. It is possible to review by specific ward/area, as well as by Clinical Business Units. The process allows teams to understand their compliance against the CQC Key Questions and Quality Statements. The scores can prioritise key areas for improvement, as well as indicate areas where teams feel they have solid, robust evidence to support a positive score.

Step 2

It is necessary to collect and review all evidence that supports scores. The SAF is just one of the Framework of Assurance “Pillars”, along with Quality Improvements (QI), Performance, Corporate Assurance, Ward Accreditation, and external reviews/accreditations. Evidence found under each of the Quality Assurance Pillars needs to be brought together, scrutinised and tested. This will be a “bottom-up” approach to ensure that all evidence is being captured and utilised effectively, rated appropriately and where there are gaps in assurance, there are suitable action plans in place to address issues, as well as having the most appropriate reporting mechanisms to oversee progress.

Step 3

When evidence has been reviewed at a local level, the SAF rating and associated evidence can then be scrutinised further by the Compliance Panel. The panel will provide an objective view, ratify the scores against the evidence portfolios and agree any areas of concern that require further support.

Step 4

Following Panel Review, a mock assessment will be undertaken. Evidence and scores will inform areas of specific focus for assessment, and test areas where the evidence would seem to indicate good results.

Step 5

Following the mock assessment review, feedback will be shared, and action plans will be implemented. Where areas of work are still in the process of being developed, actions can be amended/updated to existing plans. Overall outcomes will be presented to QCOG and action plans (and progress against the plans) will be monitored and measured through this group.

Step 6

Follow up mock assessments will be scheduled, prioritising the areas that have provoked more gaps in assurance.

Step 7

As the improvement work will be a continuous cycle, the Compliance Panel will meet weekly to review amendments to evidence portfolios.

A SAF electronic form has been developed to replace the previous Excel spreadsheet used to collect information. It has been simplified for the user, and it provides better functionality for the Compliance Team. When a rating form is submitted, a notification is automatically sent to the Compliance Team. Associated evidence is then gathered and reviewed at CBU/Care Group level, prior to the panel review. The forms can be used to temperature gauge team perceptions about how they feel their area is performing against the standards. It provides a lot of additional potential to test evidence going forwards.

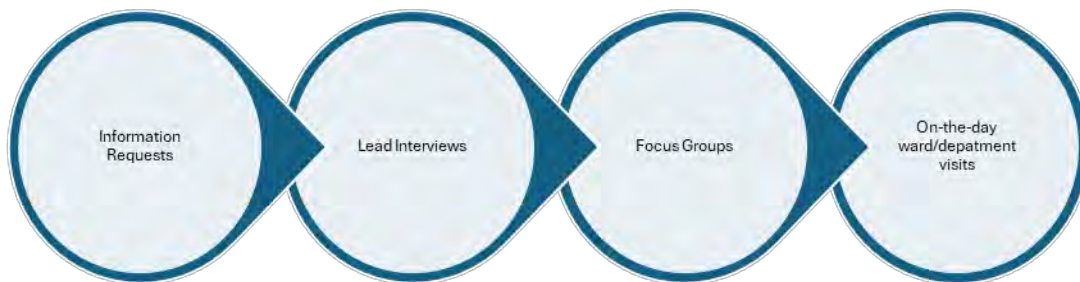
An evidence directory template has also been developed, and Digestive Diseases are currently piloting the system, by populating their evidence against the CQC Quality Statements. The directory will indicate the name of the piece of evidence, where it is stored, the “owners” and contact details. The system allows evidence lists held within the directory to be filtered in a variety of ways. A user can filter by Care Group, CBU, Ward/Department, under the CQC Key Question or even by a particular quality statement. The evidence lists will be managed and owned by the Care Groups.

2.3 UPDATE ON PUBLICISING CQC RATINGS

CQC ratings must be displayed conspicuously both at premises and on-line. A review took place to identify the different CQC promotional posters being displayed in and around the Trust. A WHH proposal for future promotional CQC rating materials was drafted, and the CQC were approached for further guidance and confirmation that the Trust’s promotional plan was fit for purpose. Changes to the on-line information were made and new displays have been positioned around the Warrington Hospital site, with a date to update the Halton site displays having been arranged for June 2025.

2.4 UPDATE ON THE MOCK ASSESSMENT PROGRAMME

A Medicines Management Mock assessment took place over 2 days during April and May 2025. An external assessor was brought in to support the assessment. The information was captured using a variety of methods:



All evidence that was captured has now been forwarded to the external assessor for final review. A formal report will be completed, with feedback to staff and QAC in the Q1 report.

The next mock assessment due to take place relates to Safeguarding on Wednesday 3 June 2025. A team of external assessors have been enlisted to support this assessment.

The 2025/26 CQC mock assessment schedule has been planned to use the information gained from the SAF scores. As the Quality Assurance programme of work continues, the schedule will be subject to change, depending on priority areas for assessment identified.

2.5 CQC ENQUIRIES AND NOTIFICATIONS

CQC Annual update 2024/25

	Q1	Q2	Q3	Q4	TOTAL
Digestive Diseases	0	0	2	3	5
Specialist Surgery	0	0	3	2	5
Women’s and Children’s	0	0	1	4	5
Urgent & Emergency Care	2	2	1	5	10
Medical Care	0	2	1	1	4
Integrated Medicine & Community	0	1	3	2	6
Clinical Support Services	0	1	0	2	3
Trust-wide	0	1 *13 separate incidents under one reference	0	2	3 (15)
04:49					41 (*53)
TOTAL Enquiries for 2024/25					
Never Events					2
IRMER					1
MRSA				1	1
RIDOR			1	1	2

Ongoing enquiries from 2024/25

Q2 remaining open

Category	Query	Comments
Opened 30.7.24 CAS-506098 Complaint – ISR	196155 (2232/22151) Concerns re: patient care in ED PSII 196155	PSII presented to the Safety Oversight Meeting (SOM) w/c 27.1.25. Final amendments were completed, and the report was resubmitted to SOM. Final report sent to the CQC 24.2.25.
Additional information request 25.04.25 - Provide a copy of the 'headache proforma to be used for escalation support from Triage within the Emergency Department' as detailed in serial 1 of the safety action summary table (Clinicians education regarding Headache management). - Provide a copy of the 'Pan Mersey red flag guidance' as detailed in serial 1 of the safety action summary table (clinicians education regarding Headache management).		

- Provide a copy of the 'audit on a dip sample of ED clinical documentation to provide assurance of compliance' as detailed in serial 1 of the safety action summary table (Documentation).
- Provide details of the induction programme for new clinicians in the Emergency Department to include any specialty training

Outstanding information was sent to the CQC within the stipulated time. Now awaiting response from the CQC. The only item that will need forwarding in due course is the Headache proforma. The amendment and final sign off need to occur. The next UEC Governance Meeting is 11 June 25. It is anticipated the document will be signed off at this meeting.

Q4 enquiries– 12 in total, of which 10 have been closed, 1 awaiting CQC sign off and 1 remains open

Category	Query	Comments
Opened 4.2.25 CAS-744669 Treatment Query Halton Hospital	Query as to why colonoscopy results were sent to GP, when patient could not attend for the procedure. Pt Tyler J Chorley Ref 24008	Pt Information sent from the CQC and received on 12.3.25. Passed to PALS. Logged as a formal complaint. Will send final response to CQC in due course. Due date 7 July 2025.
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.	Request for a copy of the post infection review. Sent to CQC on 9/5/25. Awaiting CQC sign off.

1 Never Event Notification – opened in Q4. PSII completion date isn't until July 2025

Opened 13.1.25 CAS-722985 Theatres 31.12.24	81-year-old female admitted 30/12/2024 following a fall and sustaining a right intracapsular #NOF. PSII 200762	During a a Hemi Hip Arthroplasty on 31/12/2024, it was recognised by the surgeon that the wrong stem was implanted with cement. The surgeon intended to use a standard offset stem but implanted a high offset stem. No harm came to the patient. After discussion at Safety Oversight Meeting (SOM), a Never Event was declared on 6.1.25, due to the unintended prosthesis. • Patient Safety Incident Investigation (PSII) lead has been identified. • Duty of Candour completed. • Reported using Strategic Executive Information System (StEIS). PSII outcome to be shared with CQC. 1st Draft completed. Went to SOM on 12/5/25. Report currently being

		redacted and then it can be shared with the CQC.

Q1 enquiries (2025/26) to date

Category	Query	Comments
Opened 15.05.25 CAS-881098 MH patient in UEC for 170 hrs waiting for transfer to MH bed	The enquiry relates to a potentially 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 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. Awaiting Core24 response and then the draft response will be completed.
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.
Opened 22.05.25 CAS-903889 Alleged unsafe discharge	Notification from a care provider alleging an unsafe discharge. Request to provide Discharge Policy and address specific issues relating to medications and dressings.	Fact finding underway.
Opened 22.05.25 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.	Fact finding underway. 2 datix incidents in the system. Would appear that duty of candour has enhanced the relative's concerns about care and treatment.

2.6 HEALTH & SAFETY INSPECTIONS

The visit from the HSE, in connection with the RIDDOR reported incident in Pathology, was undertaken on Friday 2 May 2025. The visit went extremely well, with excellent feedback.

- o The HSE inspector was pleased with the robust processes in place, and how the Microbiology Team rectified an IT issue immediately following the incident.
- o The inspector also commented how positive it was that Pathology work closely with the Health & Safety Team.
- o Following the visit the HSE inspection, confirmed no further actions required. The HSE closed the incident.
- o Please note, approximately 5 years ago the HSE decided to only write an outcome letter to a Trust if the investigation was less than satisfactory. As a consequence, WHH will not receive an outcome letter. However, this is positive, as it confirms the matter is fully completed.

2.6 HEALTH & SAFETY INSPECTIONS

The visit from the HSE, in connection with the RIDDOR reported incident in Pathology, was undertaken on Friday 2 May 2025. The visit went extremely well, with excellent feedback.

- o The HSE inspector was pleased with the robust processes in place, and how the Microbiology Team rectified an IT issue immediately following the incident.
- o The inspector also commented how positive it was that Pathology work closely with the Health & Safety Team.
- o Following the visit the HSE inspection, confirmed no further actions required. The HSE closed the incident.
- o Please note, approximately 5 years ago the HSE decided to only write an outcome letter to a Trust if the investigation was less than satisfactory. As a consequence, WHH will not receive an outcome letter. However, this is positive, as it confirms the matter is fully completed.

3. CQC PLAN NEXT STEPS

- Evidence gathering will be completed by Care Groups and support services. The aim is to complete the evidence directory and undertake mock assessments for all areas that have been identified in line with trajectory plan.
- The 2025/26 Quality Assurance Cycle of Business workstreams have been planned for the year and will be monitored rigorously via QCOG.
- Work with the Associate Director of Nursing (Corporate Services) aligning elements of the CQC mock assessments with the established Ward Accreditation scheme where relevant.
- Finalise the Medicines Management mock assessment report and communicate widely via Trust processes.
- Undertake the Safeguarding Mock Assessment and complete report.
- Work with the care group and support functions on action plan requirements related to SAF and mock assessments in line with the annual plan.
- Continue the QCOG work in line with the workplan.
- Plan and prepare for the next CQC Engagement Meeting scheduled to take place on 17 July 2025.
- Complete assurance evidence guidance document for staff and circulate in line with trajectory plan.
- Set up CQC evidence review groups in line with assessment schedule, ensuring they are aligned.
- Manage all CQC Enquiries effectively.

4. RECOMMENDATIONS

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

Maternity Review of 2024/25

Trust Board – August 2025



Working
Together



Excellence



Inclusive



Kind



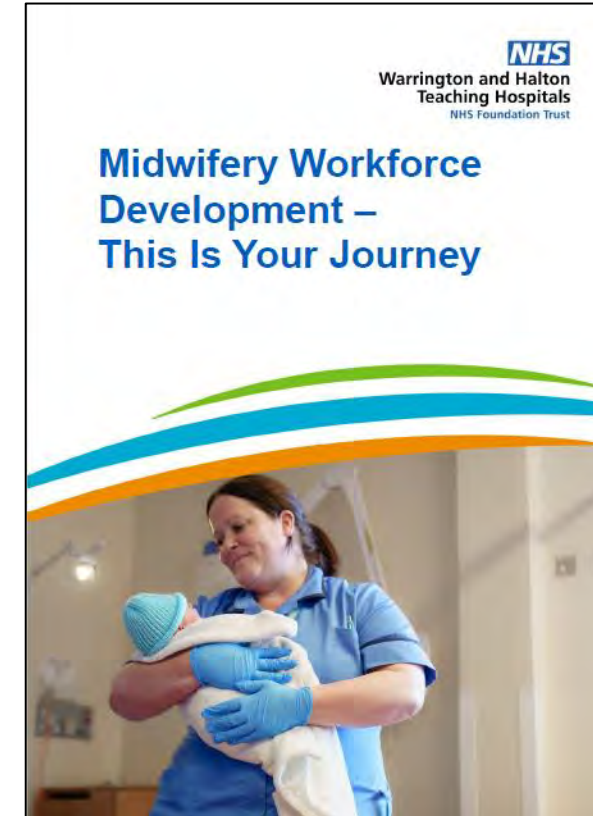
Embracing
Change

Driver	Completed activity
❖ Ockenden recommendations ❖ Maternity Incentive Scheme ❖ Three Year Delivery Plan for Maternity & Neonatal Services	Birth Rate+ assessment of midwifery establishments completed - findings shared
	Robust workforce planning to monitor midwifery staffing on a daily, weekly basis and appropriate escalation processes now fully embedded
	Consultant Obstetrician workforce fully established
	Revenue request to support Triage staffing model successful and additional establishment recruited
	Culture workstream in place – series of ‘ideas sessions’ held with staff and actions underway
	Thank You Thursday communications implemented
	Programme of activity to support wellbeing of newly qualified midwives implemented utilising ringfenced Ockenden monies
	Focussed work to support internationally educated midwives



Workforce

Driver	Completed activity
❖ Ockenden recommendations ❖ Maternity Incentive Scheme ❖ CQC Inspection report ❖ Three Year Delivery Plan for Maternity & Neonatal Services	Robust programme of skills and drills implemented reflecting learning from incidents and best practice in place
	Annual training plan refreshed to facilitate increased opportunity for MDT learning and ensuring personalised care planning and human factors is a consistent thread
	Focus on maintaining and improving compliance with mandatory training
	Sustained improvement in compliance with mandatory training
	Ten newly qualified midwives successfully supported through preceptorship programme.
	Recruitment of eight newly qualified midwives
	Ongoing review of preceptorship programme reflecting needs of service and feedback form newly qualified colleagues
	Midwifery workforce development guideline “This is your journey” implemented



Workforce – outcomes/outputs



**Warrington and Halton
Teaching Hospitals**
NHS Foundation Trust

Sustained improvement in midwifery workforce metrics

- Vacancy rate has remained consistently under Trust target
- Midwifery retention have fluctuated largely due to retirement but rates below the Trust target have been maintained since December 2023

All requirements of Maternity Incentive Scheme Year 6 and Saving Babies Lives v3 in relation to workforce achieved

Excellent retention of newly qualified midwives

- 17 NQM/early career midwives have attended Thrive training sessions to support resilience.
- Wellbeing days arranged and well received

Good performance against key 'red flag' measures Jan 2025-March 2025

- Provision of 1:1 care in labour – no episodes recorded in SafeCare
- Birth Suite Coordinator supernumerary - No occasions where a Birth Suite coordinator was not allocated at the beginning of the shift. There are 5 episodes recorded in BR+ where the Birth Suite Coordinator is NOT supernumerary. These were all for short periods and the escalation policy was initiated

All internationally educated recruits now completed supernumerary period

- One IR has also been supported to complete the Your Future, Your Way programme

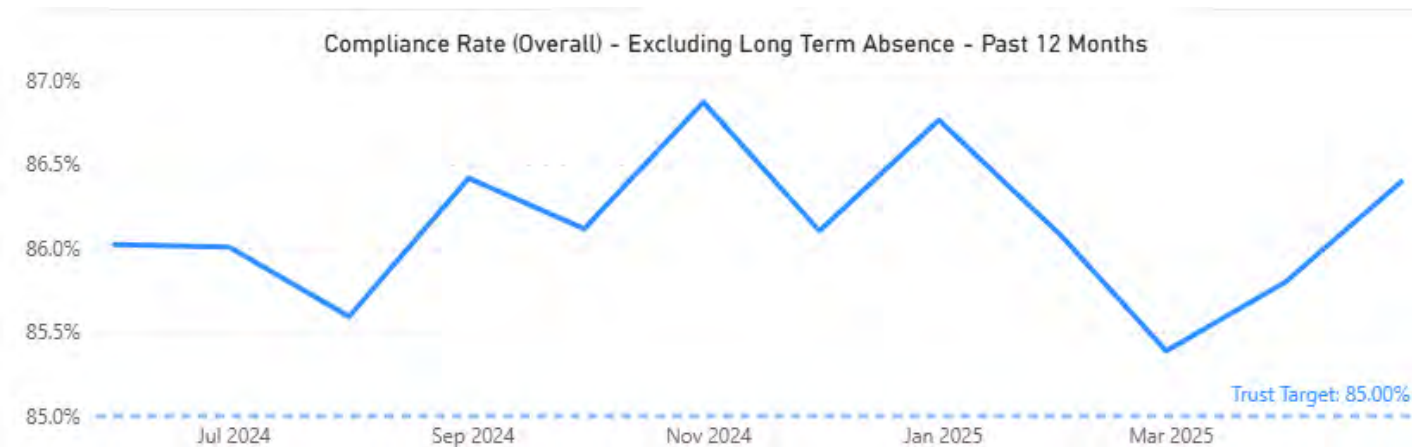


Workforce – outcomes/outputs #2

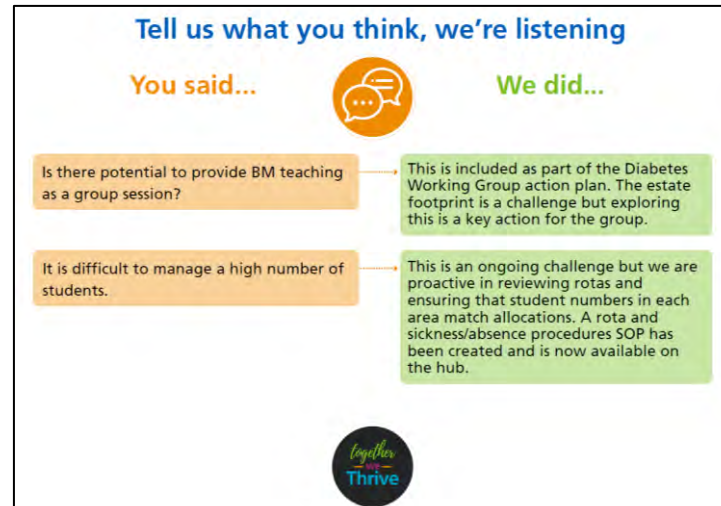
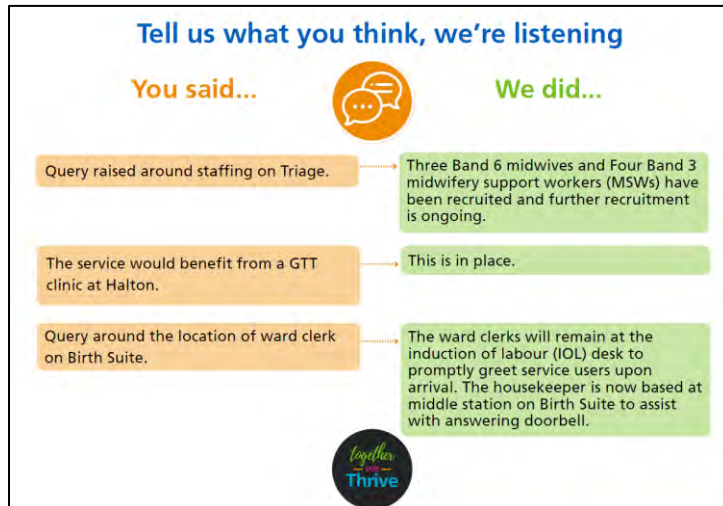
Current position – Training compliance - maternity specific

	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)	Newborn Life Support Level 2	MAMU 3
Midwives	94.1%	97%	97.6%	95.6%	97.4%
Obstetric Consultants	100%	90.9%	100%	n/a	n/a
Other Obstetric	100%	96.1%*	91.6%	n/a	n/a
Obs Anaesthetic	93.1%	n/a		n/a	n/a
Maternity Support Workers	100%	n/a		n/a	93.1%
Neonatal medical and ANNP	n/a	n/a	n/a	Awaiting Data	n/a

Excellent compliance against maternity specific mandatory training and overall compliance against all competencies consistently above Trust target of 85%



Workforce – outcomes/outputs #3



Personalised Care



**Warrington and Halton
Teaching Hospitals**

NHS Foundation Trust

Driver	Completed activity
❖ Ockenden recommendations ❖ Maternity Incentive Scheme ❖ Three Year Delivery Plan for Maternity & Neonatal services ❖ Guidance from All-Party Parliamentary Group on Birth Trauma	Robust birth reflection offer led by the Consultant Midwife and supported by specialist and senior midwives across the maternity service. New self referral pathway was introduced in January 2025.
	Continued focus on reducing inequality and ensuring relevant specialist pathways are in place
	MDT Perinatal Pelvic Health Service now embedded including access to advice and support in antenatal and postnatal periods via specialist midwifery and physiotherapy input and single point of access MDT post-natal perineal clinic.
	Birth Trauma Advocate training completed by WHH staff. 20 members across the MDT now trained and able to support debrief processes
	Personalised care planning offer established
	Enhanced Maternity Support Worker role now embedded and highlighted as exemplar of best practice by Chief Midwife for England
	BRAINS decision making tool has been embedded to support decision making and prompt discussions around care offers



Personalised care – outcomes/outputs

150 Personalised care planning appointments with Consultant Midwife since January 2025, additional to routine birth choices offer

Positive results in C&M Personalised Care Planning Survey

- Feedback 94% respondents felt they were offered choice throughout their maternity care.

New self referral pathway for birth reflections has facilitated 75 self referrals, 53 via BadgerNet, 128 Jan-June 2025

- New process also allows better capturing of demographic information and theming of experience which has informed service delivery

Feedback from birth reflections suggests communication in relation to birth choices has improved



Personalised care – feedback from families



**Warrington and Halton
Teaching Hospitals**
NHS Foundation Trust

"I just wanted to share with you some lovely feedback from a lady I saw in Birth Talks Clinic. She was seeing me for out of guideline care following a previous traumatic birth at a different trust. She was really emotional in telling me how much happier she is this pregnancy since choosing to have her care at Warrington.

She described some of the trauma from her first pregnancy which was affected by COVID restrictions. She remembers asking the sonographer at the time if she could write down the gender of her baby so that she could share the surprise with her husband as her wasn't allowed in. Unfortunately, she declined her request and wasn't very nice to her. So fast forward to this pregnancy and her husband was now at home caring for their daughter at the time of this scan and she asked one of our sonographers the same question? Who replied with no problem and went away and returned with a sealed envelope for her.

She then told me how that evening they invited their friends around to share the surprise with them and when she opened the envelope expecting a hand written note saying boy/girl she was overwhelmed to find blue confetti with a printed out note with a baby's footprint, congratulating them on their baby Boy! 💜 She cried telling me because she thought this was such a beautiful act of kindness and totally unexpected following her previous pregnancy experiences. Her little girl was so excited throwing the confetti up in the air, she said it was such a wonderful memory to have."

Kay is a fantastic midwife and an absolute credit to your team. From the moment I met her she made me feel safe and well cared for. She understood my needs and listened to my wishes. When I felt unsure or a bit lost, she gave me advice and information to allow me to make an informed decision. She advocated for me and went above and beyond to ensure I was reassured and happy each step of the way. She checked in on me after I had my baby and even came to the ward before her shift at the hospital to congratulate us and to see how I was. Kay deserves every bit of recognition and more. My only wish is that she would have been assigned to me from day one. She really has been amazing. The care that she has provided throughout has been exemplary and our new little family will be forever grateful for her

Personalised care – recognition

Firdous Patel was awarded the Trust You Made a Difference award for April in recognition of the way in which she went above and beyond to provide compassionate care to a family following the loss of their baby.

Rachel Doodson was awarded a Chief Executives Award to reflect beautiful feedback from a family regarding the personalised care she provided.

Celena Biggs was awarded the Trust You Made a Difference award to recognise the individualised and incredibly compassionate care she provided to a family experiencing a terminal diagnosis and bereavement.

Team River awarded the Planned Care Team of the Year at Trust Thank You awards



Care Pathways

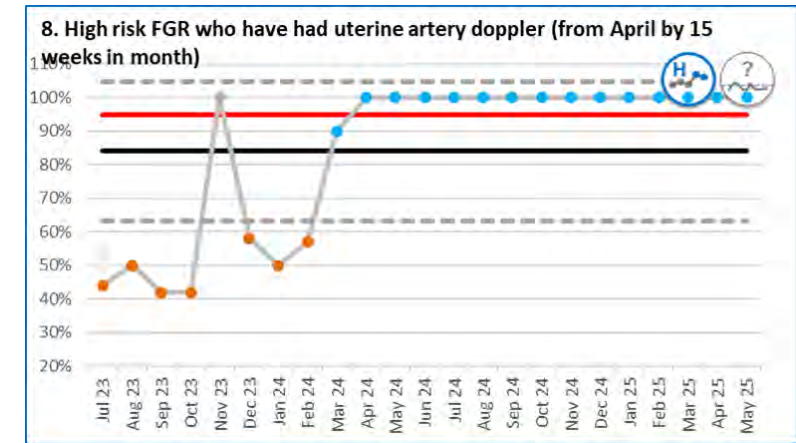
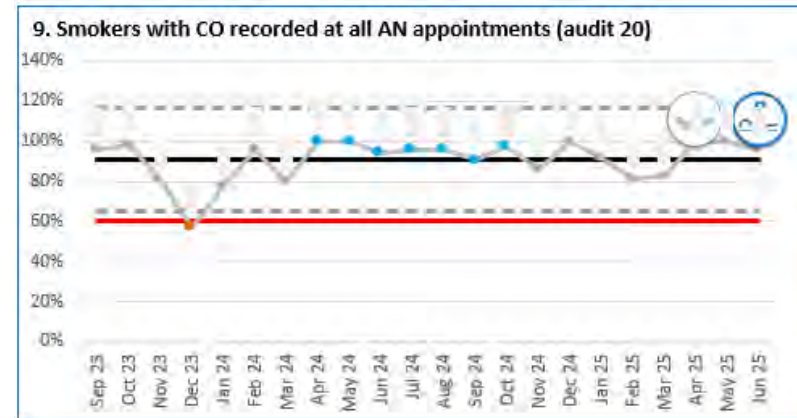
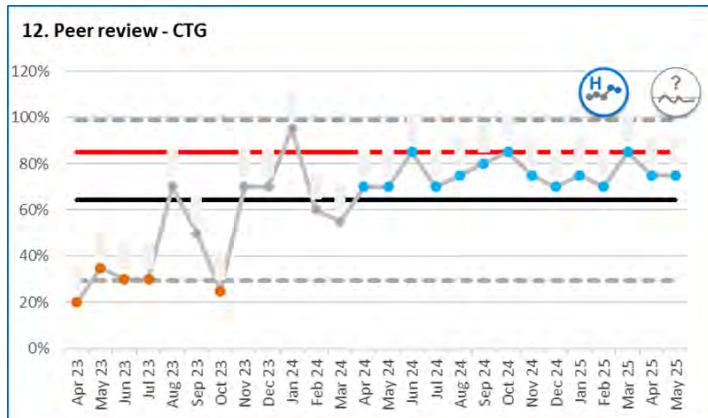
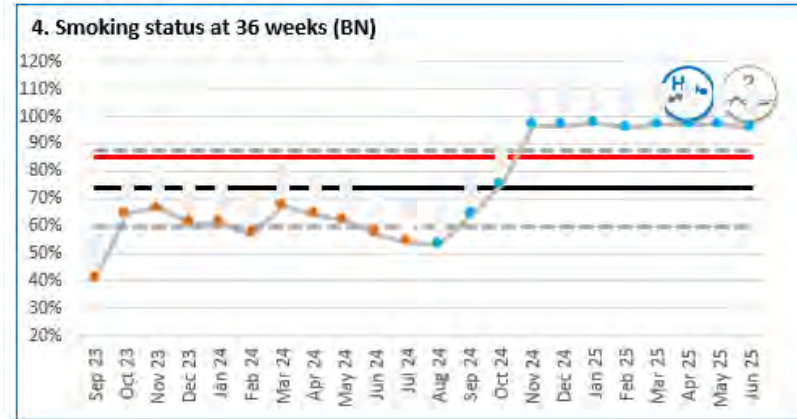
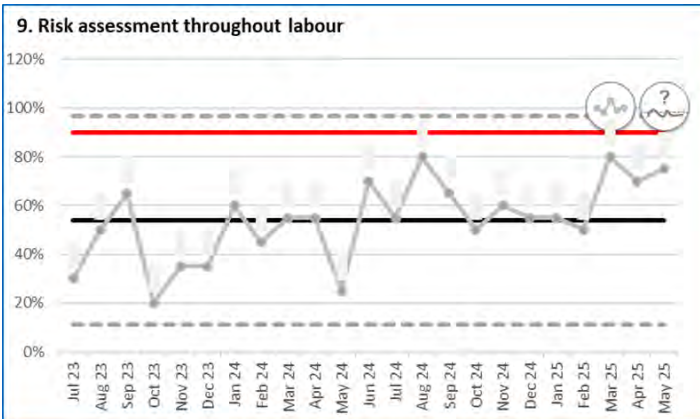


**Warrington and Halton
Teaching Hospitals**
NHS Foundation Trust

Driver	Completed activity
❖ Ockenden recommendations ❖ Maternity Incentive Scheme ❖ CQC Inspection report ❖ CQC Maternity Survey	Personalised care planning in place with regular audit of compliance against best practice
	Updated processes to ensure risk assessment completed at onset of labour to inform decision making
	Refreshed processes to ensure ongoing risk assessment during intrapartum period
	Targeted work to improve recording of smoking status at all antenatal appointments
	Quality Improvement project completed to support improvement with fetal surveillance fresh eyes peer review
	Implementation of new failsafe process to completion of uterine artery dopplers for those at risk of fetal growth restriction
	Estates project to relocate Induction of Labour care to Birth Suite
	Establishment of project group to review pathways related to induction of labour
	Project initiated to provide more sustainable midwifery led intrapartum service (Nest and homebirth)



Care pathways - outputs

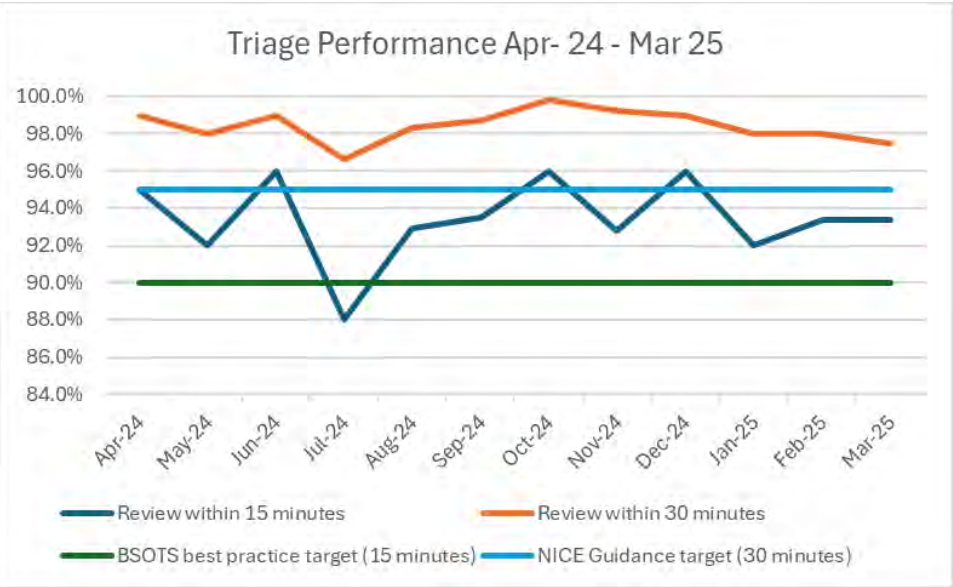


Care pathways - outputs

WHH Stillbirth Data Over 12-month Period:

Metric	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	12-month total
Number of live births	612	677	599	580	2468
Total number of stillbirths >24 weeks	1	1	0	2	4
Total Stillbirth Rate >24 weeks (per 1000 births)	1.63	1.47	0.00	3.44	1.62
Number of intrapartum still birth rate	0	0	0	0	0
Number of stillbirths >37 weeks	1	0	0	1	2

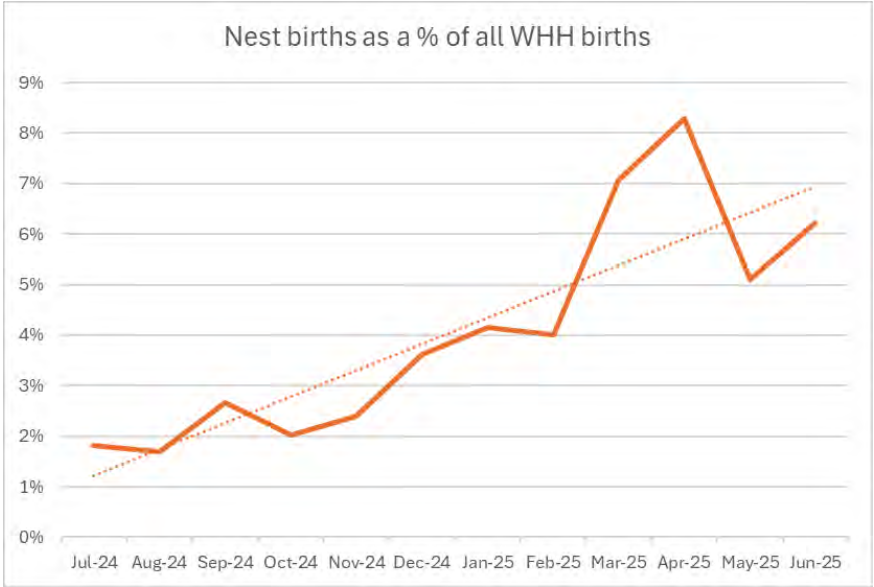
WHH stillbirth rate
1.62/1000 births, national
rate 4.0/1000 births



Maternity Triage
consistently meeting NICE
guidance and BSOTS best
practice standards for
initial triage assessment



Warrington and Halton
Teaching Hospitals
NHS Foundation Trust



Positive trajectory in women birthing on the Nest



Equality & Equity workstreams

Driver	Completed activity
❖ Three Year Delivery Plan for Maternity & Neonatal Services	Maternity established as anchor service as part of Living Well Hub offer
	Full programme of population health workstreams in place (smoking cessation, BFI accreditation, perinatal mental health pathway, vaccination)
	Equalities dashboard developed and will launch September 2025
	Service a pilot site for Cheshire & Mersey led health literacy project with focus on accessibility of information for those with diabetes in pregnancy
	Team Sunlight key partner in Halton family hubs model
	Service successful in obtaining external funding to pilot infant specialist maternity support worker on the maternity ward
	Review of demographics completed and geographical allocation of continuity teams (CoC) to increase the number of women at risk of poor outcomes assigned to a CoC pathway
	Collaboration with partners to improve outcomes now business as usual approach for the maternity service
	Targeted piece of work completed to ensure Vitamin D supplementation offered to Black and Asian women offered vitamin D.



Equality & Equity outcomes/outputs



**Warrington and Halton
Teaching Hospitals**
NHS Foundation Trust

Vaccination service

- Ongoing piece of work to further develop service and widen accessibility.
- Maternity vaccinators increased from 13 in 2023 to 25 in 2024
- Significant improvement in timeliness of BCG vaccination, recognised at Annual Trust Quality Academy Showcase.
- RSV service now established – assurance from national team that WHH performing well regionally and nationally

Improved rates of breastfeeding at discharge from inpatient care

- Since appointment of specialist MSW, 4.1% increase in the number of women discharged from maternity ward exclusively breastfeeding and a 3.2% increase in women partially breastfeeding compared to the previous 6 months.

Continuity of Carer

- Percentage of women in bottom decile of deprivation at 29 weeks on a CoC pathway increased to 54.4% for December 2024 - compared to 17-30% in previous months.
- This figure would be 66% if out of area women were not included in the dataset.

Working with partners identified as exemplar

- Service identified as a exemplar of good practice by the CQC in the way it works with local stakeholders to reduce health inequalities

Vitamin D supplementation.

- October 2024 88% of Black and Asian women offered vitamin D. May 2025 position 94% (15/16 women in this population group)

“The trust demonstrated outstanding practice in relation to the commitment to the equality and equity agenda, working in collaboration with external stakeholders such as, people who use the service, Warrington Borough Council and integrated care boards. This had led to improvements in the offer available in the local communities and in people’s homes. Specific pieces of work had been carried out to address the barriers faced by the community the trust served.

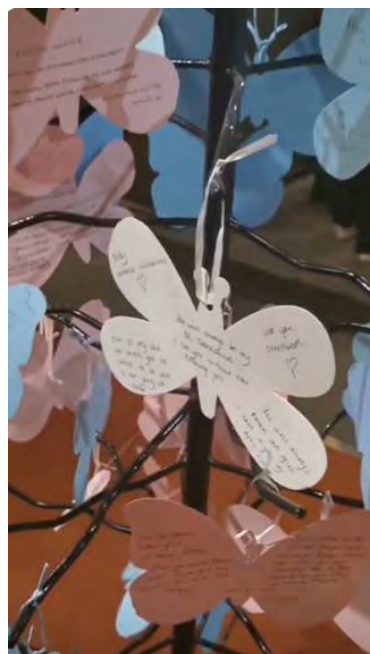
The service had established an antenatal and postnatal clinic in a hotel which was housing asylum seekers in the local area, to reduce barriers to accessing care and support some of society’s people who are (or might be) made vulnerable or in vulnerable circumstances..

The service created communication cards for non-English speaking women to support them in communicating their communication needs.

The service provided care packages of essential items for parent and baby, to support women in need, working closely with local charities.”

Bereavement care

Driver	Completed activity
❖ Ockenden recommendations ❖ Maternity Incentive Scheme	Robust bereavement service now in place – bereavement care graded A or B in 7/8 cases reviewed via PMRT process in 2024
	Trust wide charities campaign to develop 'Willow Tree Hub' to provide bespoke offer for Butterfly and Rainbow families underway
	Series of events held to mark Baby Loss Awareness Week designed to reflect feedback from families



Neonatal Care



**Warrington and Halton
Teaching Hospitals**
NHS Foundation Trust

Driver	Completed activity
❖ Ockenden recommendations ❖ Maternity Incentive Scheme ❖ CQC Inspection report	Introduced Consultant of the week tier 3 provision.
	Full review of Transitional Care pathways completed with a Revenue Request underway.
	Implementation of dedicated AHP resource on the unit.
	PEEP for 30 QI completed
	Expanded the Maternity Voices Partnership role to a Maternity & Neonatal Voices Partnership role



Neonatal Care – outcomes/outputs

Redesign of the Neonatal Community outreach team

- Increased days of service from 5 days per week to 6 and expanded patient criteria to support earlier discharges.

Piloted CPAP in the delivery room to support the reduction in term admissions.

Positive feedback as part of the NW Neonatal ODN annual assurance visit

- WHH commended for commitment to quality improvement.

Introduced a Nursing Associate role to the unit to provide a diverse MDT approach.

Sustained positive workforce retention rates with only 1 vacancy across the unit.



Clinical Governance

Driver	Completed activity
❖ Ockenden recommendations ❖ Maternity Incentive Scheme ❖ CQC Inspection report	Quadrumvirate leadership model now fully embedded
	Monthly programme of Maternity Safety Champion walkarounds in place
	Quarterly meetings of the 'Quad' and Non-Executive Director Safety Champion established
	PSIRF now fully embedded with robust systems and processes to learn from patient safety events
	Shared learning processes well embedded
	Creation of Operational Review Group to review operationally related patient safety events e.g. divers
	Robust peer and MDT review processes across all clinical areas
	New Action review group established to provide senior leadership team oversight of actions/action plans related to patient safety events including escalation processes via CBU and speciality governance



Clinical Governance - outcomes



**Warrington and Halton
Teaching Hospitals**
NHS Foundation Trust

Maternity complaints processes well managed

- Breached complaints - 0
- Complaints over 6 months old - 0
- Reopened complaints - 0

Good position achieved in relation to guidelines/policies and adherence to national guidance

Requirements of Maternity Incentive Scheme Year 6 in relation to Board assurance achieved

- Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues alongside emerging local and regional matters.

Numerous successful workstreams implemented as a result of learning from patient safety events and triangulations of data including:

- Project to reduce post natal readmissions due to wound infections
 - Incidence of 3rd and 4th degree tears
 - Maternity diverts/deflects
 - Neonatal closures
- 
- Three thick, curved, overlapping lines in green, blue, and orange colors, located at the bottom right of the slide.

External Assurance



**Warrington and Halton
Teaching Hospitals**
NHS Foundation Trust

CQC Maternity Survey 2024

- One of eight Trusts across the country and one of only two in the north- west whose results were rated as 'better than expected' overall
- Rated in the top five across the northwest region for seven out of ten overarching measures

Maternity Incentive Scheme Year 6 achieved

Service consistently high performer against Safety Action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the SBLCBv3.

Successful Cheshire and Mersey Local Maternity and Neonatal System (LMNS) annual assurance visit

Quarterly review of progress against Three Year Delivery Plan by LMNS Maternity Performance Oversight Panel noted good assurance (all actions graded as green/blue)

Compliance with SBLCBv3 April 2025

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially Implemented	40%	Fully Implemented	100%	CNST Met
Element 2	Fetal growth restriction	Partially Implemented	25%	Fully Implemented	100%	CNST Met
Element 3	Reduced fetal movements	Not Implemented	0%	Fully Implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Not Implemented	0%	Fully Implemented	100%	CNST Met
Element 5	Preterm birth	Partially Implemented	4%	Fully Implemented	100%	CNST Met
Element 6	Diabetes	Not Implemented	0%	Fully Implemented	100%	CNST Met
All Elements	TOTAL	Partially Implemented	14%	Fully Implemented	100%	CNST Met

Work to do:

Current workstreams

3rd/4th Degree Tears

- Position – 3 months to January 2025, 43/1000, births. C&M position 27/1000
- Improved position since Feb. 2025 but remains common cause variation
- Ongoing workstream

Post partum haemorrhage >1500ml

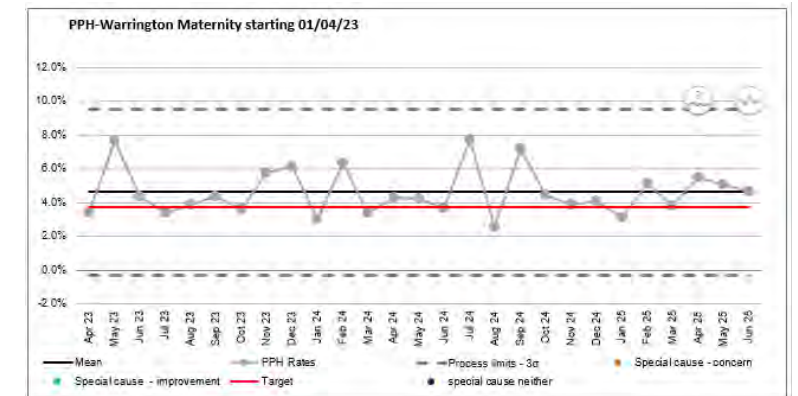
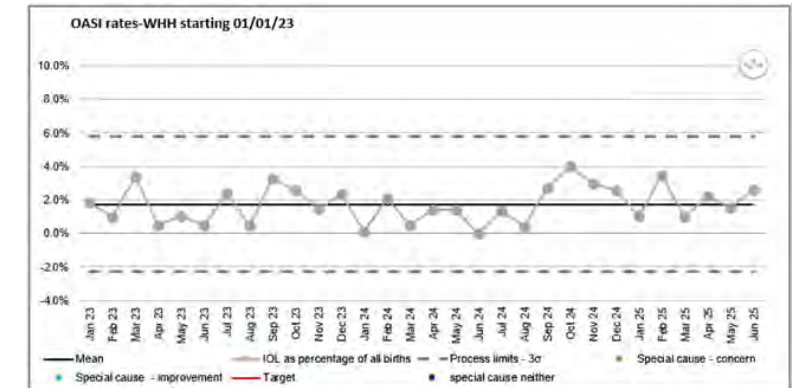
- Position - October- December 2024 per 1000 births 41.6/1000
- C&M position 34 per 1000 births
- Action plan in place, some reduction noted last three months but remains common cause variation

Robson Group 2

- Formal audit completed, presenting to QSSG July 2025
- IOL project group already in place with detailed action plan.

Apgar Score < 7

- Persistent high rates
- Most recent LMNS data WHH 23/1000, C&M 11 per 1000)
- Detailed audit underway. Once complete, learning will inform actions



Work to do:

Current workstreams

ATAIN

- Rate above the 6% threshold for the rolling 4 quarters - 24/25
- Work ongoing to reduce, PEEP for 30 has supported
- Sustainability of Transitional care (TC) staffing model remains a challenge and is contributing.
- TC staffing model being developed

Delays in IOL

- Working group in place – developing into formal QI
- Action plan developed.
- Working group lead working collaboratively with other providers to ensure shared best practice.

Sustainable transitional care (TC) model

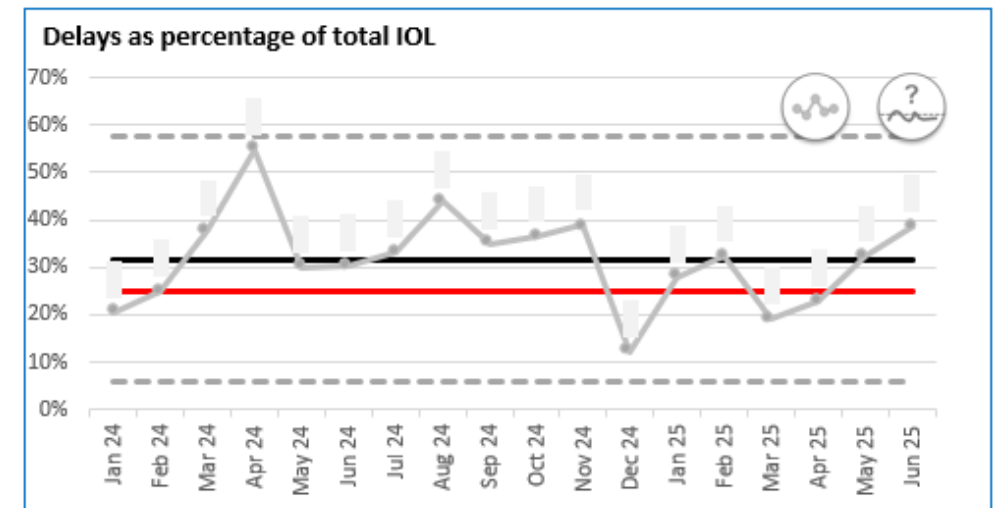
- Working group in place – formulating staffing model
- Quarterly audits completed to ensure all eligible babies are cared for within the TC pathway and inform working group activity

Staffing resilience in Team Lunar (homebirth team)

- New model for midwifery led pathway in train

Maternity Diabetes pathway

- Working group in place, meeting bi-monthly
- Robust action plan with senior oversight





**Warrington and Halton
Teaching Hospitals**
NHS Foundation Trust

Any questions



REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/25/08/65																										
SUBJECT:	Maternity & Neonatal Update February-May 2025																										
DATE OF MEETING:	6 August 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. 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	<i>Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</i> <table border="1"> <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> </table> Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum and improving safety and outcomes for this cohort. <table border="1"> <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> </table> Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum and improving safety and outcomes for this cohort. <table border="1"> <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> </table>			1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	Yes	No	N/A		✓			2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	Yes	No	N/A		✓			3. Foster good relations between people who share a protected characteristic and those who do not	Yes	No	N/A		✓		
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	Yes	No	N/A																								
	✓																										
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	Yes	No	N/A																								
	✓																										
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 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. The paper provides Board 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 5 (<i>Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues</i>) alongside emerging local and regional matters. This report provides a summary of the following: • April Maternity Quality & Safety update • May Maternity Quality & Safety update • June Maternity Quality & Safety update • July Maternity Quality & Safety update • Maternity Incentive Scheme Year 5 and 6 position • ATAIN Q4 2024/25 • Transitional Care Q4 2024/25 • PMRT Q4 2024/25 • PMRT 2024 annual review • Biannual review of obstetric, anaesthetic, neonatal and Q4 midwifery staffing • Biannual Maternity Self Assessment • Maternity Harms Review September 2024-February 2025 • Fetal Surveillance deep dive		
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 Strategic People Committee	
	Agenda Ref.	QAC/25/04/020 QAC/25/05/041 QAC/25/06/060 QAC/25/07/082 SPCIC/25/0/077	
	Date of meeting	8 April 2025 13 May 2025 10 June 2025 8 July 2025 16 July 2025	
	Summary of Outcome	Noted and approved	

FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: <i>(if relevant)</i>	None

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity & Neonatal Update February-May 2025	AGENDA REF:	BM/25/08/65

1. BACKGROUND/CONTEXT

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

The paper provides Board 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 5 (*Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues*) alongside emerging local and regional matters.

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

- April Maternity Quality & Safety update
- May Maternity Quality & Safety update
- June Maternity Quality & Safety update
- July Maternity Quality & Safety update
- Maternity Incentive Scheme Year 5 and 6 position
- ATAIN Q4 2024/25
- Transitional Care Q4 2024/25
- PMRT Q4 2024/25
- PMRT 2024 annual review
- Biannual review of obstetric, anaesthetic, neonatal and Q4 midwifery staffing
- Biannual Maternity Self Assessment
- Maternity Harms Review September 2024- February 2025
- Fetal Surveillance deep dive

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

2. 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 the period February-May 2025 themes from patient safety events were as follows:

- Admission of term babies admitted to Neonatal Unit (NNU)
- Postnatal readmission
- Postpartum Haemorrhage (PPH) 1000ml-1500ml
- Postpartum Haemorrhage (PPH) >1500ml
- Neonatal – infant feeding concern

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:

2.1.1 Term Admissions to NNU

All term admissions are reviewed via the ATAIN process, which reports quarterly to the Quality Assurance Committee (QAC). An overview of the Q4 2024/25 report is included in section 4 of this summary paper.

2.1.2 Postnatal Readmissions

A process of quarterly review of postnatal readmissions was introduced in Q2 2024/25 due to ongoing patient safety concerns.

In Q4 2024/25, 15 women were readmitted following 579 births, yielding a 2.6% readmission rate - a 1.6% decrease from Q3. Of these, 73.3% were deemed unavoidable, while 26.7% were avoidable, marking a 6.7% increase in avoidable cases from Q3.

Three avoidable readmissions were linked to suboptimal hypertension management, primarily due to premature discharge without stabilised observations or timely prescription of long acting antihypertensives. In two cases, discharge documentation lacked clarity on community follow-up, delaying treatment. These findings will inform the hypertension working group. The fourth avoidable case involved mastitis, attributed to inadequate feeding support; learning has been shared with the midwifery team.

Mastitis related readmissions dropped by 18.1% from Q3, suggesting the previous spike was an anomaly. The wound-related readmissions (11.76% of total) were deemed unavoidable and showed a sustained decrease from 50% of total readmissions in Q2. Surgical site infections also declined year-on-year from 7.15% to 3.47%.

No consistent themes emerged among unavoidable readmissions. Postnatal readmissions have not featured as a significant theme in patient safety events since April 2025.

2.1.3 Postpartum Haemorrhage (PPH)

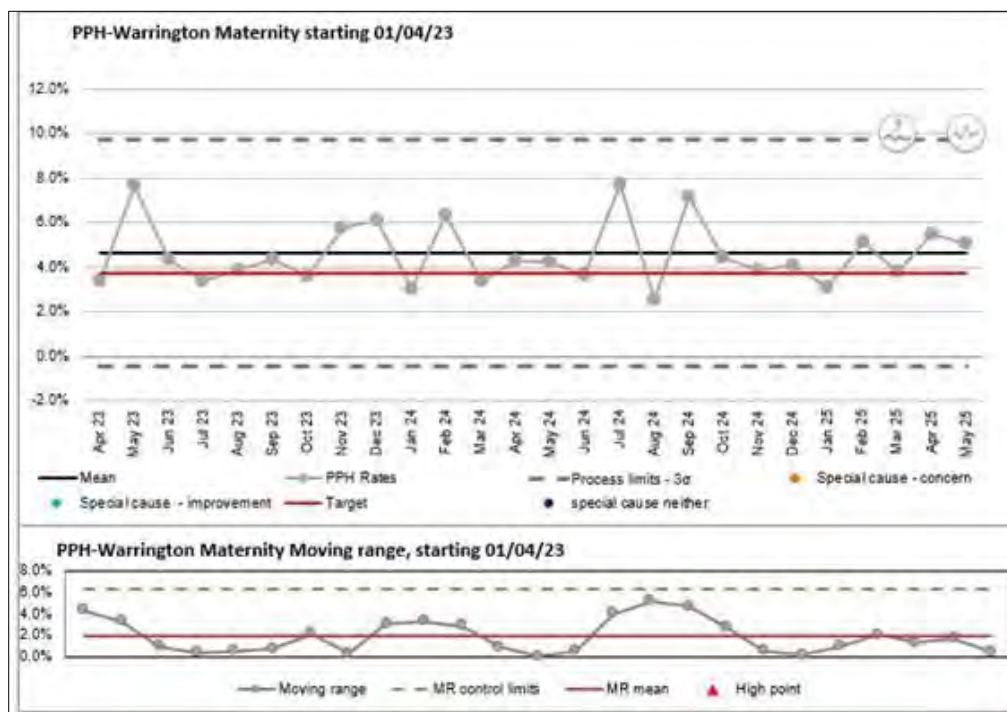
All cases of PPH are reviewed and learning shared. The PPH QI project has reverted to a working group to support with the implementation of the new regional guideline.

In the interim the service has implemented additional local changes to support reduction in PPH. This includes:

- Change of Inco pads at the point of delivery to support accurate blood loss measurement.
- Measures implemented to improve communication regarding ongoing weighed blood loss.
- Encouragement of the use of the boards in theatre to ensure contemporaneous documentation.
- Measures to ensure earlier recognition of major obstetric haemorrhage (MOH) including appropriate use of the emergency buzzer to alert the correct members of staff and improved communication with the shift co-ordinator.

- Plans underway to organise a joint SIM with the laboratory colleagues to support effective management of MOH, in the interim, ongoing and continuous SIMs within the ward areas.

The SPC chart for PPH ≥ 1500 mls to end of May continues to show common cause variation.



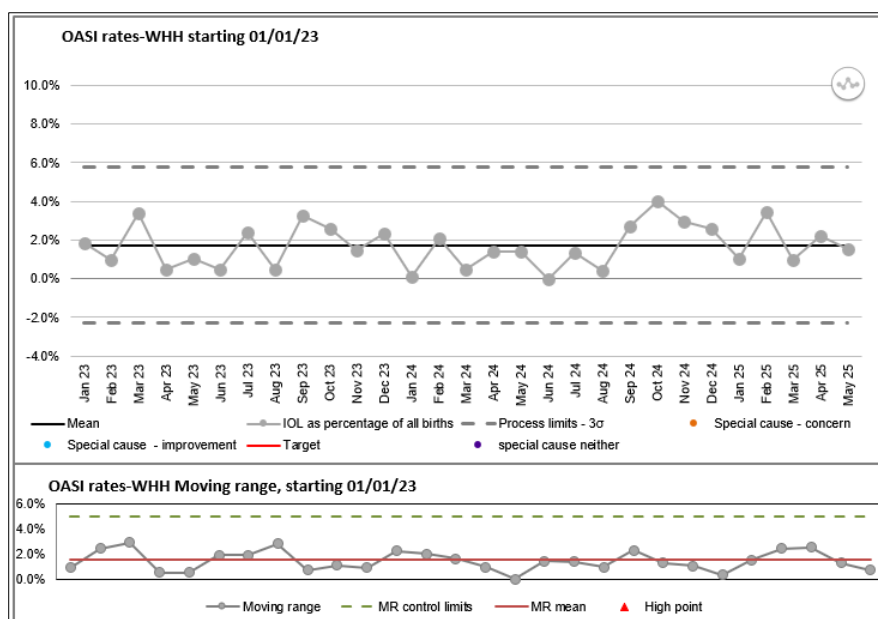
2.1.4 - Infant feeding concern

There were six cases of infant feeding concern in May 2025. This appears to be a new theme but is 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. A cluster review of these cases is being completed to ensure all learning is captured.

2.2 Harm Events

There were no fatal harm events in the service in the period February-May 2025. There was one severe harm event in April 2025. This was a baby born in poor condition and transferred to Liverpool Women's Hospital where the baby sadly passed away. The case has been referred to MNSI and to the coroners service.

There were 17 moderate harm events in the period February-May 2025. Two related to the cases of stillbirth which have been investigated via the PMRT process. The remaining moderate harm cases related to cases of 3rd/4th degree tears (OASI). All cases of OASI are reviewed by the maternity MDT through Intrapartum Review Group which informs the ongoing workstream focussed on reducing rates of OASI. To date, the SPC chart for OASI shows common cause variation.



In addition, a cluster review process is in place to ensure all wider learning from cases of OASI is captured.

The Q4 cluster review has been completed and identified the following:

- No theme in mode of birth (50% vaginal birth / 50% instrumental birth)
- No theme in relation to the individual practitioner supporting birth.
- 6/10 of births were conducted by Registrars (ST3-5)
- 2/10 women had previously experienced a third degree tear.
- The OASI care bundle was not always documented as having been discussed with women at the time of booking.
- Manual perineal protection (part of the care bundle) is documented in the birth summary as being offered in 100% of cases. However further detail in the clinical narrative is present in only two cases. Further details and commentary would have supported identification of additional learning.

Learning/actions

1. OASI Care Bundle and reducing the risk of perineal tears should be discussed during booking and documented. Service to explore making this a mandatory field in BadgerNet.
2. Learning to be shared with team in relation to providing additional narrative regarding the measures adopted during birth, in particular whether manual perineal protection has been offered and implemented .
3. To continue to include teaching about OASI and manual perineal protection as part of maternity mandatory training via Prompt and obstetric led departmental teaching

2.3 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 May compliance for mandatory training across maternity and child health colleagues is 88.84% for Trust mandatory training (including safeguarding training) and 88.54% 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 77.2% at the end of May 2025. A plan is in place to achieve full compliance by end of August 2025.

Good compliance with maternity specific training standards is largely being sustained with an improvement noted at the end of May 2025 following a slight deterioration in position previously reported.

Current position – Training compliance - maternity specific

	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)	Newborn Life Support Level 2	MAMU 3
Midwives	94.1%	97%	97.6%	95.6%	97.4%
Obstetric Consultants	100%	90.9%	100%	n/a	n/a
Other Obstetric	100%	96.1%*	91.6%	n/a	n/a
Obs Anaesthetic	93.1%	n/a		n/a	n/a
Maternity Support Workers	100%	n/a		n/a	93.1%
Neonatal medical and ANNP	n/a	n/a	n/a	Awaiting Data	n/a

Turnover for maternity and child health staff (permanent staff) in May 2025 was 12.4% and 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. This is illustrated in the graph below:



2.4 Family feedback

The updated birth reflection process has enhanced the collection of individual feedback on maternity care, particularly through ward manager involvement. Most recently, this has helped identify both ongoing and new issues within the maternity ward.

A key concern raised by all families was the stark contrast in environmental quality between Triage/Nest and the ward, with the latter described as outdated and appearing unclean. Bed spaces were also criticised for being cramped and difficult to navigate, making it hard to manage personal belongings, an issue previously noted but unresolved due to space limitations.

A newly identified concern involved handwashing facilities. Due to the design of ward footprint, one sink and bin are located within a bed space, leading to discomfort for both users and occupants due to perceived privacy intrusions. A provisional plan to expand bed space on C23 using the former induction of labour areas is in development. This will focus on safety, quality and experience.

Feedback also revealed dissatisfaction with arrangements for partners remaining overnight and the number of visitors allowed per bed space, with families highlighting concerns with overcrowding and noise.

All feedback will be considered and actions agreed in collaboration with the Maternity and Neonatal Voices Partnership (MNVP).

2.5 Staff feedback

Trust Board will be aware of the programme of work is ongoing across the Maternity and Neonatal Services to further improve workplace culture. As reported previously, a series of ideas events with clinical teams were held and a thematic analysis of the feedback completed. Through this process three areas for improvement were identified:

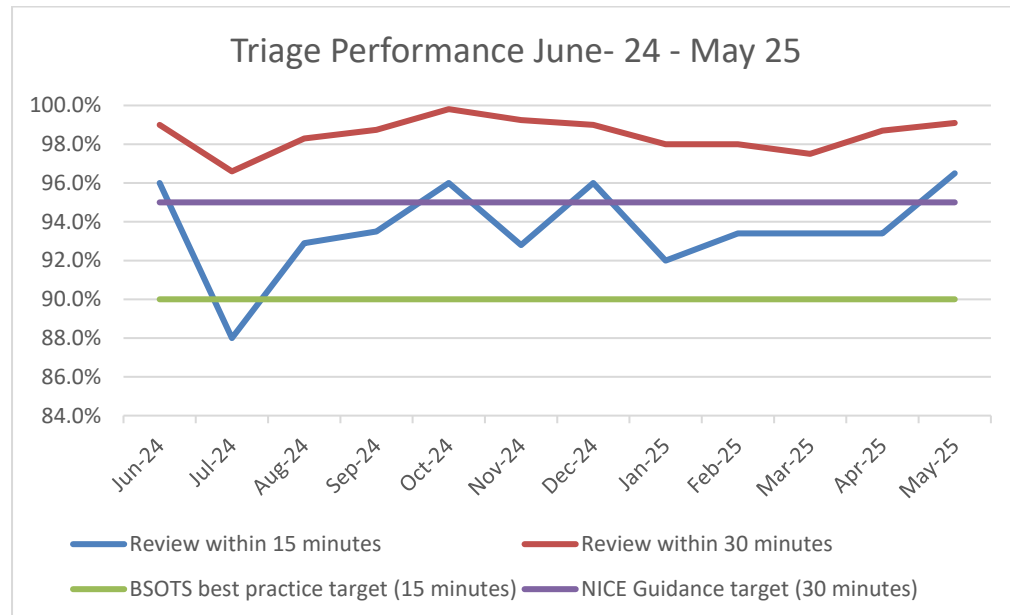
- Care Pathways
- Culture
- Workforce models (including staffing)

The sessions provided rich learning for the senior midwifery leadership team and subsequently feedback has been shared with managers for each clinical area. Each manager has, as a result developed a series of next steps and actions. The outputs from

these actions have been formed into a series of “you said, we did” infographics which will be shared across the maternity service in July and August.

2.6 Maternity Triage

The Maternity Triage service consistently meet its KPIs (initial review within 15 minutes of arrival - best practice guidance and initial review within 30 minutes of arrival - NICE guidance).:



A significant piece of work has been completed to improve performance against other key Triage audit measures with positive results:

Categorisation of Urgency Audit

- Audit to determine if incorrect categorisation of clinical urgency is a theme.
- 20 sets of notes audited.
- 85% of women were categorised correctly, this is a considerable improvement from the previous audit when only 65% of women were categorised correctly.
- Learning has been shared with the Triage team.

Holistic Triage Assessment Audit

- Audit to capture date and time of assessment, reason for attending, symptoms on arrival, observations, urinalysis, fetal movements, evidence of palpation, FH auscultated, risk level completed, and review of risks confirmed.
- 20 sets of notes audited.
- 80% had a full holistic assessment recorded (as above)
- This is a significant improvement from last month when the audit showed only 45% had had a full holistic assessment recorded.
- Findings fed back to Triage midwives.

SBAR Audit

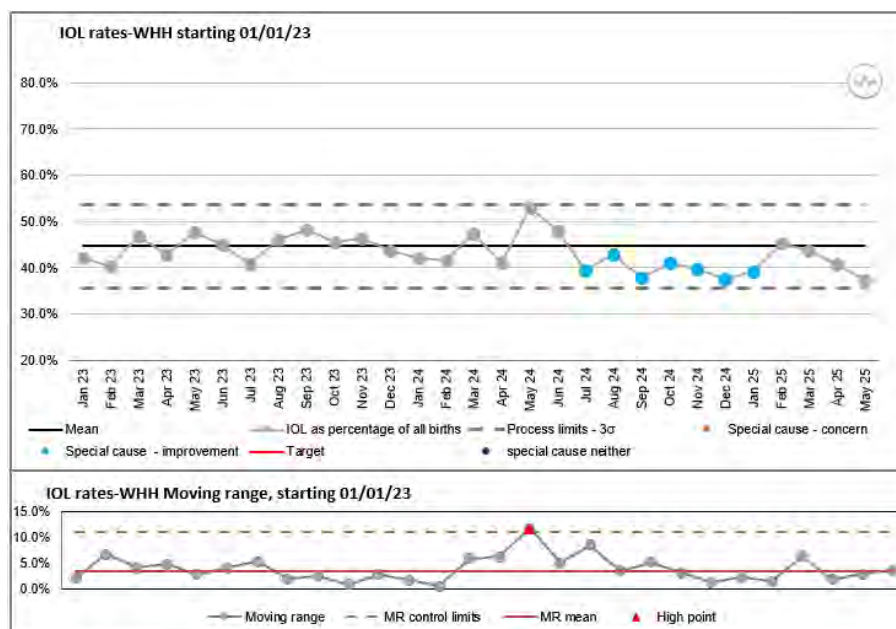
- Audit to ensure SBAR handover tool used when women are transferred from Triage to Birth Suite, C23 or The Nest
- 10 sets of notes audited.
- 90% had evidence of an SBAR handover.
- Again, this is an improvement from the position in the last audit when 80% of notes had evidence of SBAR.
- Learning has been shared with the Triage team.

Following approval of a revenue request to increase the staffing establishment for Maternity Triage, recruitment into the new midwifery and maternity support worker posts (MSW) has now been completed. A sustainable staffing model for maternity triage remains on the CBU risk register. Following the commencement of new midwives the risk rating has been reduced. The current rating is 9. This will reduce further once all new starters join the organisation.

2.7 Induction of Labour (IOL)

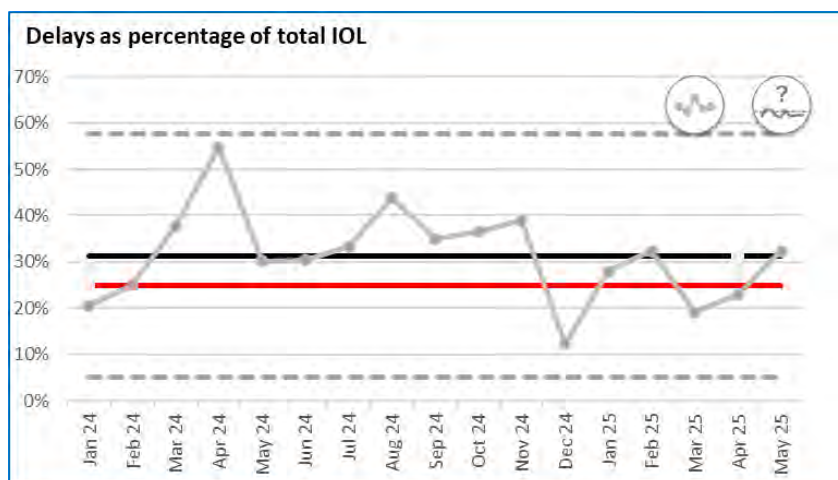
Trust Board will be aware the service was identified as an outlier during 2024 within the LMNS with regard to the timeliness of induction of labour processes. As a result, a significant IOL workstream is underway.

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 May 2025, presented as a percentage of all births. The service's aim is to reduce this rate.



In May 2025, the WHH induction rate was 37%, this is the lowest rate in over two years. A monthly audit continues to monitor appropriateness of IOL as inappropriate IOL had been identified as an issue previously and a number of actions implemented to improve. In May 2025 6.5% inductions were identified as inappropriate. This is an improvement from April 2025 when 14% of IOL were identified as inappropriate.

Work to reduce delays in IOL is ongoing. The service has a target to achieve sustained reduction in delays to around 25%. Again, this is being monitored via a SPC chart.



From 1st July 2025, an IOL bleep holder role has been introduced, alongside implementation of the Cheshire and Merseyside regional IOL guideline, the IOL triage SOP has been ratified and will go live with the regional guideline.

The IOL bleep holder provides daily oversight and support with forward planning workload. Changes in process have been shared with staff, on the updated IOL booking process and the introduction of 12-hourly CTG monitoring for all women undergoing IOL, as per the new regional guidance.

A live tracker is also in development to support real-time monitoring of delays. Patient information videos are being developed with the support of the Trust communications team to support those birthing at WHH in understanding the IOL process and improve patient experience. These will be made available in multiple languages with support from the wider teams.

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

2.8 Maternity and Newborn Safety Investigation (MNSI) position

2.8.1 Background

To ensure oversight of the service's position with regard to cases being investigated by MNSI a monthly update is now provided to QAC and on to Trust Board. This ensures discussions regarding safety intelligence are taking place in line with MIS Safety action 9.

2.8.2 MNSI cases year to date

For the period April 2024 – May 2025, MNSI have accepted four maternity related cases for investigation. Two cases relate to patient safety events which occurred in 2024.

MNSI position 30/6/2025:

Incident Date	MNSI No.	Criteria	Status	Draft Report Received	Final Report Received	SOM Sign-off	QAC
25/08/2024	MI-038061	HIE/Cooling	In progress	26/03/2025	20/6/2025	22/7/2025	12/08 2025
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		
April 2025	MI-041411	Maternal death	In progress	Awaiting	Awaiting		

The case of maternal death has been reported to both MNSI and MBRRACE. This relates to the case of a 26 year old woman who experienced a miscarriage in March 2025. The woman subsequently attended at Halton UEC in early April with a history of shortness of breath. Following this attendance her condition deteriorated and she was admitted to ITU at WHH where she sadly passed away. Any woman who dies within 12 months of the end of pregnancy must be reported to MBRRACE and any women who dies within 42 days of the end of the pregnancy is reportable to MNSI.

One MNSI report was received in the period (MNSI reference MI-039124). In the final report, there were four specific safety recommendations. Actions to meet these recommendations have been developed and are underway. A case on a page has also been developed and shared with all maternity staff (appendix one).

The final MNSI report is included in full in appendix two for information.

2.9 Retrospective study of MBRRACE-UK Perinatal Mortality surveillance (2015-21)

A retrospective academic study (appendix three) has been published which identified hospital trusts in England most consistently reporting higher-than-average rates of extended perinatal mortality (EPM), including stillbirths and neonatal deaths.

This study considered MBRRACE-UK Perinatal Mortality Surveillance Reports (2015–21) comparing EPM rates for births occurring in 124 hospital trusts in England between 2013 and 2019. Utilising MBRRACE-UK definitions and designations, including coloured bands (red and amber indicate higher death rates), the study team devised a scoring method to determine which trusts most consistently reported higher-than-average rates of EPM throughout seven years.

The study identified 23 (18.5% of 124) 'red flag' trusts most consistently falling into MBRRACE-UK red and amber bands. WHH was not identified as red flag Trust within this report.

2.10 LMNS Quality Metrics Reporting pack

The maternity service receive a bimonthly Clinical Quality Metrics reporting pack from C&M LMNS. These metrics are intended to allow C&M LMNS Quality and Safety Surveillance Group to have oversight of the quality and safety of maternity and neonatal services as well as providing a supportive benchmarking tool for maternity providers across C&M.

In reviewing the metrics the LMNS will highlight metrics with high variations. In March 2025 four areas were noted as requiring feedback from the Trust. The four areas highlighted were:

- 3rd/4th Degree Tears (November 2024 data)
- PPH >= 1500ml (December 2024 data)
- Robson Group 2 criteria - primigravid women having an elective caesarean section/induction (November & December 2024 data)
- Apgar Score < 7 (November 2024 data)

The details of the queries from the LMNS, information requested and responses provided are included in appendix four. These responses were provided to the LMNS in line with their deadline.

2.11 Complaints

Eight complaints were received relating to care in the maternity and neonatal services in the period Feb-May 2025.

ID	Specialty	Description	Complaint Received in the Trust
23781	Maternity	Patient gave birth and baby had bruising and haematomas in eyes which were not noted.	04/03/2025
24174	Maternity	Concerns relating to the lead up to the birth of the baby and the aftercare on the ward.	29/4/2025
24037	Maternity	Concerns relate to 2017 and the birth of baby	11/4/2025
24155	Maternity	Concerns relating to the care provided. Complainant experienced ongoing abdominal pain throughout pregnancy and went on to need to have her gallbladder removed and a stent in her kidney due to a blockage. Complainant wonders why this was not picked up earlier.	23/4/2025
24165	Maternity	Multiple concerns regarding care and birth of baby. Balloon catheter was inserted but was overfilled causing pain and discomfort	29/4/2025
24263	Maternity	Patient was advised she was 10cm dilated but was only 5 causing stress and confusion. Labour not progressing due to baby's positioning making vaginal birth impossible.	13/05/2025
24335	Maternity	Patient believes she is not receiving support from the Trust in relation to her pregnancy.	22/05/2025
24274	Maternity	Patients care delayed as refused to be seen by Gynae and maternity advised she did not have infection. Patient had sepsis and has questioned if pathway was followed correctly.	14/05/2025

2.12 Coroner Enquiries

No Regulation 28 enquiries have been received.

3. MATERNITY INCENTIVE SCHEME (MIS)

3.1 Background

NHS Resolution's (NHSR) Maternity Incentive Scheme (MIS) aims to enhance maternity and perinatal care by ensuring compliance with ten Safety Actions. These actions support the national goal of reducing stillbirths, neonatal and maternal deaths, and brain injuries by 50% from the 2010 rate by the end of 2025.

The reporting period for MIS Year 6 ended on 30 November 2024. Guidance for the seventh year of the scheme was published on 2 April 2025 outlining eligibility conditions for payment under the scheme.

3.2 MIS Year 6 outcome

The outcomes for MIS year 6 have been officially announced. It has been confirmed following the external verification process, WHH have met the requirements of all ten safety actions. As a result, WHH is now eligible for the return of the Trusts contribution into the incentive fund and a share of the unallocated funds.

3.3 MIS Year 7 - progress

On 11 June 2025, the first quarterly meeting with the LMNS was held to assess the Trust's progress against Saving Babies' Lives and the Maternity Incentive Scheme (MIS) Year 7. These meetings aim to support continuous evidence review throughout the year. The Trust received positive feedback for evidence submitted to date.

4. Q4 2024-25 AVOIDING TERM ADMISSIONS INTO NEONATAL UNIT (ATAIN)

The ATAIN objective is to reduce the number of avoidable admissions of infants $\geq 37+0$ 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 Q4 2024/25 ATAIN rate is 5.69%, which is below the national target (6%) and just outside of the NWNODN target (5.6%). This is an improvement of 0.37% on the last quarter.

All term admissions in Q4 were reviewed and learning from these cases has informed the ATAIN action plan.

Significant improvement has been seen in Q4 2024/25 in the proportion of admissions assessed as avoidable had care been optimal. The ATAIN action plan is monitored at the monthly Women's & Children's (WCH) Governance Meeting. A quality improvement project is currently underway to further enhance the service's transitional care(TC) offering, which it is anticipated will further reduce term admissions.

5. Q4 2024/25 TRANSITIONAL CARE 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 Q4 2024/25 Transitional Care audit

An audit of babies who received TC within Q4 2024/25 was completed and identified the following:

- 15 babies who met the broad admission criteria for TC in Q4.
- One baby received TC from day 3 of life.
- Three babies were suitable to receive TC from birth; however, this was not facilitated due to staffing on the Neonatal Unit (NNU)
- The majority of babies required some level of respiratory support and were initially provided with care via NNU.

5.2.1 Good Practice from the Q4 2024/25 audit:

- Excellent neonatal care for babies, thus ensuring safety of babies who have been separated from their mothers.
- Cluster review conducted following Q3 audit.
- 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
- NNU Matron continues to deliver training at MAMU (Maternity Mandatory Updates).
- Unavailability of TC now added to terms of reference for Operational Review Group to ensure senior oversight and review.

5.2.2 Recommendations from the Q4 2024/25 audit:

- Risk assessment to be implemented when unable to facilitate TC.
- Utilise TC to reduce term admissions.
- Focussed learning from TC review to be included on Neonatal Natter and OWL
- 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.
- TC review group to continue to review and discuss cases and monitor actions/progress against the action plan.

5.2.3 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.

Where learning and actions have been identified through the audit process, these have been added to the TC action plan. The action plan is monitored via Women's & Children's Governance (WCH) and the Neonatal Oversight Meeting.

5.3 TC Cluster review

As part of the wider work around TC. A cluster review has been completed of all babies who did not receive TC in Q3 2024/25. This identified further learning from which the team have developed actions for improvement:

- Transitional care code to be added to the sub-category drop down under maternity/neonatology in Datix to support audit.
- Risk assessment proforma to be developed to support MDT decision making when the team are unable to facilitate transitional care.
- Add review if transitional re provision to the team leader assurance checklist for oversight.
- Continue quarterly review for thematic learning and include TC champion/team leader representation.
- Share review with NNU team and wider teams for learning.
- Incorporate learning into TC action plan.

5.4 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. Other models are being considered and will be shared once fully costed.

6. PERINATAL MORTALITY REVIEW TOOL (PMRT)

6.1 2024 annual review of PMRT cases

Since 2013 "Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK" (MBRRACE-UK) have produced an annual "Perinatal Mortality Surveillance Report". This report provides rates for stillbirths and neonatal deaths for each provider as well as reporting the national picture. WHH participates in reporting data into the Perinatal Mortality Review Tool (PMRT) which allows the analysis to take place. The timelines for submissions of deaths and the analysis of these means that when the reports are published by MBRRACE that they are based on deaths that occurred two years previously.

In January 2023, a paper was submitted to Quality Assurance Committee (QAC) to review WHH MBRRACE-UK Reports over 5 years (2016-2020). The paper proposed a number of recommendations including:

- Provide an annual report to QAC in April each year which includes all relevant deaths in the previous year and the findings of the reviews, including trends and themes and improvement activities.

As a result, an overview of WHH deaths from 1/1/2024-31/12/2024 alongside an overview of the key findings, learning and good practice for these cases was shared to April QAC.

During 2024 WHH reported 10 babies to Mothers and Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK). This comprised of two late fetal losses (gestation 22-24 weeks) six stillbirths and two neonatal deaths.

WHH stillbirth rate for 2024 was 2.41 per 1000 births. The most recent MBRRACE-UK national rate is 4.0 per 1000 births.

WHH rate for neonatal deaths in 2024 was 0.8 per 1000 live births. Office for National Statistics rate for England in 2023 was 3.0 per 1000 births.

The North West Operational Delivery Network (NWODN) will flag when trusts are identified as an outlier in relation to neonatal mortality. WHH has not been identified as an outlier in 2024.

6.2 Quarter 4 2024-25 Perinatal Mortality Review/Audit

The PMRT process is incorporated into Safety Action One of the Maternity Incentive Scheme with the requirement for Trust Boards receive quarterly perinatal mortality review reports.

The report shared at May QAC reported the WHH position for Q4 2024/25. During Q4, WHH reported two babies to Mothers and Babies Reducing Risk through Confidential Enquires across the UK (MBRRACE-UK). This was one baby born at 39+3 weeks gestation and one baby born at 36+0 weeks gestation. This baby was the second baby born in a twin pregnancy.

PMRT review panels for these cases took place in May 2025 and the key findings, learning, good practice, and action plans will be reported to QAC as part of the Quarter 1 2025/26 PMRT audit report in August 2025.

WHH stillbirth rate for Q4 2024/25 was 3.44 per 1000 births. WHH annual mean stillbirth rate (2023/24) is 2.71 per 1000 births. The MBRRACE-UK national stillbirth rate for 2023 is 4.0/1000 births. WHH neonatal mortality rate during Q4 2024/2025 was 0.0 per 1000 live births. The MBRRACE-UK national neonatal rate is 1.64/1000 live births. During Q4, there were no babies requiring review through PMRT panel at WHH.

7. MATERNITY SELF ASSESSMENT

The revised Maternity self-assessment tool is a national assurance tool to support trusts to benchmark their services against national standards and best practice guidance. Evidence of completion of the tool is required as part of the North West Region Maternity Performance Oversight Panel (MPOP) assurance process.

The Maternity self-assessment tool identifies 159 criteria. As at 30th April 2025, WHH was fully compliant with 133/159 criteria. This equates to 84% of the criteria, an improvement from 78% when the last assessment was completed. Actions are ongoing to achieve full compliance. It is anticipated further progress will be made against all ongoing actions by the end of Q2 2025/26. The detail of the self-assessment is included in appendix five.

8. BIENNIAL REVIEW OF OBSTETRIC, ANAESTHETIC, NEONATAL STAFFING AND Q4 MIDWIFERY STAFFING

A detailed paper was presented to Strategic People Committee in July 2025 to provide assurance in relation to workforce within the maternity and neonatal services, in particular with regard to the standards within the MIS year 7, specifically:

- Safety action 3 - Can you demonstrate that you have transitional care services in place and are undertaking quality improvement to minimise separation of parents and their babies.
- Safety action 4 - Can you demonstrate an effective system of clinical workforce planning to the required standard?
- Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

The paper noted challenges with regard to neonatal staffing in particular medical and AHP staffing and in the provision of robust TC service.

MIS also requires the service to demonstrate the completion of a systematic, evidence-based process to calculate midwifery staffing establishment (Birthrate Plus®) within the last three years. The paper reported the outcome of the 2024 assessment with the following key matters to note:

- A total clinical requirement for face to face care of 131.57wte. WHH current total clinical establishment is 127.99wte. This has resulted in a shortfall of 3.58wte between the 2025 recommended Birthrate Plus® establishment and existing funded establishment.
- The total clinical establishment excludes the management, and the non-clinical element of the specialist midwifery roles needed to provide maternity services. For WHH this equates to an additional staff of 15.79wte. The current establishment for these roles is 14.50wte for these roles. This is a variance of 1.29wte.
- As a result, the 2024 Birthrate Plus® assessment suggests a total shortfall in registered midwifery posts of 4.87wte

Ongoing monitoring of safe staffing levels via the red flag process is a further requirement of the Safety Action 5, via 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.

The paper noted in Q4 2024/2025 there are no episodes recorded in SafeCare where the Birth Suite Coordinator is NOT supernumerary as per the technical standard. Furthermore, there are no episodes recorded in SafeCare where a woman in active labour is NOT receiving one-to-one care.

The paper also provided details of key midwifery workforce metrics with no issues to escalate. The paper is included in full as appendix 6 to ensure Board oversight.

9. HARMS POSITION SEPT 2024-FEBRUARY 2025

A review of harm events within the maternity service for the period September 2024-February 2025 was presented to QAC in April 2025. This is included for information in appendix 7.

10. FETAL SURVEILLANCE DEEP DIVE

A deep dive of the service position with regard to fetal surveillance was presented to QAC in July 2025. This is included for information in appendix 8.

11. MONITORING/REPORTING ROUTES

The contents of this report are reported via the Women's Health Governance meeting. Items for escalation are monitored at W&C CBU Governance meeting monthly.

12. ASSURANCE COMMITTEE

The contents of this report have previously been noted and discussed at Quality Assurance Committees on 8 April 2025, 13 May 2025, 10 June 2025 and 8 July 2025 and Strategic People Committee on 16 July 2025.

13. RECOMMENDATIONS

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

Learning from Investigations

The Case

The Mother was 30 years old in her second pregnancy. She was assessed at booking as having increased chance of complications due to a raised body mass index and the possibility of a recurrence of chronic villitis of unknown origin and the associated risk of her Baby being small for gestational age. This meant her care was led by an obstetric team, receiving appointments with both obstetric and the community midwifery care team. A plan was made for the Mother to have regular serial growth ultrasound scans.

The Mother planned to have a waterbirth on the consultant led maternity unit. During pregnancy, the Mother became anxious about her labour due to her previous birth being traumatic and her experience of postnatal depression and stress disorder. She was referred for additional support from a specialist midwife at the birth choice's clinic. This did not occur.

At 40+1 weeks the Mother contacted the maternity triage unit when she was in labour, and she was advised to attend. The Mother was transferred to Birth Suite, and she received one to one midwifery care. Concerns about Baby's heart rate were first recognised on the CTG (cardiotocograph) when the Mother was in the active second stage of labour at 03:08 hours. Urgent escalation was made to the obstetric team and following an episiotomy, Baby was born at 03:28 hours, weighing 3,570g on the 27 centile.

Baby was born in poor condition and following initial resuscitation was admitted to the neonatal unit. Arrangements were then made to transfer Baby to a regional neonatal intensive care unit for therapeutic cooling treatment. Magnetic resonance imaging (MRI) of Baby's brain was performed at 8 days of age which showed no brain abnormality. Baby was discharged home at 6 days of age, with no ongoing care needs and is receiving follow up appointments.

MNSI Findings

*The Mother did not meet the priority criteria for an appointment in the birth choices clinic. This led to feeling let down and had been unable to fully explore her options for a waterbirth.

*CEFM was commenced as staff understood a raised body mass index to be a risk factor which it was not.

*There was loss of contact with CEFM for a 20-minute period during attempts at siting an epidural with no assurance of fetal wellbeing.

*When the epidural was not successful, the Mother was given further diamorphine without assessment of labour progress

*There was ongoing increased frequency of uterine contractions which was not recognised. This meant that the cardiotocograph was not categorised as being suspicious and escalation did not occur. Senior midwifery review did not occur as expected and this meant that there was no oversight of changes in the fetal heart rate pattern. This led to a delay in escalation and recognition of the trace becoming pathological.

*Once the CTG concerns were recognised, escalation was made, and an obstetric review was performed. The urgency of the need for the birth was recognised and plans were to expedite the birth. Baby's birth occurred 18 minutes later.

*There had been no escalation to the neonatal team and baby was born requiring resuscitation. This meant that the neonatal team were not immediately available to provide optimal resuscitation. A decision was made for therapeutic cooling treatment and care was provided in line with local and national guidelines.

*Magnetic resonance imaging was performed when Arlo was 8 days of age and there was no evidence of any brain injury.

MNSI Safety Recommendation	Trust actions and learning
It is recommended that the Trust ensures that staff are supported to undertake regular cardiotocograph assessments including fresh eyes fresh reviews in line with local and national guidelines (Saving Babies' Lives care bundle v3 (2023) and that this is not impeded by workload demands so that time-critical escalation takes place when needed.	- We have seen increased improvement particularly over the last 12 months and continue to share learning and training regarding review requirements and escalation processes. This is included within MAMU-2 delivered by the Fetal Surveillance Team and is also highlighted in PROMPT and via safety briefs. - Escalation QI project required to build on work already completed through the RCOG Escalation Toolkit
It is recommended that the Trust support staff to assess and accurately document the rate of contractions during cardiotocograph reviews to enable accurate cardiotocograph categorisation and to inform decision making.	'CTG of the week' board for sharing learning commenced in the intrapartum area.
It is recommended that the Trust support staff to escalate cardiotocograph concerns in the second stage of labour even when birth is thought to be near, to support multidisciplinary oversight and input into care.	Escalation QI project required to build on work already completed through the RCOG Escalation Toolkit
It is recommended that the Trust support staff to ask the neonatal team to attend a birth when a cardiotocograph is pathological and a decision has been made to expedite birth, to support resuscitation of a baby.	Learning shared by the birth suite manager with the inpatient areas through safety brief
MNSI Safety Prompts	Trust actions and learning
The Mother was referred to the birth choices clinic, this referral was not accepted as Samantha did not meet the criteria and this meant that Samantha did not have an opportunity to fully discuss her birth options as expected.	Birth Choices referral process reviewed and updated.
A CTG was started due to the Mother having a raised body mass index.	- Learning to be shared through MAMU-2 Fetal Surveillance mandatory study day. - Not identified as a theme in reviews complete prior to or since. Fetal Surveillance Specialist Midwife to audit CTG criteria on admission to Maternity Triage for assurance.
Staff were unable to continuously monitor during the attempt to re-site the Mother's epidural.	- Learning to be shared through MAMU-2 Fetal Surveillance mandatory study day. - Fetal Surveillance Specialist Midwife to audit CTG during administration of Epidural for assurance.
A vaginal examination, to assess progress in labour, was not performed prior to a second dose of diamorphine being given. The investigation considers that there was opportunity for a vaginal examination to be done prior to this to check Samantha's progress in labour as this can have an impact upon the fetal heart variability and the condition of a baby at birth.	- No indication to reassess less than 4-hourly with the previous examination having been undertaken 2.5 hours earlier. Baby was born 1hr 42 minutes following the second administration of diamorphine – The Mother felt her pain relief choices were not explained to her. - Learning to be shared across the intrapartum areas to inform future care

Maternity Investigation

MI-039124

Independent report by the
Maternity and Newborn Safety Investigations (MNSI) programme.

Final investigation report, May 2025

© Maternity and Newborn Safety Investigations (MNSI) copyright 2025.

The text of this document (this excludes, where present, the Royal Arms and all departmental and agency logos) may be reproduced free of charge in any format or medium providing that it is reproduced accurately and not in a misleading context.

The material must be acknowledged as Maternity and Newborn Safety Investigations (MNSI) copyright and the document title specified. Where third party material has been identified, permission from the respective copyright holder must be sought.

Any enquiries regarding this publication should be sent to us at enquiries@mnsi.org.uk

About the MNSI programme

The Maternity and Newborn Safety Investigation programme (MNSI) is hosted within the Care Quality Commission (CQC). MNSI is responsible for patient safety investigations of NHS maternity care in England which meet the criteria outlined in the Care Quality Commission (Maternity and Newborn Safety Investigation Programme) Directions (2023). Details of our criteria can be found in appendix 1, and on our website: [What we investigate \(mnsi.org.uk\)](https://mnsi.org.uk)

MNSI investigations replace the local investigation carried out by the healthcare organisation. We work closely with those who received care, their families and healthcare staff affected by patient safety incidents, and we do not attribute blame or liability.

We acknowledge the health inequalities that impact some mothers, pregnant persons and their babies. MNSI is committed to working with relevant organisations to understand the factors behind these health inequalities and to inform changes that support safer maternity care. The information we collect during our investigations will be used to support wider work regarding addressing the known disparities in maternal, fetal and neonatal outcomes for people from certain ethnic or socio-economic backgrounds.

MNSI's investigation approach

Most harm in healthcare results from problems within the systems and processes that influence how care is delivered. Our investigations seek to identify the contributory factors that have led to harm, or the potential for harm. Safety recommendations for healthcare organisations and safety prompts identified within our reports aim to improve healthcare systems and processes, reduce risk, and improve safety.

Findings, safety recommendations and safety prompts

This report contains **findings** from our analysis of the evidence gathered during our investigation. The report may also contain **safety recommendations** and **safety prompts**.

Safety recommendations are made to an NHS organisation when the evidence indicates a change is needed to make care safer.

Safety prompts describe an action that may help to improve safety at a local level and where there was insufficient evidence to support a safety recommendation. This could be because the issue fell outside the direct scope of the investigation.

Not all reports will contain **safety recommendations** or **safety prompts**. On these occasions, maternity services are encouraged to use the findings within the report to promote and support learning.

A note of acknowledgement

We would like to thank Samantha and James whose experience is central to this investigation and detailed in this report. Samantha and James generously gave their time and shared their thoughts openly with the investigation. Information shared by Samantha and James helped to inform the investigation and provided valuable insight into the impact of such events.

We would also like to thank the healthcare staff involved in the investigation. MNSI acknowledges staff involved in safety events may be adversely affected and require additional support. The investigation found the healthcare staff were open and willing to support improvements.

In accordance with their wishes, Samantha, James and their baby, Arlo are referred to by name throughout this report.

About Arlo

Arlo is the second child of Samantha and James, and is the younger brother to big sister Lyra. They hope this report will make care safer for other families and help them to understand what happened during Arlo's birth. They are all enjoying getting to know Arlo, and Lyra enjoys giving him kisses and cuddles every day.

Executive summary

The Maternity and Newborn Safety Investigation (MNSI) programme was informed about Arlo's birth because of the risk of him having a brain injury in the first 7 days of life and receiving cooling therapy. This met the criteria for an independent investigation by MNSI. A scan of Arlo's brain, magnetic resonance imaging (MRI), was completed when he was 8 days of age and showed 'no brain abnormality'. After a multi-disciplinary discussion, the case was continued by MNSI due to concerns raised by the Trust regarding the care provided.

Incident overview

Samantha, who was 30 years old, White British and English speaking, was assessed at booking as having increased chance of complications due to her raised body mass index and the possibility of a recurrence of chronic villitis of unknown origin and the associated risk of her Baby being at risk of being small for gestational age. This meant her care was led by an obstetric team, receiving appointments with both obstetric and the community midwifery care team. A plan was made for Samantha to have regular serial growth ultrasound scans. Samantha planned to have a waterbirth on the consultant led maternity unit.

During pregnancy, Samantha was anxious about her labour due to her previous birth being traumatic and her experience of postnatal depression and stress disorder. She was referred for additional support from a specialist midwife at the birth choice's clinic. This did not occur.

At 40+1 weeks Samantha contacted the maternity triage unit when she was in labour and she was advised to attend. Samantha was transferred to the labour ward and she received one to one midwifery care. Concerns about Arlo's heart rate were first recognised on the CTG (cardiotocograph) when Samantha was in the active second stage of labour at 03:08 hours. Urgent escalation was made to the obstetric team and following an episiotomy, Arlo was born at 03:28 hours, weighing 3,570g on the 27th population based centile.

Arlo required resuscitation prior to being admitted to the local neonatal unit. Arrangements were then made to transfer Arlo to a regional neonatal intensive care unit for therapeutic cooling treatment. Magnetic resonance imaging of his brain was performed at 8 days of age which showed 'no brain abnormality'. Arlo was discharged home when he was 6 days of age, with no ongoing care needs and he is receiving follow up appointments.

Findings

1. Due to workload capacity and as Samantha was not requesting to 'birth outside of guidance' she did not meet the priority criteria for an appointment in the birth choices clinic. This meant that she was not sent an appointment to attend. Samantha was unaware of this. This led to Samantha feeling let down and had been unable to fully explore her options for a waterbirth.
2. The staff were unable to offer Samantha a waterbirth during her labour. The investigation was unable to establish the reason why. This meant that Samantha did not get the opportunity to experience the birth experience that she had planned and expected.
3. Continuous CTG was started as staff understood a raised body mass index to be a risk factor. There was no evidence that this was initially required or discussed with Samantha. This meant that she was unable to make an informed choice.
4. Due to Samantha's position during the re-siting of the epidural it was not possible to monitor the well-being of the Arlo. This meant that staff could not be assured of how the Arlo was coping for a 20 minute period.
5. Samantha was given further diamorphine, when insertion of an epidural was unsuccessful, this was given before assessment of labour progress by vaginal examination had been completed. This meant that the stage of Samantha's labour did not inform decision making about her pain relief options.
6. The ongoing increased frequency of Samantha's uterine contractions was not recognised. During CTG reviews it had not been documented that the rate of uterine contractions was above a rate of 4:10. This meant that the cardiotocograph was not categorised as being suspicious and escalation did not occur.
7. Acuity, staffing and workload within the unit led to the Cardiotocography reviews not being conducted in line with local or national guidelines. Senior midwifery review did not occur as expected and this meant that there was no oversight of changes in the fetal heart rate pattern. This led to a delay in escalation and recognition of the trace becoming pathological.
8. Once the CTG concerns were recognised, escalation was made and an obstetric review was performed. The urgency of the need for the birth was recognised and plans were to expedite the birth. Arlo's birth occurred 18 minutes later.

9. There had been no escalation to the neonatal team and Arlo was born requiring resuscitation. This meant that the neonatal team were not immediately available to provide optimal resuscitation. A decision was made for therapeutic cooling treatment. Care was provided in line with local and national guidelines.
10. Magnetic resonance imaging was performed when Arlo was 8 days of age and there was no evidence of any brain injury.

Safety recommendations and safety prompts

Safety recommendations

1. It is recommended that the Trust ensures that staff are supported to undertake regular cardiotocograph assessments including fresh eyes fresh reviews in line with local and national guidelines (Saving Babies' Lives care bundle v3 (2023) and that this is not impeded by workload demands so that time-critical escalation takes place when needed.
2. It is recommended that the Trust support staff to assess and accurately document the rate of contractions during cardiotocograph reviews to enable accurate cardiotocograph categorisation and to inform decision making.
3. It is recommended that the Trust support staff to escalate cardiotocograph concerns in the second stage of labour even when birth is considered to be near, to support multidisciplinary oversight and input into care.
4. It is recommended that the Trust support staff to ask the neonatal team to attend a birth when a cardiotocograph is pathological and a decision has been made to expedite birth, to support resuscitation of a baby.

Safety prompts

1. The Mother was referred to the birth choices clinic, this referral was not accepted as Samantha did not meet the criteria and this meant that Samantha did not have an opportunity to fully discuss her birth options as expected.
 - What guidance is available to staff to understand the criteria for mother's attending the birth choices clinic? Do staff understand the current pathways?

- What is the process for closing the communication loop following a referral to ensure a mother has been updated about the outcome?
 - How are mothers supported to discuss birth options when they do not meet the criteria for the birth choices clinic?
2. A CTG was started due to the Mother having a raised body mass index.
- How are staff supported to understand which risk factors meet the criteria for continuous CTG?
 - How are staff supported to document informed decision making conversations with a mother about the options available for monitoring the well-being of a baby during labour?
3. Staff were unable to continuously monitor during the attempt to re-site the Mother's epidural.
- How are staff supported to ensure that the quality of a CTG trace is continued during the insertion of epidurals; ensuring that the wellbeing of a baby can be effectively monitored?
 - Are there any barriers with communication or escalation during siting of epidural when monitoring of fetal heart rate cannot be obtained?
4. A vaginal examination, to assess progress in labour, was not performed prior to a second dose of diamorphine being given.
- How are staff supported to assess labour progress prior to giving diamorphine?
 - How does local guidance inform decision making about pain relief options in established labour?

Contents

About the MNSI programme	1
MNSI's investigation approach	2
A note of acknowledgement	3
About Arlo	3
Executive summary	4
Incident overview	4
Findings	5
Safety recommendations and safety prompts.....	6
Safety recommendations	6
Safety prompts	6
1. Investigation approach	11
1.1 Summary of investigation process	11
1.2 Terms of reference	11
1.3 Information gathering	12
2. Background and context.....	13
2.1 Potential severe brain injury – Moderate or severe encephalopathy (with active cooling) 13	
2.2 Ethnicity and health inequalities	14
2.3 Personalised antenatal birth planning	15
2.4 Hyperstimulation	16
2.5 Fetal heart rate monitoring using cardiotocography (CTG).....	17
2.5.1 Features and categorisation of a CTG.....	18
2.6 Use of diamorphine in labour	21
2.7 Magnetic resonance imaging (MRI)	21
2.8 Placental histology	21

3. The safety event that affected Samantha and Arlo	23
3.1 Antenatal care	23
3.2 intrapartum care and Arlo's birth	26
3.3 Care of Arlo after birth	30
4. Investigation analysis and findings	33
4.1 Personalised birth planning in the antenatal period.	33
4.2 Cardiotocography (CTG)	35
4.2.1 Criteria for using cardiotocography (CTG)	35
4.2.2 Loss of contact on the cardiotocograph and re-siting of the epidural.....	36
4.2.3 Process for a fresh eye CTG review and categorisation.	37
4.3. Preparation and timing for Arlo's birth.....	39
Appendices	40
Appendix 1: Additional information about the Maternity and Newborn Safety Investigation programme (MNSI).....	42
Further information about the MNSI programme's approach to gathering information	43
Review of information	43
Family interviews	43
Specialist review panels	43
Staff interviews	43
Communication during investigations	44
Post-mortem examination.....	44
His Majesty's Coroner information	44
Analysis	44
Appendix 2 - CTG categorisations during labour	46
Appendix 3: Algorithm for neonatal resuscitation.....	47
Appendix 3	48

Appendix 4: Reference list.....49

1. Investigation approach

1.1 Summary of investigation process

The Trust contacted MNSI to inform them of a case involving a baby that required therapeutic cooling following their birth. The event met the criteria for MNSI to carry out an independent investigation (The Care Quality Commission (Maternity and Newborn Safety Investigation Programme) Directions 2023).

During the investigation, advice was provided by experienced and senior clinicians in relevant specialities. Following evidence collection and analysis, the findings were written in a draft report. This was reviewed by senior members of the MNSI programme. The draft report was then shared with the Trust and Samantha and James for their review and comment before being finalised.

The healthcare organisation is responsible for acting on any safety recommendations and safety prompts directed to them.

1.2 Terms of reference

The terms of reference were shared with, and informed by, those affected by the event. For the purposes of the investigation the clinical records for Samantha and Arlo were reviewed. Following this, the terms of reference (the key areas to be explored) for investigation were agreed. Ethnicity and other health inequalities will be explored as part of the following terms of reference.

The terms of reference for this investigation were:

The investigation will review all aspects of care from the initial booking appointment until the birth of the Baby. This will enable the investigation to understand the context and situational factors that influenced the care provided to Samantha and her baby, Arlo. To include a review of the initial neonatal brain imaging reports.

The investigation will focus on the care provided during labour with an emphasis on:

- the systems and processes for individualised birth planning in the antenatal period.
- the systems and processes that assist staff to categorise and act upon a CTG trace.

The investigation will consider any healthcare factors that may have influenced the care that the Mother and Baby received and ensure that the family's perception of events is captured, along with those of the staff involved in her care.

The investigation will not include any review of neonatal care. Review of this care should be considered by the Trust in line with locally agreed processes.

1.3 Information gathering

The investigation used different sources of evidence to help understand the circumstances surrounding Samantha and Arlo's care, and any factors that may have contributed to the outcome. Consideration was given to ethnicity and other health inequalities, the environment, equipment, tasks, policies, and processes to understand how these may have influenced staff decisions and actions. This allowed the investigation to form an understanding of the healthcare systems involved and how they contributed to care and the outcome.

Information sources included:

- a meeting and telephone conversation(s) with Samantha and James
- a review of relevant guidance
- a review of Samantha's and Arlo's clinical records
- reviews with advisors with a specialist knowledge in obstetrics and midwifery
- interviews with staff who provided clinical care to Samantha and Arlo
- meetings with staff working at the Trust to understand the healthcare systems and processes which impacted on the care that Samatha and Arlo received.

The evidence gathered was analysed to identify learning. These informed the identification of themes and the development of safety recommendations and safety prompts.

Further details about the MNSI programme's criteria and approach to information gathering can be found in appendix 1.

2. Background and context

2.1 Potential severe brain injury – Moderate or severe encephalopathy (with active cooling)

Neonatal hypoxic ischaemic encephalopathy (HIE) is a condition in which there is disturbed neurological function caused by an interrupted supply of oxygen to a baby's brain occurring during the antenatal, intrapartum or postnatal period.

HIE occurs in 1.0 to 3.5 per 1000 live births in the United Kingdom (The British Association of Perinatal Medicine (BAPM), 2020). An interrupted oxygen supply can also affect other organs as well as the brain which can lead to severe, lifelong disability or death.

The key feature of moderate or severe HIE (BAPM, 2020) is the disturbance in the degree or quality of a baby's consciousness (lethargy, stupor or coma) and at least one of the following:

- Reduce muscle tone (hypotonia)
- abnormal reflexes including eye movement (oculomotor) or pupil responses (pupillary)
- absent or weak suck
- clinical seizures.

Therapeutic hypothermia (active cooling) should be considered in infants that meet specific criteria following birth.

Criteria A

Babies of more than 36 weeks who are less than 6 hours old with at least one of the following:

- Apgar score equal to or less than 5 at 10 minutes of age
- Continued need for resuscitation at 10 minutes of age
- pH of less than 7.00 or base excess less than -16mmol/L in any blood sample taken within 60 minutes of birth.

Criteria B

Development of encephalopathy evidenced by abnormal neurological examination including seizures,

- reduced or absent response to stimulation and at least one of the following:
- abnormal reflexes
- poor muscle tone

Criteria C:

Abnormal cerebral function monitoring (CFM) (which measures the electrical activity of the brain). It is recognised that CFM may not be available in all circumstances, and inability to obtain CFM should not prevent or delay treatment if there is evidence from A and B criteria.

The UK total body cooling trial confirmed that 72 hours of cooling to a core temperature of 33-34°C within 6 hours of birth for babies with potentially moderate or severe HIE reduces death and disability at 18 months of age and improves neurodevelopmental outcome in survivors. Therapeutic hypothermia is a procedure where a baby is cooled to between 33°C and 34°C, with the aim of preventing further brain injury following a hypoxic (lack of oxygen) injury.

Therapeutic cooling therapies are described as:

- Passive – Prior to active cooling, a baby once resuscitated can have passive cooling by turning off heating equipment and removing any coverings from the baby.
- Active – Hypothermia is usually induced by cooling the whole body with a blanket or mattress and this is referred to as active cooling.

2.2 Ethnicity and health inequalities

Maternity and Newborn Safety Investigation programme (MNSI) acknowledges that maternity care requires system level changes to make the navigation of maternity services safer for Black and Asian mothers who are more likely to die than White mothers (MBRRACE-UK, 2022a).

In our reports, we refer to ethnicity and not race. Under the Equality Act 2010, ethnicity includes ‘colour, nationality and ethnic or national origins’ (NHS Digital, 2022).

Health inequalities are avoidable differences in health outcomes between groups or populations – such as differences in how long we live, or the age at which we get preventable diseases or health conditions (The Office for Health Improvement and Disparities, 2022).

‘Ethnic minorities’ refer to all ethnic groups except the White British group. The term ‘ethnic

minorities' includes White minorities, such as Gypsy, Roma and Irish Traveller groups (Race Disparity Unit, 2021).

MNSI aims to raise awareness of health inequalities and ethnicity in maternity care and supports changing the current system to reduce health inequalities leading to better outcomes for mothers, babies and families from Black, Asian or minority ethnic backgrounds.

MNSI will share findings and recommendations with all hospitals and organisations working with maternity care services across England.

The 2022 MBRRACE-UK perinatal surveillance report (MBRRACE-UK, 2022b) explains the effects ethnicity and deprivation have on perinatal and maternal mortality:

- Black mothers are 3.7x more likely to die than White mothers (MBRRACE-UK, 2022a).
- Asian mothers are 1.8x more likely to die than White mothers (MBRRACE-UK, 2022a).
- Stillbirth and neonatal mortality rates increased with deprivation across all ethnic groups.
- Stillbirth and neonatal mortality rates were lowest for babies of White ethnicity from the least deprived areas (2.78 stillbirths per 1,000 total births and 1.26 neonatal deaths per 1,000 live births).
- The impact of ethnicity and deprivation is highlighted by a stillbirth rate of 8.10 and 7.96 per 1,000 total births for babies of Black African and Black Caribbean ethnicity respectively from the most deprived areas.
- Rate of neonatal death were over 3 per 1,000 live births for babies of Pakistani and Black African ethnicity from the most deprived areas.
- More babies of Black African, Black Caribbean, Pakistani and Bangladeshi ethnicities are from deprived areas, they are disproportionately affected by the higher rates of stillbirth and neonatal death associated with deprivation'.

2.3 Personalised antenatal birth planning

In line with national guidelines (NHS England, 2021) maternity care should be personalised and safe. Care should be centred on the mother, her baby and her family; based around her needs and decisions, where there has been genuine choice informed by unbiased information. This is essential to ensuring that mothers receive the best care possible.

Personalised care and support planning involves a series of facilitated conversations in which the mother actively participates to explore the management of their health and well-being within the context of their whole life and family situation so that all considerations that may impact on safe care are accounted for.

The plan is developed following an initial holistic assessment of a mother's health and well-being need, with the mother's involvement. The agreed plan should set out the decisions she makes about the care and support she wants to receive. The agreed 'personalised' plan will cover antenatal care, birth plan and postnatal care. This should be reviewed by the midwife and/or obstetrician with the mother at each contact.

Locally, the Birth Talks Service has been developed for mothers requesting to choose care options outside of local guidelines. In response to the requests of mother's seeking additional information and support to explore their birth options, including the opportunity to discuss the risks and benefits of these choices. The local, out of guidance, guideline (Trust, 2022) indicates that referrals should be made to the 'Birth Talks Clinic' as soon as the mother requests or raises questions regarding birth planning to any member of the Maternity Team. All mothers who are referred for support to discuss their care and birth options will be seen by a consultant midwife and/or their named consultant obstetrician.

2.4 Hyperstimulation

The National Institute for Health and Care Excellence (NICE, 2021) specifies that hyperstimulation is overactivity of the uterus following induction of labour. This is when the uterus contracts too frequently or contractions last too long, which can lead to changes in fetal heart rate and result in fetal compromise. It is defined when there are more than 5 contractions per 10 minutes for at least 20 minutes (uterine tachysystole) and/or when contractions are lasting at least 2 minutes (uterine hypersystole/hypertonicity). These contractions may or may not be associated with changes in the fetal heart rate pattern. There is no guidance related to hyperstimulation following the onset of spontaneous labour.

Uterine hyperstimulation can have a detrimental effect on a mother and the baby. In line with local guidance (Trust, 2024), to help manage hyperstimulation, a medicine called terbutaline may be given as an injection under the mother's skin to slow down contractions. This process, called tocolysis, helps space out contractions and reduce stress on the baby.

Locally there has been education to inform staff about the differences between hyperstimulation and tachysystole. Both terms are used to describe the presence of more than 5 contractions in a 10 minute period. Tachysystole is locally defined when the fetal heart rate remains unaffected compared to hyperstimulation when there are any concerning fetal heart rate changes. Both conditions requiring senior obstetric review and ongoing observation as both are a common cause of fetal hypoxia.

In the event of a hyperstimulation concern local guidance directs that staff should:

- Undertake full maternal observations including assessment of uterine activity
- Perform a cardiotocograph (CTG) if contractions last longer than 60 seconds in length (hypertonus), or if there are more than 5 contractions in 10 minutes (tachysystole).
- Obtain obstetric review and ongoing management plan.
- Terbutaline to be considered as part of obstetric review.

In line with national guidelines (NICE, 2022), 5 or more contractions in 10 minutes, leading to reduced resting time between contractions, would meet an amber criteria and result in a CTG categorisation of 'suspicious'.

2.5 Fetal heart rate monitoring using cardiotocography (CTG)

A CTG is an electronic means of recording an unborn baby's heart rate pattern, to assess their wellbeing. This can be used both during the antenatal period, and during labour. It is usually performed externally, using two devices (transducers) placed on a mother's abdomen, to monitor the baby's heart rate and the mother's contractions. A clip (pulse oximeter) may be placed on a mother's finger, to simultaneously record her heart rate, and ensure it is the baby's heart rate pattern being monitored by the abdominal transducer. This machine produces a printed or electronic record referred to as the CTG.

In line with local guidance (Trust, 2023) a CTG should be offered to mothers who meet certain criteria or where maternal or fetal risk factors develop in labour (intrapartum).

Raised body mass index is not specified as a risk factor for continuous fetal heart rate monitoring in local or national guidance (Trust, 2023; NICE, 2022). The local and national guidance does suggest that staff should 'Consider continuous CTG monitoring if, based on clinical assessment and multidisciplinary review, there are concerns about other antenatal factors not listed above that may lead to fetal compromise'. The guidance also specifies that

fetal heart rate monitoring should be discussed with the mother and her birth companion(s) including the reasons for offering continuous CTG monitoring.

When undertaking CTG monitoring it is important to ensure that the CTG trace is of high quality and, if not, action should be taken to improve the trace (for example, by repositioning the transducers or by using a fetal scalp electrode) (NICE, 2022, Trust, 2023). A fetal scalp electrode is a small clip placed on the unborn baby's head or bottom, if external monitoring produces an unreadable CTG. It is applied during a vaginal examination.

2.5.1 Features and categorisation of a CTG

Fetal heart rate monitoring is a tool to provide guidance on a baby's condition, and not a standalone diagnostic tool. The findings from monitoring, need to be looked at together with the developing clinical picture for both mother and baby (NICE, 2022).

When categorising a CTG, four features of the baby's heart rate pattern are considered: baseline, variability, accelerations and decelerations.

The baseline rate is the average of a baby's heartbeat over a period of time. The expected range is between 110 beats per minute (bpm) and 160bpm. Variability is the fluctuation in a baby's heart rate from one beat to the next and is expected to be between 5bpm and 25bpm. Accelerations are a temporary rise in a baby's heart rate, often associated with fetal movements, and are generally a sign that a baby is healthy (NICE, 2022). Decelerations are a temporary slowing of a baby's heart rate and can be described in multiple ways.

- Early - Repetitive and periodic slowing of a baby's heart rate with onset early in the contraction and return to baseline at the end of the contraction.
- Variable decelerations - Intermittent and periodic slowing of the fetal heart rate with a variable time in relation to the contraction.
- Late - Repetitive and periodic slowing of the fetal heart rate with onset mid to end of the contraction and the lowest point more than 20 seconds after the peak of the contraction and ending after the contraction. This means the lowest point of the deceleration comes after the peak of a uterine contraction. Late decelerations are associated with a 'higher risk of fetal compromise' if there is also reduced variability (NICE, 2022).

When assessing the significance of decelerations in a baby's heart rate, it is recommended that the following are considered:

- Their timing in relation to the peaks and duration of the contractions

- The duration of the individual decelerations
- Whether or not the baby's heart rate returns to the baseline heart rate
- How long they have been present for
- Whether they occur with over 50% of contractions (defined as repetitive)
- The absence of shouldering (a brief increase in a baby's heart rate immediately before and after a deceleration).
- The variability within the deceleration

It is outlined that the following should be regarded as concerning characteristics of variable decelerations:

- Lasting more than 60 seconds
- Reduced variability with the deceleration
- Failure or slow return to baseline fetal heart rate
- Loss of previously present shouldering

National guidelines (NICE, 2022) advise that the previous fetal heart rate monitoring results be reviewed, including any previous CTG traces, as part of an hourly risk assessment and in conjunction with other antenatal or intrapartum risk factors and determine if there are any heart rate changes. If there are changes in the fetal heart rate pattern over time which indicate a change in the baby's condition, then a review of antenatal or intrapartum risk factors for hypoxia (reduced oxygen level) is required.

Locally it has been agreed that the fresh eye review should be undertaken every other hour by a band 7 senior member of the midwifery team. Local CTG interpretation guidance (Trust, 2023) indicates that staff should:

- obtain an in-person review of every hourly assessment by another clinician (fresh eyes) for mother's on CTG, to be completed before the next assessment takes place.
- Review the previous fetal heart rate monitoring results, including any previous CTG traces, as part of the hourly risk assessment and in conjunction with other antenatal or intrapartum risk factors.
- Ensure one-to-one support is maintained by having a midwife remain with the mother throughout labour.
- perform and document a systematic assessment of the condition of the mother and unborn baby every hour, or more frequently if there are concerns.

- Evaluate changes on traces over time to ascertain changes in the baby's condition
- Document any changes in the CTG trace from the previous review
- Review the changes alongside any existing and new intrapartum risk factors
- Think about the possible reasons of any changes and take these and the whole clinical picture into account when planning ongoing care
- At each assessment include maternal antenatal risk factors for fetal compromise, fetal antenatal risk factors for fetal compromise, new or developing intrapartum risk factors and progress in labour including characteristics of contractions (frequency, strength, and duration).

If a cardiotocograph (CTG) is not categorised as normal, the clinical team may recommend care with the aim of improving a baby's environment. This can include changing a mother's position, correcting low blood pressure, or reducing the frequency of contractions. These are referred to as conservative measures

In line with the local (Trust, 2023) and national guidance (NICE, 2022) when a CTG is categorised as suspicious and there are additional intrapartum risk factors staff are expected to:

- Perform a full risk assessment, including a full set of maternal observations, considering the whole clinical picture, and document the findings
- Assess if the CTG trace was previously normal, consider possible underlying reasons for the change.
- Obtain an urgent review by an obstetrician or senior midwife
- Consider fetal scalp stimulation or expediting the birth
- Note that if accelerations are present then fetal acidosis is unlikely.

Acidosis is when there is a high level of natural acid in the blood. This can happen if the lungs are not working well or if there is not enough oxygen reaching parts of the body, or for both of these reasons (MNSI).

When a CTG is categorised as pathological this requires urgent senior review and action to further assess fetal wellbeing and the need to consider if a baby's birth should be expedited.

2.6 Use of diamorphine in labour

Diamorphine is an opioid medicine that may be used to relieve a mother's pain in labour. It may also be used to help a mother relax during the early stages of labour. It is usually given as an injection into her thigh or buttock. It may also be used as part of a patient controlled analgesia (PCA) system during or after labour and birth. The dose used depends on how it is to be given. Diamorphine is less likely to affect a baby's ability to breathe immediately after birth compared to pethidine.

In line with national guidance (NICE, 2023) mothers should be informed that it may have significant side effects for both her (for example, drowsiness, nausea and vomiting) and her baby (for example, short-term respiratory depression and drowsiness, which may last several days).

Opioids cross the placenta and the most appropriate use for them is earlier in labour, when they can be processed by the mother's system. An extra dose will not be given if the birth is expected within three to four hours, although it is not easy to predict the timing of births.

Opioids in your baby's system can affect their breathing after birth. This can mean your baby is transferred to the neonatal unit for help with breathing.

2.7 Magnetic resonance imaging (MRI)

All babies undergoing cooling therapy should have a cranial ultrasound within 12 hours to exclude some other causes of encephalopathy. All infants undergoing cooling therapy should have an MRI scan undertaken between 5 and 15 days, preferably between 5 and 7 days after birth. This should be reported by a consultant radiologist with expertise in neonatal brain MRI interpretation.

There is strong evidence that magnetic resonance imaging is a reliable predictor of neurological outcomes in infants treated with therapeutic hypothermia (BAPM,2020).

2.8 Placental histology

The Royal College of Pathologists (Evans et al 2022) recommend that 'as a minimum', all placentas from a birth where there has been severe fetal distress, defined as: pH less than 7.05 or base excess less than -12 millimoles per litre (mmol/l) or scalp lactate greater than 4.8mmol/l receive a histological examination.

Histopathological examination (under a microscope) of the placenta may provide an explanation of the pregnancy complications. This explanation can be beneficial to the patient to understand and make sense of what has happened. It may also provide information relevant to the management of subsequent pregnancies.

3. The safety event that affected Samantha and Arlo

This section summarises Samantha's pregnancy, her labour and Arlo's birth and immediate neonatal care based on the recollections of family, staff and the medical records.

3.1 Antenatal care

Samantha who was 30 years of age and White British and English speaking, was booked for pregnancy care by the community midwifery team, when she was 7 weeks and 4 days pregnant (7+4 weeks). This was her second pregnancy. Samantha was assessed at booking to be at increased chance of complications due to her raised body mass index of 39.6kg/m².

Body mass index in pregnancy

BMI is a measure for indicating nutritional status in adults. It is defined as a person's weight in kilograms divided by the square of the person's height in metres (kg/m²) (WHO). The World Health Organisation (WHO) classifies BMI as follows:

BMI	Nutritional status
Below 18.5	Underweight
18.5 - 24.9	Normal weight
25.0 - 29.9	Pre-obesity
30.0 - 34.9	Obesity class I
35.0 - 39.9	Obesity class II
Above 40	Obesity class III

Obesity in pregnancy is associated with an increased risk of several serious adverse outcomes, including miscarriage, fetal congenital anomaly, thromboembolism, gestational diabetes, pre-eclampsia, dysfunctional labour, postpartum haemorrhage, wound infections, stillbirth and neonatal death. Fetal heart rate monitoring can be a challenge, and closer surveillance is required, with recourse to fetal scalp electrode or ultrasound assessment of the fetal heart if necessary. (RCOG 2018)

Additionally, Samantha had risks associated with a previous birth related villitis of unknown aetiology (VUE) and chorioamnionitis (inflammation of the placental membranes).

Villitis of unknown aetiology

Villitis of unknown aetiology (VUE) is inflammation of the structures covering the surface of the placenta. These structures ensure a baby receives enough nutrients and oxygen from their mother. VUE is associated with intrauterine growth restriction (IUGR), brain injury due to lack of oxygen and stillbirth. In high grade VUE the inflammation is widespread within the placenta. This leads to the part of the placenta where oxygen and nutrient exchange takes place (terminal villi) losing their blood supply and fibrotic (non-functional) tissue developing. VUE cannot be identified antenatally and can only be diagnosed by histology of the placenta. VUE cannot be treated or prevented. VUE has been reported to recur in up to 30% of subsequent pregnancies. (MNSI)

Samantha was booked for shared care, this meant her care was led by an obstetric team, receiving appointments with both the obstetric and the community midwifery care team. Due to her risk factors, serial growth ultrasound scans were scheduled at 3 weekly intervals from 32 weeks. All ultrasound scan and Doppler results remained within the normal range.

Growth ultrasound scan

This is an ultrasound scan performed to check the overall wellbeing of a baby. It involves some combination of assessing a baby's size, the amount of fluid around a baby and the measurement of blood flow to the placenta and within a baby using Doppler ultrasound. (MNSI)

Doppler

Doppler ultrasound is a test performed during an ultrasound examination that measures blood flow in a baby and/or the placenta. It is used in a variety of situations to check on the health of a baby. (MNSI)

Samantha planned to have a waterbirth on the consultant led maternity unit at the hospital. During pregnancy Samantha experienced ongoing anxiety about her labour due to her previous traumatic birth and her experience of postnatal depression and stress disorder. She continued to take anti-depressant medication (citalopram) throughout her pregnancy.

Samatha did not see the same midwife consistently and she asked about having the opportunity to talk about her plans and gain confidence in her choice to have a waterbirth. A

referral was made, at 29+3 weeks, to a consultant midwife for a mode of birth discussion appointment. The referral indicated that Samantha had 'significant anxiety resulting from previous birth experience'. It was additionally noted that she had post-traumatic stress disorder from her previous forceps birth and 'uterine infection'. Samantha became increasingly anxious in later pregnancy in case it happened again.

It was documented that a reminder email was to be sent at 31+3 weeks to confirm that the referral for a birth discussion had been received. There was no evidence that any follow up email had been sent.

When Samantha was 32+2 weeks, she reported a small amount of "vaginal blood loss on wiping". All observations were within the expected range. A speculum (instrument to visualise a mother's cervix) examination was performed and a vaginal swab was taken and sent to the laboratory. Group B streptococcus was diagnosed and a plan was made for antibiotic treatment to be given during labour.

Group B streptococcus

Group B streptococcus (GBS) is one of the many bacteria that live in the body and mothers may carry it in their vagina without any problems to themselves. If a mother is known to carry GBS, antibiotics would be recommended in labour, to prevent a rare and potentially serious infection in a baby. These should be given within an hour of onset of active labour or within one hour of admission if a mother is already in active labour. If a mother has a urinary tract infection (UTI) with GBS during pregnancy she should be offered antibiotics at the time to treat the UTI as well as antibiotics in labour.

Further information from: [RCOG - Group B streptococcus](#)

Samantha was seen in the obstetric clinic after her growth ultrasound scan at 32+4 weeks. Her placenta was seen to be no longer low lying. It was noted that Samantha was awaiting a birth options appointment and that if she chose to have a vaginal birth she was 'keen for labour ward care and she would like to use the birthing pool if possible'. There was no documented evidence that a birth discussion occurred at this time.

At 34+2 weeks it was documented that Samantha was 'anxious' and was 'waiting for an appointment to discuss her plan with the consultant midwife'.

Samatha had a routine 'birth chat' with a member of the community midwifery team at 36+3 weeks and it was documented that Samatha wanted a waterbirth. Samatha recalls that she intended to explore this further when she met with the consultant midwife.

The appointment with the consultant midwife did not occur as expected and Samantha did not have the opportunity to discuss her plans for birth in the detail she needed.

Samantha's labour started spontaneously at 40+1 weeks and following a telephone call to the triage unit at 18:14 hours she was advised to attend.

3.2 intrapartum care and Arlo's birth

On admission to the maternity triage unit at 18:55 hours all maternal and fetal (baby) observations were within the normal ranges.

A CTG was started at 19:02 hours. The reason for starting a CTG was documented to be because of an 'abnormal doppler', a raised BMI and she appeared to be in established labour. It is unclear from the documentation why staff considered there to be an abnormal Doppler as all ultrasound results were within the normal range and the Baby's heart rate heard with the handheld Doppler (a device used to listen to a baby's heart rate) on admission was within the normal range.

A vaginal examination was done at 19:06 hours and Samantha's cervix was 5cm dilated.

Vaginal examination

A mother may be offered a vaginal examination during her pregnancy or labour. During a vaginal examination, a clinician will insert two fingers into a mother's vagina to assess the vagina, cervix (neck of her womb) and, during labour, the position of the baby's head within the birth canal. A vaginal examination may be offered for several reasons including to break the waters around a baby, to insert medications for induction of labour and to assess the opening of a mother's cervix. (MNSI)

Uterine contractions were occurring at a rate of 3 in a 10 minute period (3:10). Arlo's movement pattern was normal and there was no vaginal loss. Samantha recalls that she informed the staff that she wanted a waterbirth and she recalls being informed that this would be passed on to the staff who would be looking after her. The CTG was stopped at 19:17 hours and categorised to be 'normal'.

Samantha was transferred to the delivery unit and her care was handed over to an allocated midwife and student. Samantha had expected to be taken to a room with pool birth facility. Samantha was informed that the using the birthing pool was not possible and recalls the

response being “vague”, leaving her feeling unheard. The investigation learned that staff on the delivery unit did not recall a request for a waterbirth being made.

The CTG was restarted at 19:43 hours. This was documented and understood by the staff and Samantha to be due to her having a raised BMI. The CTG was categorised as normal at 19:57 hours. Subsequent CTG categorisations can be seen in a table in **Appendix 2**.

Samantha was provided with a birthing ball and gas and air; she was described to be coping well.

‘Gas and Air’

‘Gas and air’ is a gas made up of 50% nitrous oxide and 50% oxygen that is used for pain relief during birth. It is administered through a mask or mouthpiece. It is simple and quick to act and wears off in minutes.

Further information from: [NHS - gas and air](#)

Due to her group B streptococcus status, intravenous antibiotics, benzylpenicillin 3g (initial dose), were started at 20:23 hours. A second dose of 1.5g (maintenance dose) was given 4 hours later as recommended.

At 20:57 hours Samantha was standing and she requested further pain relief medication as her contractions were increasing in intensity and frequency. Diamorphine (opioid pain relief) and prochlorperazine (anti sickness medication) 12.5mg were given by injection into a muscle at 21:01 hours. There was no record of the prescription or dosage of the diamorphine given as this was not entered onto the medication chart. Some periods of reduced variability on the CTG were noted following its administration and Samantha had become more relaxed. James recalls that Samantha became sleepy and appeared “completely out of it”.

A face to face obstetric review was undertaken at 22:57 hours and no concerns were noted.

The next routine vaginal examination was done at 23:15 hours and Samantha’s cervix was 4cm dilated. Samantha’s waters were broken (artificial rupture of membranes) as her labour had not progressed as expected. The colour of her liquor (the amniotic fluid around a baby) was clear.

Samantha requested to have an epidural and this was inserted between 23:45 hours and 23:57 hours.

Epidural

An epidural is a method of pain relief which is inserted by an anaesthetist. An anaesthetist is a doctor who is specially trained to provide pain relief and general anaesthetics. The anaesthetist inserts a needle into the lower part of the back and uses it to place an epidural catheter (a very thin tube) near the nerves in the spine. The epidural catheter is left in place when the needle is taken out so a mother can be given painkillers during labour. The painkillers may be a local anaesthetic to numb the nerves, small doses of opioids (strong painkiller), or a mixture of both.

An epidural can usually be topped up to provide pain relief for the duration of labour or for any intervention that might be recommended such as an instrumental birth or a caesarean birth.

Further information from: [OAA - pain relief for labour and birth](#)

At 23:58 hours Samantha was having some periods of uterine contractions occurring at a rate of 5:10 and this was being closely observed; the CTG was categorised as normal. The epidural was not yet effective and Samantha continued to use the gas and air. At 00:03 hours all Samanthas observations remained within the normal ranges.

Uterine contractions were observed to be 4:10 at 00:25 hours and at 00:27 hours it was documented that her uterine contractions appeared to be getting closer together at a rate of 5:10. At 00:42 hours staff recognised 'reduced variability' of Arlo's heart rate on the CTG and this was being observed.

The anaesthetist was asked to re-attend at 00:46 hours as Samantha's epidural was not effective; a decision was made for this to be re-sited at 00:56 hours.

At 00:58 hours uterine contractions were closely observed and were occurring at a rate of 5:10. It was documented that the obstetric team were aware.

At 01:14 hours Samantha was sat up and prepared for her epidural to be re-sited. James recalls that it seemed to take a long time and that Samantha was very sleepy and finding it difficult to sit still with her pain. Whilst Samantha had been sitting for the procedure, staff were unable to locate Arlo's heartbeat and the contact with the CTG was lost.

The re-siting of the epidural could not be achieved and the procedure was abandoned after 20 minutes. The CTG contact was established from 01:32 hours.

At 01:37 hours Samantha was given a second dose of diamorphine 10mg, as an injection into her muscle for pain relief. Following this a vaginal examination was done to check her progress in labour at 02:00 hours; Samatha's cervix was 9cm dilated.

At 02:02 hours the CTG was categorised as normal and it was documented that Samantha was having some urges to push with some contractions. Uterine contractions were occurring 4 to 5:10 and further escalation was made to the obstetric team.

An obstetric face to face review occurred at 02:23 hours and they categorised the CTG as 'normal'. It was understood by the staff that there were variable decelerations that did not have any concerning characteristics. Blood stained liquor was seen and Samantha was now getting urges to push. The investigation learned it was understood Samantha's cervix was almost fully dilated with only a 'rim' of her cervix remaining. It was considered that it was likely that labour was progressing rapidly and that terbutaline was not required as uterine contractions were documented to be occurring at a rate of 4 to 5 in a 10 minute period and there were no concerns. Samantha continued to use the gas and air and she was able to rest in between. She continued to have some involuntary pushing urges with some of her contractions.

The CTG was categorised as normal at 02:30 hours and 02:59 hours.

The investigation learned that there was some discussion in the room about "late decelerations". The CTG was described as 'variable decelerations noted, now deeper'. At 03:04 hours Arlo's head was visible and staff considered that the birth was imminent and escalation was not required. The CTG was visible from outside the room on the central monitoring system.

Central monitoring system

A system to allow remote viewing of one or more cardiotocographs (CTGs) by clinicians outside the birth room. (MNSI)

A senior staff member had entered the handover room, where the CTG was displayed, and they recognised that the baseline was not maintained and there were late decelerations.

They attended the birth room immediately at 03:08 hours and upon entry they were informed that the Arlo's head was advancing. Following the next uterine contraction at 03:09 hours there was some advancement of Arlo's head seen, prior to a deep deceleration of his heart rate to

85bpm. Samantha was encouraged to push and the senior staff member left the room to gain obstetric assistance.

Escalation was made to the obstetric team and shift leader at 03:10 hours. The shift leader went to obtain some local anaesthetic from a locked cupboard and followed the team back into the room to provide additional support. A review of the CTG by the obstetric team at 03:11 hours indicated that there was a rising baseline and that the variable decelerations with concerning features, which had been occurring for 20 minutes. The CTG was categorised as pathological.

Pathological CTG

If a CTG is categorised as pathological this requires prompt senior review and action to further assess fetal wellbeing and consider if a baby should be born sooner. (MNSI)

Samatha was assisted into a lithotomy position (when a mother's legs are elevated and supported in rests) and verbal consent was obtained for an assisted vaginal birth (a birth with ventouse or forceps). Arlo's head was almost crowning and was noted to be very tight against Samantha's perineum; attempts were made to administer the local anaesthetic from 03:16 hours until 03:23 hours. An episiotomy (a cut made at the end of labour to widen the vaginal opening) was performed at 03:26 hours and Arlo's head was spontaneously born. The birth of Arlo occurred following the next uterine contraction at 03:28 hours.

3.3 Care of Arlo after birth

Arlo, who weighed 3,570g on the 27th customised centile, required resuscitation following his birth. His heart rate was below 60bpm and he was not breathing. The umbilical cord was clamped and cut immediately and his were transferred to the resuscitaire and resuscitation was started.

Paired umbilical cord (where samples of blood are taken from the venous and arterial vessels in an umbilical cord) blood gas samples were obtained and were recorded to be:

arterial: pH 7.03, base excess -9.0mmol/l

venous: pH 7.28, base excess -5.0mmol/l.

Umbilical cord blood testing

The umbilical cord usually contains three blood vessels. One large vein carries oxygenated blood to the unborn baby. Two smaller arteries carry deoxygenated blood from the unborn baby.

The two most commonly reviewed indicators of a baby's wellbeing that are measured in the cord blood are the pH and the base excess (BE). These indicators are significant because they can be associated with an increased risk of brain injury due to lack of oxygen (hypoxic ischaemic encephalopathy, or HIE).

A cord pH less than 7.0; or cord BE less than -16mmol/L , may be associated with HIE.

Because of this it may be necessary to cool a baby. Some babies may be born in poor condition despite the cord gas results outside the description above. They may also need cooling. (MNSI)

*BE is expressed as a negative number, numbers less than -16mmol/L (such as -20mmol/L) are smaller numbers. A BE of -20mmol/L suggests a more significant disruption of a baby's acid/base balance than a BE of -16mmol/L .

An emergency call was made for the neonatal team to attend. Inflation breaths were given successfully on the first attempt and the neonatal team arrived during the third cycle of ventilation breaths when Arlo was 2 to 3 minutes of age.

Inflation and ventilation breaths

If a baby is not breathing by themselves following birth, they may require inflation breaths to help fill their lungs with air and expel the fluid that is within the lungs in the womb. These are given using emergency breathing equipment designed for newborn babies on a resuscitaire or carried by the midwife at a homebirth. Once the lungs have been adequately inflated, if a baby still needs support with breathing the same equipment is used to provide shorter, more frequent ventilation breaths to a baby. (MNSI)

Arlo's heart rate improved and was within the normal range. Their colour was dusky and intermittent breathing effort was noted. Arlo's airway was taken over by the neonatal staff and the oxygen was increased to 60% prior to their colour rapidly improving. Oxygen saturation monitoring increased from 40% to 90% over the first 5 to 6 minutes.

Oxygen saturation

Oxygen saturation is measured by placing a special probe on the hand or foot of a baby. This is an indicator of the amount of oxygen flowing through a baby's blood vessels. (MNSI)

Respirations were more regular from 7 minutes of age and Arlo was assessed as having 'increased work of breathing'. Due to ongoing moderate chest recession, a decision was made to transfer Arlo to the neonatal unit for high flow oxygen and respiratory support.

A septic screen and further blood gas was performed and it was noted that the Arlo's tone was below the normal range and they had no gag reflex.

Septic screen

A septic screen is a standard screening process to detect the presence of an infection involving blood cultures, swabs and a urine sample. (MNSI)

Following discussions with the consultant and regional transport team, a decision was made that Arlo met both criteria A and B for therapeutic cooling.

Cerebral function monitoring was started and this appeared normal. Although there was some improvement, a repeat neurological examination remained abnormal. A decision was made for active cooling and this started at 05:47 hours. Samantha and James recall that during this time they had not heard how Arlo was doing and this added to their distress. The target temperature was reached at 08:30 hours, when Arlo was around 5 hours of age. Therapeutic cooling continued at the regional intensive care unit for 72 hours before Arlo was rewarmed.

A cranial ultrasound (a scan of the brain) was normal and magnetic resonance imaging (MRI) at 8 days of age showed no evidence of any brain injury.

The smell of the liquor was noted at birth to be 'offensive' and the placenta was sent for histological examination. This reported an inflammatory response 'with features of acute funisitis and chorioamnionitis'. These changes being likely to be seen in association with infection of the membranes.

Funisitis

Inflammation in the umbilical cord, involving the external surface of the cord and the Wharton's jelly (a jelly like substance within the cord which supports and protects the internal blood vessels). (MNSI)

4. Investigation analysis and findings

This section describes the investigation's findings in relation to Samantha's and Arlo's care. It focuses on the context and factors that influenced their care and the decisions and actions of clinicians at the time. The investigation found areas where there are opportunities for improvement. Findings are discussed under the following headings:

- Personalised birth planning in the antenatal period.
- Cardiotocography and the process for a fresh eye review and categorisation.
- The timing and preparation for Arlo's birth

There was no evidence that ethnicity or health inequalities directly impacted on the care or outcome during Samantha and Arlo's care. While this had no impact during this episode of care, MNSI is committed to working with other system partners to understand and further reduce the factors behind health inequalities faced by mothers, babies and families from Black, Asian or minority ethnic backgrounds.

4.1 Personalised birth planning in the antenatal period.

Samantha had expected, following referral at 29+3 weeks, to have a meeting with a consultant midwife about her birth choice options. This did not occur as she did not meet the referral criteria as she did not have complex needs and she was not 'birthing outside of guidance'. Following the rejection of the referral there was no closed loop communication and Samantha was unaware. This meant that the service did not meet Samantha's expectations, she felt like she had been let down and unable to make an informed choice.

Referrals are made electronically and the reason for the referral is selected from a drop down box. Anxiety around birth is one of the options and was described to the investigation as being common. The investigation learned that there were 23 referrals for birth option discussions with a consultant midwife during the month of Samantha's referral. All referrals are added to a local spreadsheet and prioritised according to the greatest need. Samantha's referral was not prioritised as it was understood that the community midwifery team would be in an ideal position to give her the "low level" support required. Community staff having opportunities at each appointment to support and address any questions or concerns.

Due to workload and staff availability the usual communication was not relayed back to the referrer to inform them of the outcome.

Usually, an electronic note would be made and this would be passed back to the referring midwife. Due to workload and a period of staff leave this did not occur. This meant that Samatha was not updated or given any explanation.

The investigation learned that due to staff availability, Samantha did not have continuity of carer during her pregnancy and was seen by various members of the community midwifery team. This meant that she did not develop any close relationships and she had repeatedly mentioned to different staff that she had not yet received an appointment from the birth choice clinic. There was no evidence that further attempts were made to ensure that the referral had been received or acted upon. This meant that there was no flag or reminder to enable the opportunity for suggestions of other options to be explored.

Usually, appointments to attend the birth choices clinic would be made for around 36 weeks. When Samantha had a routine 'birth chat' with a member of the community midwifery team at 36+3 weeks it was documented that Samantha wanted waterbirth. Samantha informed the investigation that the option of a waterbirth was not fully explored and she did not ask all of her questions at the time as she was hoping to have this conversation at her birth choices appointment. There was no evidence that staff had recognised that she did not meet the criteria and that she required routine midwifery birth planning discussions.

The investigation learned that when initially set up the criteria for referral to the birth choice service was left quite broad to identify the needs of the local population. The criteria is currently under development and over the last year a number of workstreams have been identified and delegation of some aspects of the role are underway for staff to help prepare and support mothers; 22 new birth trauma advocates have recently been appointed to assist with this service.

The investigation learned that there are two birthing pools available on the obstetric consultant led unit and equipment is available to monitor a baby wirelessly. When Samantha attended in labour, she was not supported to use the birthing pool in line with her intended birth plans. It is unknown why Samantha's request for a waterbirth was not enabled following her admission in spontaneous labour.

MNSI safety prompt.

The Mother was referred to the birth choices clinic, this referral was not accepted as she did not meet the criteria and this meant that the Mother did not have an opportunity to fully discuss her birth options as expected.

- What guidance is available to staff to understand the criteria for mothers attending the birth choices clinic? Do staff understand the current pathways?
- What is the process for closing the communication loop following a referral to ensure a mother has been updated about the outcome?
- How are mothers supported to discuss birth options when they do not meet the criteria for the birth choices clinic?

4.2 Cardiotocography (CTG)

4.2.1 Criteria for using cardiotocography (CTG)

There is evidence that a CTG was started when it did not align with Samatha's risk factors. There is no guidance locally (Trust, 2024) or nationally (NICE, 2022) that indicates that a CTG is required for a mother based upon a raised body mass index with no other risk factors. The staff were aware that a CTG had been performed on the triage unit and this was then continued following her transfer. Samantha does not recall this being discussed.

The investigation acknowledges that risk factors did develop during labour that did then warrant the use of a CTG.

MNSI safety prompt.

A cardiotocograph was started due to the Mother having a raised body mass index.

- How are staff supported to understand which risk factors meet the criteria for continuous CTG?
- How are staff supported to document informed decision making conversations with a mother about the options available for monitoring the well-being of a baby during labour?

4.2.2 Loss of contact on the cardiotocograph and re-siting of the epidural

There is evidence from the investigation that during the attempt to re-site Samantha's epidural contact with Arlo's heart rate on the CTG could not be maintained, this meant his wellbeing could not be assured for 20 minutes.

Prior to starting the procedure there had been concerns that the CTG was showing reduced variability and Samantha was having frequent uterine contractions at a rate of 5:10. The investigation learned that there had not been earlier consideration for using a fetal scalp electrode as the quality of the CTG trace was considered to be good. This meant that during the procedure the contact with Arlo's heart rate was via the abdominal transducers and the position required for the procedure then meant Arlo's heart rate was not recorded during this time. The investigation learned that staff considered that the procedure would not take long and not additional action was taken to ensure Arlo's wellbeing during this time. In line with local (Trust, 2024) and national guidance (NICE, 2022) staff should ensure that the CTG trace is of high quality and, if not, action should be taken.

MNSI safety prompt.

Staff were unable to continuously monitor the Baby's wellbeing during the attempt to re-site the Mother's epidural.

- How are staff supported to ensure that the quality of a cardiotocograph trace is continued during the insertion of epidurals; ensuring that the wellbeing of baby can be effectively monitored?
- Are there any barriers with communication during siting of epidural when monitoring of fetal heart rate cannot be obtained?

The attempt to re-insert Samantha's epidural was not successful and a further dose of diamorphine was given. The Father recalls that he was concerned about this as the previous dose had made Samanth very sleepy and "out of it". The investigation considers that there was opportunity for a vaginal examination to be done prior to this to check Samantha's progress in labour as this can have an impact upon the fetal heart variability and the condition of a baby at birth. The investigation learned that there is no guidance to support staff to undertake a vaginal examination prior to the administration of diamorphine and the last vaginal examination had

only been completed 2.5 hours earlier. Arlo was born 1 hour and 42 minutes later after the diamorphine being given.

MNSI safety prompt.

A vaginal examination, to assess progress in labour, was not performed prior to a second dose of diamorphine being given.

- How are staff supported to assess labour progress prior to giving diamorphine?
- How does local guidance inform decision making about pain relief options in established labour?

4.2.3 Process for a fresh eye CTG review and categorisation.

There is evidence from the investigation that the process for reviewing and categorising the CTG was not performed in line with local and national guidance (NICE, 2022). It had not been recognised that there were CTG concerns that required earlier escalation when signs of an evolving hypoxia became evident. This meant that there was a delay in the decision to expedite the birth.

There is evidence from the investigation that there was evidence of a developing fetal hypoxia as demonstrated on the CTG with opportunities for earlier escalation. CTG reviews were not always completed hourly (see Appendix 2). There was no evidence of any CTG review between 00:27 hours and 02:02 hours. On some occasions when a CTG review had been undertaken it was not followed by a fresh eyes hourly peer review. There was evidence in the notes that the staff were waiting for an additional staff member to attend. Barriers to this were explored and acuity in the unit and workload of staff being suggested as a cause. The investigation learned that there was one midwife less than the usual staffing establishment working on the delivery unit overnight. There was no evidence that escalation had occurred when a peer review had not been possible to obtain.

The CTG should ideally be reviewed by a senior midwife every other hour to enable a holistic helicopter view to be maintained; this last occurred at 22:12 hours. Fresh eye reviews, on some occasion being done by a junior member of the team. This meant that there was no senior oversight of changes in the fetal heart rate pattern. This led to a delay in recognition of any CTG concerns.

Staff had recognised that Samantha was having an increased frequency of uterine contractions of 4 to 5:10 and they continued to observe. At the time of performing each electronic CTG

review staff had never entered, that her uterine contractions were at a rate more than 4:10. This meant that in the absence of other concerns, the CTG would meet the 'green' criteria and be categorised as normal. If a uterine contraction rate of 5:10 or 6:10 is entered the CTG categorisation tool this would meet the 'amber criteria' and result in a suspicious CTG interpretation. This requiring an earlier senior midwifery or obstetric review.

There was evidence from the investigation that Samatha's uterine contractions remained at a rate of 5:10 from 23:58 hours and they increased to a rate of 6:10 from around 02:30 hours. Staff had not recognised that uterine contractions were occurring at a rate of more than 5:10. This meant that the incorrect number of contractions was entered into the electronic CTG review tool. This led to the CTG being categorised as normal.

The unit was busy and by the time that an obstetric review occurred at 02:23 hours. It was not recognised at this time that Samantha was contracting at a rate of 6:10. Staff had understood and were reassured that the uterine contractions had by now reduced, without entering the number of contractions into the CTG review tool the CTG was categorised as 'normal' and it was considered that no additional treatment or intervention was needed. It is unknown why the correct rate of uterine contractions was not recognised and documented inaccurately.

The investigation learned that there was a discussion, when the CTG was reviewed at 02:59 hours and the decelerations were suggested to be "late". Some staff at this time considered that escalation was not required as Arlo's head was now visible. Staff were expecting Arlo to be born and birth was considered imminent.

The investigation learned that the unit became increasingly busy and there were no support staff on the shift, due to last minute absence. There were six other mothers awaiting to be transferred to the delivery suite for induction of labour. Some had been waiting for over 24 hours. When a room became available the senior midwifery staff, who were available as they were not providing one to one care, were busy cleaning and preparing a delivery room for another mother who was awaiting transfer. This impacted on the oversight and awareness of the evolving changes and no escalation from inside the room had been made for them to attend.

Following completion of their task and on return to the handover room was the CTG recognised as being pathological from a review of the central monitoring system. From outside the room, it was recognised that there was an increased fetal heart rate baseline, reduced variability, decelerations were late and slow to recover.

After attending the birthing room, to assess the situation, urgent escalation was made which resulted in a plan to expedite the birth.

The investigation considers that the CTG was suspicious at around 02:24 hours and pathological from around 03:00 hours when the decelerations had changed to have concerning characteristics.

There is evidence from the investigation that decelerative changes on the CTG were initially more subtle. This meant that the concerns were less recognisable to the staff and the CTG had been categorised as normal until it was recognised as being pathological at 03:08 hours.

MNSI safety recommendation.

It is recommended that the Trust ensures that staff are supported to undertake regular CTG assessments including fresh eyes fresh reviews in line with local and national guidelines (Saving Babies' Lives care bundle v3 (2023) and that this is not impeded by workload demands so that time-critical escalation takes place when needed.

MNSI safety recommendation.

It is recommended that the Trust support staff to assess and accurately document the rate of contractions during CTG reviews to enable accurate CTG categorisation and to inform decision making.

MNSI safety recommendation.

It is recommended that the Trust support staff to escalate CTG concerns in the second stage of labour even when birth is considered to be near, to support multidisciplinary oversight and input into care.

4.3. Preparation and timing for Arlo's birth

Arlo was born 18 minutes after the obstetric team attended. The investigation was informed that the situation felt "frantic", with some passage of time after a decision was made for an assisted vaginal birth whilst there were difficulties in injecting the local anaesthetic as Samantha's perineum was very tight around Arlo's head. During this time the CTG was

pathological and there was no request made for the neonatal team to attend for Arlo's birth. This meant that his initial resuscitation was started by the midwifery team.

The investigation learned that the usual practice and expectation would be to inform the neonatal team when there is a pathological CTG and a decision has been made to expedite a birth. The investigation learned that at the time of Arlo's birth the staff were focussed on his birth and the tasks required to achieve this. This meant there was no contact with the neonatal team until after his birth, when it was realised that their support was required.

The local guidance (Trust, 2023) supports staff to escalate a pathological CTG to the neonatal team as part of their preparation for an urgent birth when there is a prolonged deceleration or a bradycardia. The investigation learned that the neonatal team would have expected and appreciated a timelier escalation.

The umbilical cord blood gas results demonstrated that Arlo's condition at birth could be attributed to an acute (recent) event. Evidence from the placental histology indicate evidence of infection (chorioamnionitis and funisitis). Although there was no indication or way of knowing about any infection until after the birth, it is known that the presence of infection during labour can impact on a baby's developing hypoxia more quickly than when infection is not a factor.

MNSI safety recommendation.

It is recommended that the Trust support staff to ask the neonatal team to attend a birth when a cardiotocograph is pathological and a decision has been made to expedite birth, to support resuscitation of a baby.

Appendices

Appendix 1: Additional information about the MNSI programme

Appendix 2 CTG categorisations during labour

Appendix 3: Algorithm for neonatal resuscitation

Appendix 4: Arlo's Apgar scores following birth

Appendix 5: References

Appendix 1: Additional information about the Maternity and Newborn Safety Investigation programme (MNSI)

MNSI investigates in line with the criteria outlined in the Care Quality Commission (Maternity and Newborn Safety Investigation Programme) Directions (2023). Eligible babies include all term babies (at least 37+0 weeks of gestation) born following labour, who have one of the following outcomes –

(a) **Intrapartum stillbirth:** when a baby was thought to be alive at the start of labour and was born with no signs of life,

(b) **Early neonatal death:** when a baby died within the first week of life (i.e. days 0–6) of any cause.

(c) **Severe brain injury:** diagnosed as occurring in the first 7 days of life, when the baby—

(i) was therapeutically cooled (active cooling only), or

(ii) has been diagnosed with moderate to severe encephalopathy, consisting of altered state of consciousness (lethargy, stupor or coma) and at least one of the following:

- low tone (hypotonia)
- abnormal reflexes including oculomotor or pupillary abnormalities
- absent or weak suck
- clinical seizures.

The defined criteria for maternal death investigations are:

Maternal death: death of a mother while pregnant or within 42 days of the end of the pregnancy*, from any cause related to or aggravated by the pregnancy or its management, and not from accidental or incidental causes.

Direct: deaths resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above. This excludes cases of suicide.

Indirect: deaths from previous existing disease or disease that developed during pregnancy and which was not the result of direct obstetric causes, and which was aggravated by the physiological effects of pregnancy in the perinatal period (during or within 42 days of the end of pregnancy).

*Includes giving birth, treatment of an ectopic pregnancy, miscarriage or termination of pregnancy

Further information about the MNSI programme's approach to gathering information

Review of information

After consent is obtained from the family to access the relevant clinical records, these are uploaded by the healthcare organisations and MNSI starts the investigation.

Records that can be used include, (and are not limited to), hospital records, GP records, ambulance service records and transcripts, and relevant trust guidelines and procedures. Information reviewed may also include an assessment of tools used to monitor staffing levels (acuity), and staff working patterns.

Investigators may undertake a walk-through of a mother's, pregnant person's or birthing parent's and baby's journey within the maternity service and observe the clinical environment.

Family interviews

Interviews and telephone conversations are held with the family to listen to their recollection of events and any concerns they may have. Families' involvement in the investigation process is central to an MNSI investigation.

Specialist review panels

Advisors with a specialist knowledge provided advice and guidance during the investigation process: signposting to evidence, including national guidance and expected practice. They assisted in formulating the investigation's terms of reference and key lines of enquiry.

Staff interviews

Face to face or video interviews are held with staff involved in a mother's, pregnant person's or birthing parent's or baby's care to understand what influenced their decision making and the care provided. Interviews may also be held with other staff members who can provide further information to support the investigation.

Communication during investigations

Throughout the investigation process, the investigator provides regular updates with families and healthcare organisations. If a safety concern that needs immediate action is identified, this is escalated to the healthcare organisation during the investigation. This helps ensure that there is an opportunity for a healthcare organisation to address safety issues in a timely manner.

Post-mortem examination

In cases which have been referred to His Majesty's Coroner and a post-mortem examination (PME) has been completed, the MNSI report will reflect the cause of death as stated in the PME. In cases where an inquest is planned to take place, the cause of death will not be confirmed until the inquest is concluded. On occasion the wording in relation to the cause of death may be changed or added to as part of the inquest process, this may occur after the MNSI report has been completed.

His Majesty's Coroner information

MNSI acknowledges it is possible that there is other information, available to the family or His Majesty's Coroner, which could have been relevant to the information MNSI considered during this investigation. For clarity, our final report was produced by accessing and reviewing all evidence that was available to us at the time of the investigation. Our recommendations were made on that basis and all evidence used for this investigation is listed within our report. If our findings differ to those from later investigations, such as by HM Coroner, the reasons for this may be due to the different evidence available to different investigations.

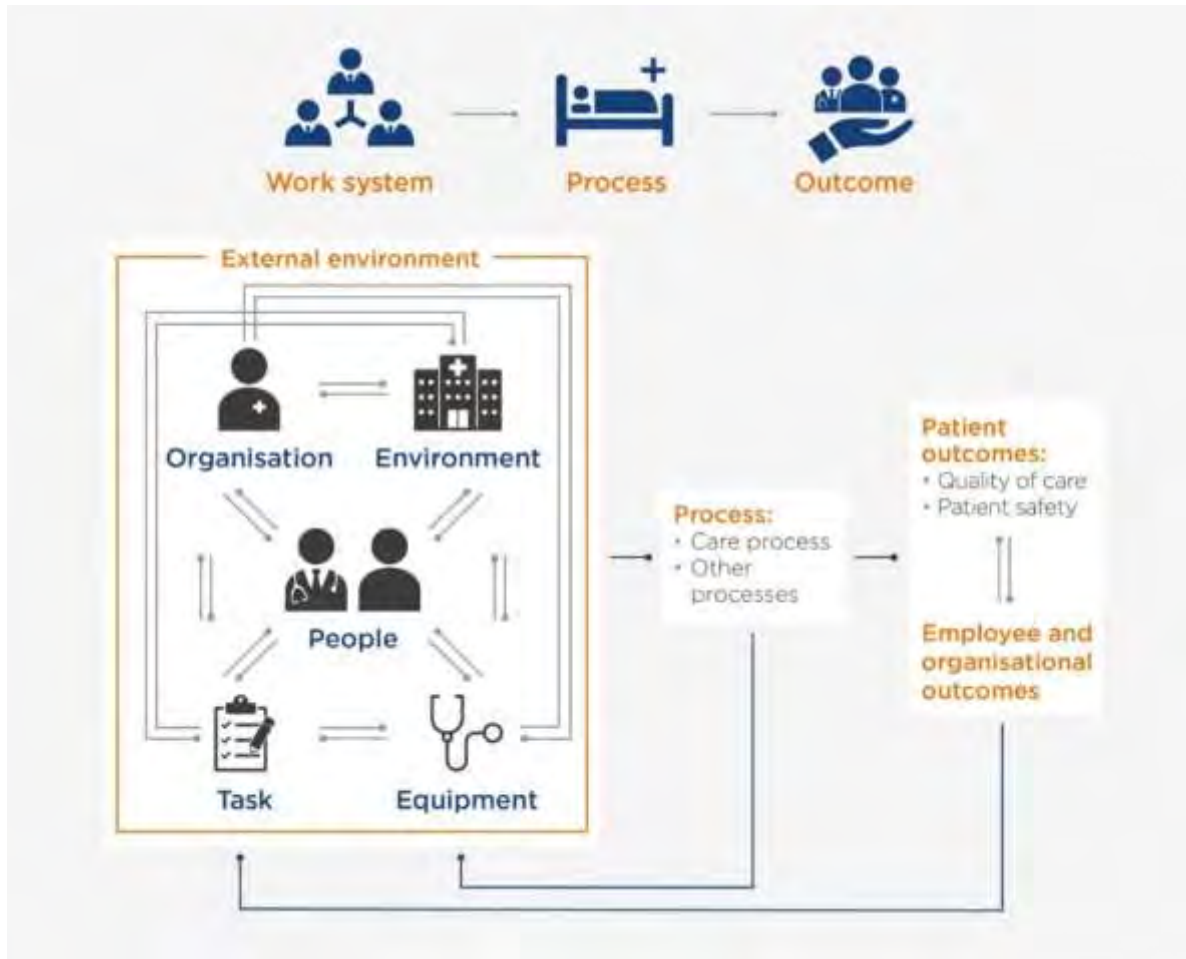
Analysis

The investigator can access a range of resources to help understand what contributed to care.

MNSI promotes use of the Systems Engineering Initiative for Patient Safety (SEIPS) model (Carayon, 2006; Holden et al, 2013) as one way to help understand why incidents occur. The investigators consider the relationships and interactions between people, tasks, technology and tools, the environment, organisational factors, and national policies and professional guidance, that contribute to how incidents occur.

Once analysis is complete MNSI may develop safety recommendations, safety prompts and findings. This is aimed at supporting the immediate and sustainable improvement of care and service provision locally and across the wider NHS.

Image 1. Systems Engineering Initiative for Patient Safety (SEIPS) model (Carayon, 2006; Holden et al, 2013)



Appendix 2 - CTG categorisations during labour

Table 2. CTG categorisations

Time of CTG review (hours)	Time of fresh eye CTG review (hours)	Frequency of uterine contractions documented	Categorisation of the CTG
19:57		3:10	Normal
20:29	20:41	3:10	Normal
21:01		4:10	Normal
21:29		4:10	Normal
22:00	22:04 and 22:12	3:10	Normal
22:32	22:57	3:10	Normal
23:00	23:04	4:10	Normal
23:30		3:10	Normal
00:25	00:27	4:10	Normal
02:02	02:23	4:10	Normal
02:30		4:10	Normal
02:59		4:10	Normal
03:11			Pathological

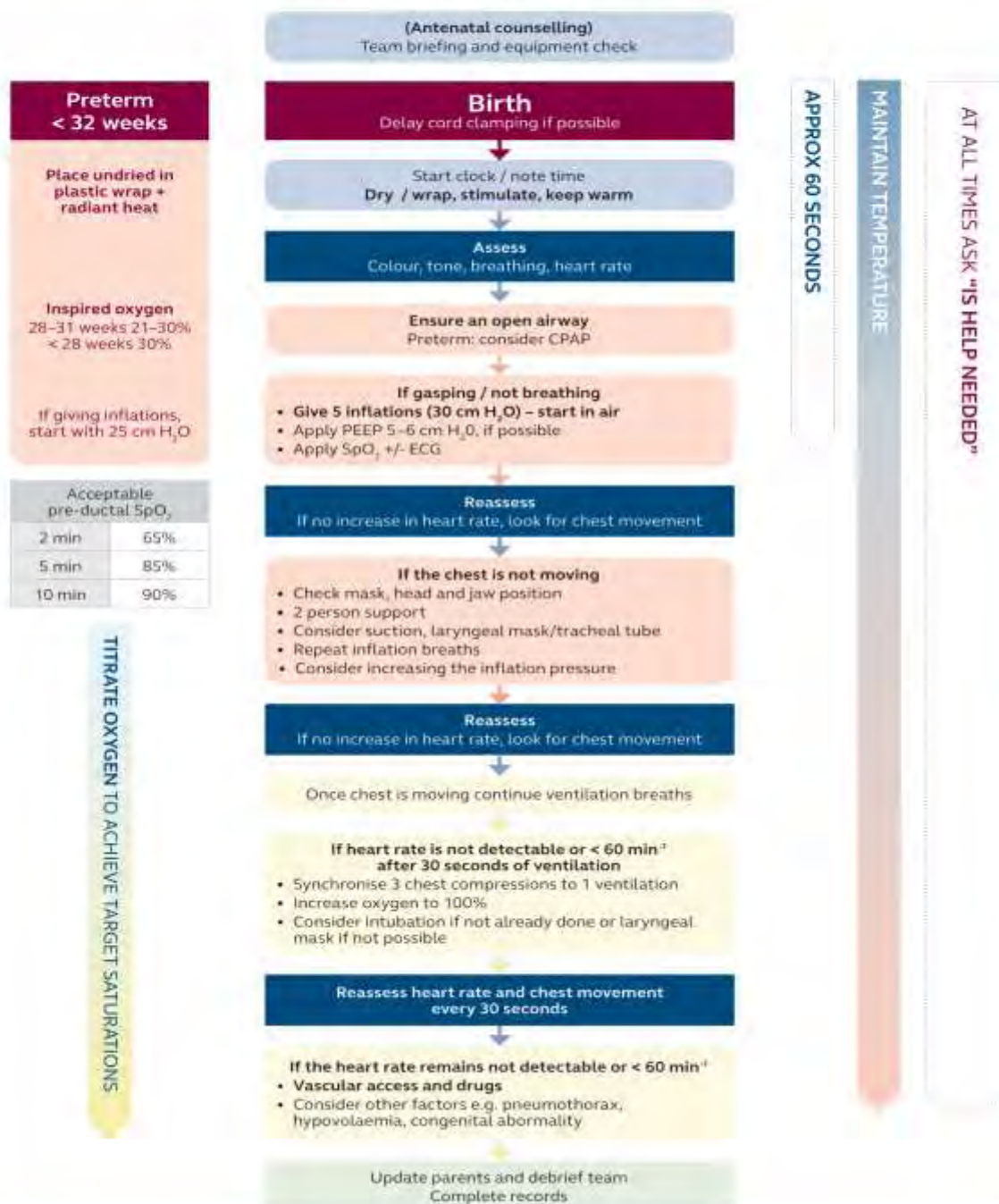
Appendix 3: Algorithm for neonatal resuscitation



Resuscitation
Council UK

GUIDELINES
✓ 2021

Newborn life support



Appendix 3

Table 2. Arlo's Apgar scores at birth

Time since birth	Heart rate	Colour	Tone	Reflex	Respiratory effort	Score/10
1 minute	1	0	0	0	0	1
5 minutes	2	1	1	1	1	6
10 minutes	2	2	1	1	1	7

Appendix 4: Reference list

British Association of Perinatal Medicine. (2020) Therapeutic hypothermia for neonatal encephalopathy - a framework for practice [Online]. Available at

<https://www.bapm.org/resources/237-therapeutic-hypothermia-for-neonatal-encephalopathy> (Accessed 02 October 2024).

Carayon, P., Schoofs Hundt, A., Karsh, B. T., Gurses, A. P., Alvarado, C. J., Smith, M., and Flatley Brennan, P. (2006) Work system design for patient safety: the SEIPS model. *Quality & Safety in Health Care*, 15 Suppl 1(Suppl 1), i50–i58.

Draper, E. S., Gallimore, I. D., Smith, L. K., Matthews, R. J., Fenton, A. C., Kurinczuk, J. J., Smith, P. W and Manktelow, B. N. on behalf of the MBRRACE-UK Collaboration. (2022b) MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2020. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester [Online]. Available at https://www.npeu.ox.ac.uk/assets/downloads/mbrpace-uk/reports/perinatal-surveillance-report-2020/MBRRACE-UK_Perinatal_Surveillance_Report_2020.pdf (Accessed 02 October 2024).

Edwards, P. (2022) Safety-netting in the consultation. *British Medical Journal*. 378:e069094. Available at: <https://www.bmj.com/content/378/bmj-2021-069094.full>. Accessed 15 January 2025

Evans, C., Goodings, L., Hargitai, B., Heazell, A., Jessop, F., Marton, T., Miller, N., Murphy, A. and Turner, K. (2022) Tissue pathway for histopathological examination of the placenta. The Royal College of Pathologists [Online]. Available at <https://www.rcpath.org/uploads/assets/ec614dfa-007c-4a93-8173cb202a071a72/a8b51280-edf3-4414-9197ab58d641bafd/G108-Tissue-pathway-for-histopathological-examination-of-the-placenta.pdf> (Accessed 02 October 2024).

Fawke, J., Wyllie, J., Madar, J., Ainsworth, S., Tinnon, R., Chittick, R., Wenlock, N., Cusack, J., Monnelly, V., Lockey, A. and Hampshire, S. (2021) Newborn resuscitation and support of transition of babies at birth. Resuscitation Council UK [Online]. Available at <https://www.resus.org.uk/library/2015-resuscitation-guidelines/resuscitation-and-support-transition-babies-birth> (Accessed 27 March 2025).

Holden, R. J., Carayon, P., Gurses, A. P., Hoonakker, P., Hundt, A. S., Ozok, A. A. and Rivera-Rodriguez, A. J. (2013) SEIPS 2.0: A human factors framework for studying and improving the work of healthcare professionals and patients. *Ergonomics* 2013 November; 56 (11)

Kenyon, S. (2023) Maternity Triage. Royal College of Obstetricians & Gynaecologists. Good Practice Paper No. 17. Available at: <https://www.rcog.org.uk/media/p13lrr3n/gpp17-final-publication-proof.pdf>. (Accessed 15 January 2025)

Knight, M., Bunch, K., Patel, R., Shakespeare, J., Kotnis, R., Kenyon, S. and Kurinczuk, J. J. (Eds.) on behalf of MBRRACE-UK. (2022a) Saving Lives, Improving Mothers' Care Core Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20. Oxford: National Perinatal Epidemiology Unit, University of Oxford [Online]. Available at https://www.npeu.ox.ac.uk/assets/downloads/mbrpace-uk/reports/maternal-report-2022/MBRRACE-UK_Maternal_MAIN_Report_2022_UPDATE.pdf (Accessed 02 October 2024).

Liberati EG, Tarrant C, Willars J, et al (2020). *British Medical Journal MJ Qual Saf* Epub:10.1136/ bmjqs-2020-010988 Available from : <https://qualitysafety.bmj.com/content/qhc/early/2020/09/25/bmjqs-2020-010988.full.pdf> (Accessed 14 January 2025)

National Institute for Health and Care Excellence. (2021) Antenatal care for uncomplicated pregnancies. Clinical guideline [NG201] [Online]. Available at <https://www.nice.org.uk/guidance/ng201>

National Institute for Health and Care Excellence. (2021) Inducing labour. NICE guideline [NG207] [Online]. Available at <https://www.nice.org.uk/guidance/NG207> (Accessed 02 October 2024).

National Institute for Health and Care Excellence. (2022) Fetal monitoring in labour NICE guideline [NG229] [Online]. Available at <https://www.nice.org.uk/guidance/NG229> (Accessed 02 October 2024).

National Institute for Health and Care Excellence. (2023a) Hypertension in pregnancy: diagnosis and management. NICE guideline [NG133]. [Online]. Available at <https://www.nice.org.uk/guidance/ng133> (Accessed 15 January 2025)

National Institute for Health and Care Excellence. (2023b) Intrapartum care for healthy women and babies. Clinical guideline [CG190] [Online]. Available at [Intrapartum care \(nice.org.uk\)](https://www.nice.org.uk/guidance/CG190) (Accessed 02 October 2024).

National Institute for Health and Clinical Excellence. (2024) Caesarean birth. NICE guideline. [NG192] [Online]. Available at <https://www.nice.org.uk/guidance/ng192>

NHS Digital (2022). Ethnicity [Online]. Available at <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/submit-data/data-quality-of-protected-characteristics-and-other-vulnerable-groups/ethnicity> (Accessed 02 October 2024).

NHS England (2021) Personalised care and support planning guidance. Guidance for local maternity systems. Available at <https://www.england.nhs.uk/wp-content/uploads/2021/03/B0423-personalised-care-and-support-planning-guidance-for-lms.pdf> (Accessed 21 March 2025).

NHS England. (2023) Saving Babies' Lives Version three. A care bundle for reducing perinatal mortality [Online]. Available at <https://www.england.nhs.uk/publication/saving-babies-lives-version-three/> (Accessed 21 March 2025). Office for Health Improvement and Disparities (2022). Health disparities and health inequalities: applying All Our Health [Online]. Available at <https://www.gov.uk/government/publications/health-disparities-and-health-inequalities-applying-all-our-health/health-disparities-and-health-inequalities-applying-all-our-health> (Accessed 02 October 2024).

Race Disparity Unit on behalf of the Cabinet Office (2021). Writing about ethnicity [Online]. Available at <https://www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity#ethnic-minorities-and-ethnic-groups> (Accessed 02 October 2024).

The Care Quality Commission. (2023). Maternity and Newborn Safety Investigation Programme Directions. [Online]. Available at: [The Care Quality Commission \(Maternity and Newborn Safety Investigation Programme\) Directions 2023 \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1184447/The_Care_Quality_Commission_Maternity_and_Newborn_Safety_Investigation_Programme_Directions_2023.pdf). (Accessed 02 October 2024).

Trust (2022) Out of guidance v1.1

Trust (2023) Fetal monitoring in labour

Trust (2024) induction of labour V7

Recurring red flags: a retrospective study of MBRRACE-UK Perinatal Mortality Surveillance (2015–21) to identify maternity services most consistently reporting higher-than-average deaths

P McDonagh Hull^{1,*} , T Boulton² and B Lashewicz²

¹Department of Community Health Sciences, Cumming School of Medicine, University of Calgary, Calgary, Alberta T2N 4Z6, Canada

²Community Rehabilitation and Disability Studies, Department of Community Health Sciences, Cumming School of Medicine, University of Calgary, Calgary, Alberta T2N 4Z6, Canada

*Address correspondence to P McDonagh Hull, E-mail pauline.hull@ucalgary.ca.

ABSTRACT

Background: This study aimed to identify hospital trusts in England most consistently reporting higher-than-average rates of extended perinatal mortality (EPM), including stillbirths and neonatal deaths.

Methods: We conducted a retrospective study of MBRRACE-UK Perinatal Mortality Surveillance Reports (2015–21) comparing EPM rates for births occurring in 124 hospital trusts in England between 2013 and 2019. Utilizing MBRRACE-UK definitions and designations, including coloured bands (red and amber indicate higher death rates), we devised a scoring method to determine which trusts most consistently reported higher-than-average rates of EPM throughout seven years.

Results: We identified 23 (18.5% of 124) ‘red flag’ trusts most consistently falling into MBRRACE-UK red and amber bands. They included Shrewsbury and Telford Hospitals NHS Trust (SaTH) and East Kent Hospitals University Trust, both under investigation during the parliamentary Health and Social Care Committee’s inquiry into the safety of maternity services in England. Seven trusts, including SaTH, reported higher-than-average deaths in all seven years. Indications of regional patterns were evident.

Conclusions: By examining maternity services mortality data over an extended period, patterns of clinical significance may emerge. We found evidence of a minority of trusts in England consistently reporting higher-than-average rates of EPM. These red flags may warrant further attention.

Keywords: health services; hospital trusts; MBRRACE-UK; mortality; perinatal deaths; research

Introduction

In 2022, following the National Health Service (NHS)’s ‘biggest maternity scandal’,¹ the final report of the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust (SaTH), chaired by midwife Donna Ockenden, concluded that some trusts ‘are still failing to adequately address and learn lessons from serious maternity events’.² In 2021, the parliamentary Health and Social Care Committee (HSCC)’s inquiry report warned that while failings identified at three NHS hospital trusts (SaTH, University Hospitals of Morecambe Bay NHS Trust (UHMBT) and East Kent Hospitals University Trust (EKHUT)) do not represent all maternity services, ‘nor are they unique, reflecting many underlying problems’.³ Dr.

Bill Kirkup CBE, who chaired the UHMBT independent investigation,⁴ warned, ‘Two clinical organisational failures are not two one-offs: they point to an underlying systemic problem that may be latent in other units’.⁵

The first annual perinatal mortality surveillance data to specifically compare outcomes at individual trusts and health boards in the United Kingdom (UK) was published in 2015;⁶ in the same year, the government published its ambition to halve the rate of stillbirths and infant deaths in England.⁷ Produced by The Infant Mortality and Morbidity Studies

Pauline McDonagh Hull, PhD Candidate

Tiffany Boulton, Assistant Professor

Bonnie Lashewicz, Associate Professor

Group (TIMMS) at the University of Leicester, on behalf of Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK), a collaboration led by the University of Oxford National Perinatal Epidemiology Unit, the MBRRACE-UK Perinatal Mortality Surveillance Reports build on work that began in 1992, when the newly established Confidential Enquiry into Stillbirths and Deaths in Infancy set out ‘to reduce mortality by identifying suboptimal patterns of practice and service provision related to those deaths and to make recommendations for improvement’.⁸ Each report designates coloured bands to represent variation from average mortality rates, and MBRRACE-UK recommends all trusts falling into red and amber bands (the two colours representing higher-than-average deaths) conduct ‘a local review’ or ‘investigation’ of potential or contributing local factors.^{6,9–14} To date, no research has examined which trusts received this communication most frequently.

Professor Sir Bruce Keogh, who led an NHS patient safety review in 2013, advised, ‘Mortality statistics require careful interpretation, but they do provide an important smoke signal’.¹⁵ In the UK, most antenatal care and births occur in the same hospital; therefore, MBRRACE-UK suggests its data can answer important research questions about pregnancy outcomes¹⁶ and ‘at least indicate where to look first’.¹⁷ Undertaking a retrospective analysis of MBRRACE-UK’s reports, we sought to identify trusts in England that most consistently reported higher-than-average rates of extended perinatal mortality (EPM), including stillbirths and neonatal deaths, which might indicate where to look next. We hypothesized that SaTH, where infant Kate Stanton-Davies, the primary catalyst for the Ockenden review, died in March 2009,¹⁸ could emerge as reporting consistently higher EPM rates.

Material and methods

We designed a retrospective study of MBRRACE-UK Perinatal Mortality Surveillance Reports, examining annual EPM data published between 2015 and 2021.^{6,9–14} To allow fairer comparisons between similar services, MBRRACE-UK classifies each trust and health board’s level of service provision into five mutually exclusive comparator groups, based on risk profile: (i) Level 3 Neonatal Intensive Care Unit (NICU) and neonatal surgery; (ii) Level 3 NICU; (iii) 4000 or more births per annum at 22 weeks or later; (iv) 2000–3999 births per annum at 22 weeks or later; and (v) under 2000 births per annum at 22 weeks or later.⁶ Within each of the five comparators, MBRRACE-UK designates ‘traffic light’¹³ coloured bands to represent each organization’s

variation from its comparator group’s average EPM rate, with red being the worst (Table 1). From 2015 to 2018, trusts falling into the red band had mortality rates ‘more than 10% higher than average’,^{6,9–11} and from 2019 to 2021, ‘more than 5% higher than average’.^{12–14} Correspondingly, from 2015 to 2018, trusts falling into the amber band had mortality rates ‘up to 10% higher than the average’, and from 2019 to 2021, this designation changed to ‘up to 5% higher or up to 5% lower than the average’. Yellow and green bands indicate lower than average mortality rates, and in 2015 and 2016 only, a dark green band denoted rates ‘lower than the “aspirational” target’, based on ‘estimated equivalent rates in the Nordic countries’.^{6,9} We utilized the Checklist for Retrospective Database studies¹⁹ and focused on English data in response to the HSCC inquiry.²⁰ To identify those trusts consistently reporting higher-than-average EPM rates, we used MBRRACE-UK definitions and designations, including its coloured bands. We determined a 7-year score for each trust by assigning numeric values (0–5) to each MBRRACE-UK coloured band (Table 1) and summing all red (value 5) and amber (value 4) designations.

Changes in the MBRRACE-UK surveillance reports between 2015 and 2021 were incorporated into our analysis. MBRRACE-UK uses stabilization to take account of some random variation and adjustment to take account of some of the factors known to affect perinatal mortality rates in particular populations, including mother’s age, socio-economic deprivation, baby’s sex and ethnicity, multiplicity and (for neonatal deaths only) gestational age at birth. To further address this, MBRRACE-UK introduced additional tables in 2019 ‘excluding congenital anomalies’ (ECAs), one of the most common causes of all perinatal deaths.¹² The collaboration noted little effect for stillbirth (accounting for 70% of deaths each year), with only two UK trusts or health boards reported as changing colour (amber to red and red to amber). For neonatal deaths, one-third of trusts changed colour, but MBRRACE-UK noted the most significant changes occurred in only eight cases, and of these, two were negative (green to amber and yellow to red), and, of the six positives, four were in Northern Ireland. We incorporated the new ECA data by identifying trusts with consistently higher-than-average EPM rates over time: (i) 2015–21 (all 7 years); (ii) 2015–18 (4 years not ECA); and (iii) 2019–21 (3 years ECA).

MBRRACE-UK also changed the definition of its amber band in 2019 [to ‘up to 5% higher or up to 5% lower than the average’ (Table 1)], so we reviewed all amber band data for 2019–21 to identify only those trusts with higher-than-average EPM rates (value 4) for inclusion in our analysis. In another coloured band change, MBRRACE-UK removed its dark-green aspirational mortality rate target in 2017.¹⁰ Lastly,

Table 1 MBRRACE-UK 'traffic light' coloured bands representing variation from comparator group average mortality rates in its annual surveillance reports (2015–21).

MBRRACE-UK band colour	2015–16 definition	2017–18 definition	2019–21 definition	Value (for 7-year score)
Red	>10% higher than the average	>10% higher than the average	>5% higher than the average	5
Amber	Up to 10% higher than the average	Up to 10% higher than the average	Up to 5% higher or up to 5% lower than the average ^a	4
Yellow	Up to 10% lower than the average	Up to 10% lower than the average	>5% and up to 15% lower than the average	3
Green		>10% lower than the average	>15% lower than the average	2
Light green	>10% lower than the average			1
Dark green	Lower than the 'aspirational' target ^b			0

^aOnly trusts with rates up to 5% higher than the average were assigned score value 4 during analysis.

^bMBRRACE-UK noted this was based on estimated equivalent rates in the Nordic countries (Norway, Sweden, Denmark, Finland and Iceland): stillbirths 3 per 1000 total births; neonatal deaths 1.3 per 1000 live births; extended perinatal deaths 4.3 per 1000 total births.

between 2015 and 2021, some local NHS trust mergers and name changes occurred. To account for this, where a trust fell into a red- or amber-coloured band more than once in MBRRACE-UK annual reports (with premerger or former names), only one numeric value (the highest) was used to calculate its 7-year score.

Results

Between 2015 and 2021, MBRRACE-UK recorded 25 170 extended perinatal deaths in England (including 17 492 stillbirths and 7678 neonatal deaths), and in those seven years, the national EPM rate decreased from 6.09 to 4.88 per 1000 total births. A total of 23 (18.5% of 124) hospital trusts most consistently fell into MBRRACE-UK's red or amber bands (indicating higher-than-average deaths). They are ranked 1–10 in Table 2. Between 2015 and 2018 (not ECA), 19 (15% of 124) trusts most consistently reported higher-than-average deaths, and, between 2019 and 2021 (ECA), this number was 29 (23% of 124). These are ranked 1–5 in Table 3.

Seven trusts reported higher-than-average deaths in all seven years. These were Birmingham Women's and Children's NHS Foundation Trust, Liverpool Women's NHS Foundation Trust, Sandwell and West Birmingham Hospitals NHS Trust, East Lancashire Hospitals NHS Trust (ELHT), The Leeds Teaching Hospitals NHS Trust, SaTH and Wye Valley Trust. The highest 7-year scores ranged from 21 to 33. SaTH reported one of the three highest scores overall (30), falling into a red band in two MBRRACE-UK reports and an amber band in five. Other notable trusts in Table 3 include EKHUT, which was also under investigation during the HSCC inquiry²⁰ (7-year score 22, and the highest 3-year score, 2019–21),

plus 8 of 14 trusts that were investigated as part of the 2013 government-led Keogh patient safety review (including 6 that were placed in special measures)²¹ following the Francis inquiry into Mid Staffordshire Hospitals NHS Foundation Trust.²²

The 23 trusts with the highest 7-year scores are depicted on a map of England in Fig. 1, indicating regional patterns. The majority (70%) of 'red flag' trusts with the highest 7-year scores were located in the Midlands and North of England.

Discussion

Main findings of this study

In this retrospective study of MBRRACE-UK Perinatal Mortality Surveillance Reports (2015–21), 23 NHS hospital trusts in England were identified as most consistently reporting higher-than-average deaths over seven years. These included EKHUT, where infant Harry Richford died in November 2017, and whose death led to the Care Quality Commission (CQC)'s unprecedented prosecution of a trust for clinical care failings.²³ Our findings are consistent with aforementioned concerns^{2,3,5} that SaTH was 'not an isolated trust',¹⁸ as five other trusts had the same or worse 7-year score (≤ 30). There are several possible explanations for our findings. MBRRACE-UK adjusts its data for numerous determinants of health and cites placental issues, cord problems and infection as primary causes of stillbirth, but structures within each trust and external, non-patient characteristics are not accounted for. For example, staffing ratio and expertise, performance endeavours on other quality measures, and public funding may all affect capacity to deliver quality care.²⁴ Previous research also cites variations and

Table 2 'Red flag' trusts in England most consistently reporting higher-than-average deaths during MBRRACE-UK Perinatal Mortality Surveillance between 2015 and 2021 (7-year score).

Rank	Trusts in England falling into red and amber bands in years 2015–21 (3 years excluding, and 4 years including, congenital anomalies)	Years n.(●,●)	7-year score
1	Birmingham Women's and Children's NHS Foundation Trust ^a Liverpool Women's NHS Foundation Trust Sandwell and West Birmingham Hospitals NHS Trust	7 (5,2)	33
2	East Lancashire Hospitals NHS Trust ^b	7 (3,4)	31
3	The Leeds Teaching Hospitals NHS Trust The Shrewsbury and Telford Hospital NHS Trust ^c	7 (2,5)	30
4	Wye Valley NHS Trust	7 (1,6)	29
5	Bradford Teaching Hospitals NHS Foundation Trust Sheffield Teaching Hospitals NHS Foundation Trust	6 (3,3)	27
6	University Hospitals Bristol and Weston NHS Foundation Trust	6 (2,4)	26
7	Calderdale and Huddersfield NHS Foundation Trust Kettering General Hospital NHS Foundation Trust Northern Lincolnshire and Goole Hospitals NHS Foundation Trust ^b Sherwood Forest Hospitals NHS Foundation Trust ^b	6 (1,5)	25
8	The Royal Wolverhampton NHS Trust	5 (4,1)	24
9	East Kent Hospitals University NHS Foundation Trust ^c University Hospitals of Derby and Burton NHS Foundation Trust ^{a,b} University Hospitals Plymouth NHS Trust ^a	5 (2,3)	22
10	East Suffolk and North Essex NHS Foundation Trust ^{a,b} Mid and South Essex NHS Foundation Trust ^{a,b} Royal Berkshire NHS Foundation Trust Royal United Hospitals Bath NHS Foundation Trust Wirral University Teaching Hospital NHS Foundation Trust	5 (1,4)	21

^aIncludes trust name changes or mergers.^bTrust investigated as part of the government-led 2013 Keogh Review²¹ or Francis Inquiry.²²^cMaternity services at this trust are subject to criminal investigation, independent review or inquiry.

challenges in maternity services around culture, staffing, funding and professional relationships.^{25–28}

Ockenden cited concerns about caesarean birth rates at SaTH being 8–12 percentage points below England's average, with pressure to keep rates low 'because this was perceived as the essence of good maternity care'.²⁹ This may be relevant, as MBRRACE-UK's inaugural report in 2015 communicated a 'clear message' for trusts and health boards 'to seek levels of clinical performance that compare with those achieved in other parts of the developed world, particularly the Nordic countries'.⁶ That same year, the World Health Organization advised: 'Nordic countries provide positive examples of strong midwifery practice. ...Lower caesarean section rates are one important outcome; Finland, Sweden, Norway and Iceland all have rates below 18%'.³⁰ Further, in 2018, a Royal College of Obstetricians and Gynaecologists (RCOG) review of SaTH described its low caesarean birth and high vaginal birth after caesarean rates as 'strengths of the maternity services'.³¹

Yet by 2020, giving evidence to parliament, Ockenden said her report indicated 'times, occasions and cases, when had a baby been delivered by a caesarean section the outcome may well have been better, and almost certainly would have been safer'.³²

In the context of care quality measures, the 'traffic light' surveillance used in MBRRACE-UK's perinatal mortality reports is very familiar to trusts. In April 2017, NHS Resolution, the organization managing clinical negligence claims against the NHS in England, implemented score-cards designed to help trusts target interventions aimed at improving patient safety. They include red, indicating claims of high value and high volume, yellow, high value and low volume, and green (the ideal), low value and low volume.³³ Almost a decade earlier, the RCOG implemented a Maternity Dashboard in hospital trusts (still in use today), which also introduced a score card with red, amber and green (RAG) threshold values for clinical performance

Table 3 'Red flag' trusts in England most consistently reporting higher-than-average deaths during MBRRACE-UK Perinatal Mortality Surveillance 2015–18 (4-year score) and 2019–21 (3-year score).

Rank	Trusts in England falling into red and amber bands in years 2015–18 (with local review or investigation recommended by MBRRACE-UK)	Years n. ( , )	4-year score
1	Birmingham Women's and Children's NHS Foundation Trust ^a Liverpool Women's NHS Foundation Trust Sandwell and West Birmingham Hospitals NHS Trust	4 (3, 1)	19
2	Sheffield Teaching Hospitals NHS Foundation Trust The Shrewsbury and Telford Hospital NHS Trust ^b University Hospitals of Derby and Burton NHS Foundation Trust ^{a, c}	4 (2, 2)	18
3	Bradford Teaching Hospitals NHS Foundation Trust East Lancashire Hospitals NHS Trust ^c East Suffolk and North Essex NHS Foundation Trust ^{a, c} Northern Lincolnshire and Goole Hospitals NHS Foundation Trust ^c The Leeds Teaching Hospitals NHS Trust University Hospitals Plymouth NHS Trust ^a Wye Valley NHS Trust	4 (1, 3)	17
4	Blackpool Teaching Hospitals NHS Foundation Trust ^c Calderdale and Huddersfield NHS Foundation Trust Manchester University NHS Foundation Trust ^a Northampton General Hospital NHS Trust Northern Devon Healthcare NHS Trust ^d	4 (0, 4)	16
5	The Royal Wolverhampton NHS Trust	3 (2, 1)	14
Rank	Trusts in England falling into red and amber bands in years 2019–21 (with local review or investigation recommended by MBRRACE-UK)	Years n. ( , )	3-year score
1	Birmingham Women's and Children's NHS Foundation Trust ^a East Kent Hospitals University NHS Foundation Trust ^b East Lancashire Hospitals NHS Trust ^c Liverpool Women's NHS Foundation Trust Sandwell and West Birmingham Hospitals NHS Trust	3 (2, 1)	14
2	Sherwood Forest Hospitals NHS Foundation Trust ^c The Leeds Teaching Hospitals NHS Trust University Hospitals Bristol and Weston NHS Foundation Trust ^a	3 (1, 2)	13
3	Kettering General Hospital NHS Foundation Trust North Cumbria Integrated Care NHS Foundation Trust ^{a, c} Royal Devon and Exeter NHS Foundation Trust ^d Royal United Hospitals Bath NHS Foundation Trust The Hillingdon Hospitals NHS Foundation Trust The Shrewsbury and Telford Hospital NHS Trust ^b Wye Valley NHS Trust Yeovil District Hospital NHS Foundation Trust	3 (0, 3)	12
4	Bradford Teaching Hospitals NHS Foundation Trust The Royal Wolverhampton NHS Trust University Hospitals of Leicester NHS Trust	2 (2, 0)	10

(Continued)

Table 3 Continued

Rank	Trusts in England falling into red and amber bands in years 2019–21 (with local review or investigation recommended by MBRRACE-UK)	Years n. (●, ●)	3-year score
5	Ashford and St Peter’s Hospital NHS Foundation Trust Bedfordshire Hospitals NHS Foundation Trust ^a Calderdale and Huddersfield NHS Foundation Trust Frimley Health NHS Foundation Trusts Gloucestershire Hospitals NHS Foundation Trust Mid and South Essex NHS Foundation Trust ^{a, c} Oxford University Hospitals NHS Trust Sheffield Teaching Hospitals NHS Foundation Trust University Hospitals Birmingham NHS Foundation Trust ^a Wirral University Teaching Hospital NHS Foundation Trust	2 (1, 1)	9

^aIncludes trust name changes or mergers.
^bMaternity services at this trust are subject to criminal investigation, independent review or inquiry.
^cTrust investigated as part of the government-led 2013 Keogh Review²¹ or Francis Inquiry.²²
^dPost-analysis, in April 2022, Royal Devon and Exeter NHS Foundation Trust merged with Northern Devon Healthcare NHS Trust to form Royal Devon University Healthcare NHS Foundation Trust. The new trust’s 7-year score in Table 6 would be 28 (0, 7).

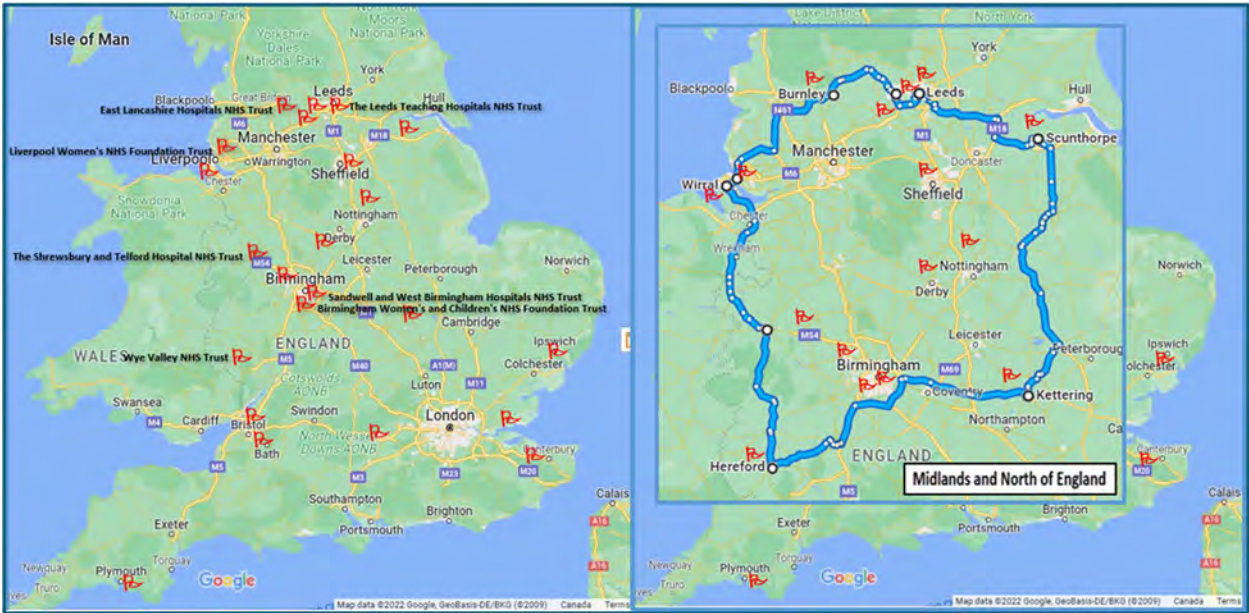


Figure 1 Indications of regional patterns for 16 (70%) of 23 ‘red flag’ trusts in England most consistently reporting higher-than-average deaths during MBRRACE-UK Perinatal Mortality Surveillance (2015–21).

and governance: ‘If a parameter enters the red zone then immediate action is needed from the highest level’.³⁴ The RCOG recommended target setting ‘by looking at the best performing trusts’ and taking ‘corrective action...when there is deviation’. On its score card, the colour green indicated a caesarean rate ‘Goal’ of <23%, with a ‘Red Flag’ rate of >25%, and instructed, ‘if >30% then cap & refer to other provider’. Trusts received financial messaging,

too. In its 2012 recommendations to clinical commissioning groups (CCGs), immediately prior to the first year of EPM data in this study, the RCOG communicated, ‘Every potential caesarean section that is enabled to be a normal birth saves £1200 in tariff price alone’, and it advised all maternity services to increase their rates of normal births and aim for an achievable and sustainable 20% caesarean birth rate.³⁵

Another area of surveillance that may have influenced our findings is trusts' accountability to the CQC, which has regulated and inspected maternity services in England since 2009. Notably, in 2017, the CQC praised SaTH for caesarean birth rates 'below (better than) the trust and national targets'.³⁶ A subsequent report, examining 312 CQC inspections at 130 trusts over 5 years (2013–18), found 95% remarked on caesarean rates and 56% on mode of birth targets.³⁷ Responding, the CQC said staff should not inspect against birth mode targets,³⁸ but, 5 years later, inspectors rating maternity safety 'inadequate' at Sheffield Teaching Hospitals NHS Foundation Trust³⁹ (7-year score 27) criticized 'worse than the national average' caesarean rates and a lack of targets on its maternity dashboard.⁴⁰ Similarly, in 2013, the first year of birth data assessed by MBRRACE-UK, the Keogh patient safety review identified a high level of stillborn babies that were not escalated or investigated at ELHT (7-year score 31).²¹ The CQC responded with a new inspection regime⁴¹ promising 'intelligent monitoring' and the use of key indicators as smoke detectors to drive quality improvement.⁴² One year later, citing award-winning, innovative work to promote normal births⁴³ and reduce 'red flag' caesarean rates,⁴⁴ the CQC recommended ELHT be taken out of special measures. This suggests that throughout MBRRACE-UK's surveillance, clinical performance in trusts' maternity services was being assessed using two, potentially conflicting, RAG ratings: their EPM rate (a birth outcome) and their caesarean rate (a birth process). Different trusts may have responded differently to these performance measures, so further research is needed to determine whether Ockenden's findings at SaTH are applicable to other NHS trusts reporting higher-than-average deaths.

A key finding in the seventh MBRRACE-UK report (2021) was the reduction in EPM of 18% between 2013 and 2019 (6.04 per 1000 total births down to 4.96 (Table 3)),¹⁴ equivalent to ~770 fewer deaths in 2019. The authors noted more than two-fifths of this reduction occurred after 2017, a trajectory they attributed to 'various national initiatives'. For context, significant national initiatives around this time included the RCOG's Each Baby Counts programme (2014–20),⁴⁵ the government's stillbirth ambition (beginning 2015),⁷ the normal birth campaign (officially ending 2017),⁴⁶ and the NHS Resolution scorecards (beginning 2017).³³ Another notable MBRRACE-UK finding in 2021 was that babies born to Black mothers, or living in the most deprived areas, were at least 'twice as likely to be stillborn' and at 'excess risk of neonatal death'.¹⁴ Further research is needed to examine the reasons for this.

Limitations of this study

Strengths of this study include the quality of MBRRACE-UK's reports. During an official launch at the RCOG in 2015,

MBRRACE-UK noted that the statistical power and precision of its data estimates would increase over time,⁴⁷ which our study utilizes. Furthermore, MBRRACE-UK maintains its data 'are robust and make an important contribution in highlighting those organisations where extra investigations should be targeted' to improve care.¹⁰ However, several limitations should be considered. Foremost, reported mortality rates are not definitive measures of care quality,⁴⁸ and the use of stabilized and adjusted rates of deaths cannot account for all potential variables. While we have identified trusts where local reviews do not appear to have improved comparative mortality rates over time, there may be factors at play that are not captured in MBRRACE-UK's reports, and these may differ from factors identified at UHMBT, SaTH and EKHUT. Similarly, while we found evidence of regional patterns that may warrant further examination of local area communication and culture, local comparison of trust maternity indicators, or the regional-based structure of CQC inspectors, additional research is needed to corroborate our findings. This includes examining which trusts most consistently report lower-than-average deaths.

What is already known on this topic

There is currently an unprecedented focus on NHS maternity services safety, with NHS Resolution projecting £69.3 billion in future settlements for maternity clinical negligence (£2.6 billion was paid in 2022/23).⁴⁹ To date, formal reviews, inquiries and investigations into perinatal deaths at hospital trusts in England have occurred following campaigns by families. MBRRACE-UK's first seven reports each identified hospital trusts with higher-than-average deaths, and the collaboration recommended local reviews or investigations at all those falling into red or amber bands.

What this study adds

Our retrospective analysis of national perinatal mortality data extends MBRRACE-UK's contribution by highlighting trusts that most consistently reported higher-than-average death rates over seven years and then considering these findings within the context of contemporary inquiries, inspections, investigations and other outcome measures.

This study directs attention towards organizational units in England with consistently higher-than-average rates of deaths, as reported by MBRRACE-UK, and considers evidence of other communication and surveillance relevant to trusts' clinical performance. Long after MBRRACE-UK ended its 2-year aspirational mortality rate target⁶ (Table 1), comparisons with Nordic maternity services persist. Former HSCC chair and Secretary of State for Health, Jeremy Hunt MP, who ordered the Ockenden review, cited

MBRRACE-UK's 2016 report⁹ in both 2021 and 2022, saying the UK 'must catch up with international exemplars such as Sweden'⁵⁰ because 'around 1,000 more babies would live every year if our maternity services were as safe'.^{51,52} Similarly, while NHS England and Improvement told trusts in 2022 that caesarean targets 'may be clinically inappropriate and unsafe in individual cases',⁵³ as directed by the HSCC (and echoing the RCOG's revised position that they are 'not appropriate in individual circumstances'⁵⁴), it still recommends the use of trust-level maternity dashboard data 'to identify where trusts may be an outlier'.⁵⁵ This suggests that as MBRRACE-UK perinatal mortality surveillance continues, the expectation remains for trusts to monitor and review both their birth processes and birth outcomes. In light of Ockenden's findings at SaTH,^{2,3,29,32} a consideration for future research might be to examine whether or not there is evidence of any of the trusts identified in our study prioritizing one RAG rating over the other.

Conclusion

Our findings provide evidence of a minority of NHS hospital trust maternity services in England that have consistently reported higher-than-average rates of deaths over seven years (2015–21). Further research is needed to examine reasons for the geographic proximity of most 'red flag' trusts, including any potential conflict around measures of clinical performance.

Acknowledgements

The bereaved families whose actions have led to reviews of maternity services. The Birth Trauma Association, for patient and public involvement (PPI) consultation. MBRRACE-UK, for providing public access to its annual Perinatal Mortality Surveillance Reports.

Supplementary data

Supplementary data are available at the *Journal of Public Health* online.

Conflict of interest

The authors declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article. PMH discloses that she is named in the Acknowledgements section of two of the MBRRACE-UK Perinatal Mortality Surveillance Reports included for analysis (2015 and

2016), listed under 'MBRRACE-UK Third Sector Stakeholder Group and representatives who attended meetings'.

Funding

No funding was received for this study.

Data availability

Data supporting the findings of this study are openly available through the University of Oxford National Perinatal Epidemiology Unit (NPEU) MBRRACE-UK Reports at <https://www.npeu.ox.ac.uk/mbrrace-uk/reports>.

Ethics

Ethical approval was not sought for this study as per Article 2.2 of the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2 2022) regarding Research Ethics Board (REB) exemption for publicly available and regulated data. The MBRRACE-UK reporting system meets the UK standards required to protect patient information. This study used MBRRACE-UK data that does not identify patients and is available in the public domain.

References

1. Dobson J. Ignoring women's experience led to the NHS's biggest maternity scandal. *BMJ* 2022;**377**:o899. <https://doi.org/10.1136/bmj.o899>
2. Department of Health and Social Care. *Ockenden Report – Final*. UK, 2022. <https://www.gov.uk/government/publications/final-report-of-the-ockenden-review>.
3. UK Parliament. *The Safety of Maternity Services in England. Fourth Report of Session 2021–22*. UK, 2021. <https://committees.parliament.uk/publications/6578/documents/73151/default/>.
4. Kirkup B. *The Report of the Morecambe Bay Investigation*. UK, 2015. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf.
5. Kirkup B. *The NHS Has Failed to Learn the Lessons of Morecambe Bay – With Devastating Consequences*. The Independent (UK), 2019.
6. Manktelow BM, Smith LK, Evans TA. *et al. MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Death for Births from January to December 2013 – Supplementary Report: UK Trusts and Health Boards*. Leicester, The Infant Mortality and Morbidity Studies Group, Department of Health Sciences, University of Leicester, 2015.
7. Department of Health and Social Care. *New Ambition to Halve Rate of Stillbirths and Infant Deaths*. UK, 2015. <https://www.gov.uk/government/news/new-ambition-to-halve-rate-of-stillbirths-and-infant-deaths>.

8. Weindling AM. The confidential enquiry into maternal and child health (CEMACH). *Arch Dis Child* 2003;**88**:1034–7. <https://doi.org/10.1136/adc.88.12.1034>
9. Manktelow BN, Smith LK, Seaton SE. *et al. MBRRACE-UK perinatal mortality surveillance report, UK perinatal deaths for births from January to December 2014*. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester, 2016.
10. Manktelow BN, Smith LK, Prunet C. *et al. MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2015*. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester, 2017.
11. Draper ES, Gallimore ID, Kurinczuk JJ. *et al. MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2016*. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester, 2018.
12. Draper ES, Gallimore ID, Smith LK. *et al. MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2017*. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester, 2019.
13. Draper ES, Gallimore ID, Smith LK. *et al. MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2018: Tables and Figures*. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester, 2020.
14. Draper ES, Gallimore ID, Smith LK. *et al. MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2019: Tables and Figures*. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester, 2021.
15. Giddens J. *Use of Special Measures Saved Lives at Keogh Hospitals*. National Health Executive (UK), 1996.
16. University of Oxford National Perinatal Epidemiology Unit. *Information for Mothers, Parents and Families*, Vol. 28. UK, 2024.
17. Mayor S. Five minutes with . . . David Field, coauthor of perinatal mortality report. *BMJ* 2016;**353**:i2790. <https://doi.org/10.1136/bmj.i2790>
18. Smith M. *The heartbreaking death of a Welsh couple's baby that led to the worst maternity scandal in the history of the NHS being uncovered*. Wales Online. UK, 2022.
19. Motheral B, Brooks J, Clark MA. *et al. A checklist for retrospective database studies—report of the ISPOR Task Force on Retrospective Databases*. *Value Health* 2003;**6**:90–7. <https://doi.org/10.1046/j.1524-4733.2003.00242.x>
20. Health and Social Care Committee. *MPs Call for Evidence on Maternity Safety and What More Must be Done to Improve it*. UK, 2020. <https://committees.parliament.uk/committee/81/health-and-social-care-committee/news/114832/safety-of-maternity-services-in-england-inquiry-launch-19-21/>.
21. Keogh B. *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England: An Overview Report*. NHS England (UK), 2013.
22. Francis R. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. UK, 2013. <https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry>.
23. Dyer C. East Kent trust is fined £733 000 for unsafe care of mother and baby. *BMJ* 2021;**373**:n1589. <https://doi.org/10.1136/bmj.n1589>
24. National Quality Forum. *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors Technical Report*. Washington, DC, USA, 2014. https://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx.
25. Sandall J, Murrells T, Dodwell M. *et al. The efficient use of the maternity workforce and the implications for safety and quality in maternity care: A population-based, cross-sectional study*. *NIHR Journals Library* 2014;**2**:1–266. <https://doi.org/10.3310/hsdr02380>
26. All-Party Parliamentary Groups (APPGs) on Baby Loss and Maternity. *Safe Staffing: The Impact of Staffing Shortages in Maternity and Neonatal Care. Report of the Baby Loss and Maternity All-Party Parliamentary Groups*. UK, 2022. <https://commonslibrary.parliament.uk/research-briefings/cdp-2022-0174/>.
27. Parekh N, Bragg R, Stoianova S. *et al. Maternity charges in NHS widen health inequalities*. *BMJ* 2022;**377**:e071154. <https://doi.org/10.1136/bmj-2022-071154>
28. McDonagh HULL P. Comparing caesarean birth rates: An institutionalized habit that is hard to break. *J Patient Saf Risk Manag* 2023;**28**:5–8. <https://doi.org/10.1177/25160435221150373>
29. Department of Health and Social Care. *Ockenden Report. Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust*. UK, 2020. <https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust>.
30. Renfrew MJ, Burns E, Gross MM. *et al. WHO pathways to strengthening midwifery in Europe*. *WHO Reg Publ Eur* 2015;**81**:12–5
31. Royal College of Obstetricians & Gynaecologists. *Report Addendum. Report of the Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust*. UK, 2018.
32. House of Commons. *Health and Social Care Committee Oral Evidence: Safety of Maternity Services in England, HC 677*. UK, 2020. <https://committees.parliament.uk/oralevidence/1418/pdf/>.
33. NHS Resolution Safety and Learning. *2018 Scorecard User Guide [Video]*. UK: NHS Resolution, 2018.
34. Royal College of Obstetricians and Gynaecologists. *Maternity Dashboard: Clinical Performance and Governance Score Card* Good Practice No. 7. UK, 2008.
35. Weston N. *Making Sense of Commissioning Maternity Services in England – Some Issues for Clinical Commissioning Groups to Consider*. Royal College of Obstetricians and Gynaecologists. UK, 2012.
36. Care Quality Commission. *The Princess Royal Hospital Quality Report*. UK, 2017.
37. McDonagh Hull P. *Five Years of Care Quality Commission (CQC) Maternity Inspections (2013–2018) Caesarean Birth*. UK, 2018.
38. Smyth C. *Hospital Inspectors Ordered to Stop Criticising Caesarean Rates*. The Times (UK), 2018.
39. Care Quality Commission. *CQC Tells Sheffield Teaching Hospitals NHS Foundation Trust to Make Urgent Improvements Following CQC Inspection*. UK, 2022.
40. Care Quality Commission. *Sheffield Teaching Hospitals NHS Foundation Trust Inspection Report*. UK, 2022.

41. Torjesen I. CQC sets out new inspection regime for hospitals in England. *BMJ* 2013;**347**:f4631. <https://doi.org/10.1136/bmj.f4631>
42. Care Quality Commission. *Annex to the Consultation: Changes to the Way CQC Regulates, Inspects and Monitors Care Services. Proposed Model for Intelligent Monitoring and Expert Judgement in Acute NHS Trusts*. UK, 2013.
43. Care Quality Commission. *Chief Inspector of Hospitals Recommends East Lancashire Hospitals NHS Trust Is Taken out of Special Measures, but with Continuing Support*. UK, 2014.
44. Care Quality Commission. *Burnley General Hospital Quality Report*. UK, 2014.
45. Royal College of Obstetricians and Gynaecologists. *Each Baby Counts: 2020 Final Progress Report*. London: RCOG, 2021.
46. 'Normal birth' campaign abandoned by royal college. *Nursing Times*. UK, 2017.
47. The National Perinatal Epidemiology Unit. *MBRRACE-UK Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. Perinatal Mortality Surveillance Report Main Analysis*. UK, 2015.
48. Diley I, Badrinath P, Annon S. Is mortality a good indicator of the clinical quality of National Health Service hospitals? A cross-sectional study of outlier trusts for mortality indices using quality dashboards. *JRSM Open* 2014;**5**(8). <https://doi.org/10.1177/2054270414533325>
49. NHS Resolution. *Annual Report and Accounts 2022/23*. UK, 2023. https://resolution.nhs.uk/wp-content/uploads/2023/07/NHS-Resolution-Annual-report-and-accounts-2022_23.pdf.
50. UK Parliament. *Is the Government on Track to Halve Baby Deaths by 2025?* UK, 2021. <https://committees.parliament.uk/committee/81/health-and-social-care-committee/news/153752/is-the-government-on-track-to-halve-baby-deaths-by-2025/>.
51. Hunt J. *The Ockenden Review Must Urgently Deliver Real Change in the NHS*. The Telegraph (UK), 2022.
52. O'Dowd A. Maternity services are not improving fast enough, say MPs. *BMJ* 2021;**374**:n1712. <https://doi.org/10.1136/bmj.n1712>
53. Wilkinson E. Hospitals in England are told to stop using caesarean rates to assess performance. *BMJ* 2022;**376**:o446. <https://doi.org/10.1136/bmj.o446>
54. Gilgunn-Jones E (On Behalf Of RCOG Press Office). *Royal College of Obstetricians and Gynaecologists Communications Statement*. UK, 2022.
55. Dunkley-Bent J. *Re-Sharing this Letter and Hoping it hasn't Been Misinterpreted*. Twitter (UK), 2022.

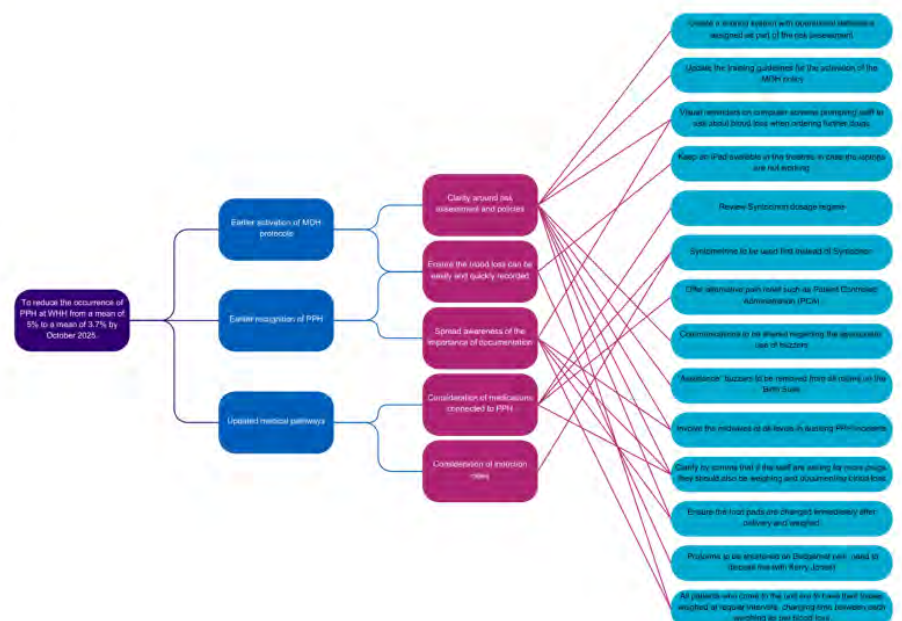
Metric	Query	Information Requested from Trust	Provider Response / Findings following Review	Actions in Place by Provider
3rd/4th Degree Tears	The Trust reported a high spike in November 24, which is significantly higher than the C&M and national performance. A review of CQIM+ dashboard data shows that the Trust is almost a national outlier and that the data for December 24 shows an upward trajectory. However, provisional data for January 25 does show a significant reduction.	Trust to provide an update following discussion at the Trust Quality Assurance Committee, where the cluster review and progress regarding rates/ongoing actions was presented (including agreed actions) - for review by the LMNS Clinical Team	- Position - October- December 2024 per 1000 births 65.9/1000 (reflecting high rate in November). - Noted as part of Q3 review of harm events. Cluster review completed and actions implemented. - Improved position - Jan-March 2025, 33.4/1000 - C&M position 28.4 per 1000	- Ongoing monitoring of rates. Cluster review of Q4 cases underway. - Actions ongoing including OASI drop in teaching sessions, individualised support where learning identified and pelvic health has already been included in mandatory MAMU-3 training, facilitated by the Specialist Midwife-Pelvic Health - Update re position and actions underway reports quarterly to Quality Assurance Committee
PPH >= 1500ml	The Trust continues to report a high rate compared with C&M peers and national performance. A review of CQIM+ dashboard data shows an upward trajectory for December 24. However, provisional data for January 25 reports a reduction, but is still above national performance.	Trust to revisit actions in place to address the high rate, pending release of the Regional PPH Guideline and provide an update to the LMNS - for review by the LMNS Clinical Team	- Position - October- December 2024 per 1000 births 41.6/1000 - Position - Jan-March 2025 per 1000 births 39.7/1000 - Position - March 2025 per 1000 births 37.7/1000 - Improving position - C&M position 34 per 1000 births	- Detailed overview of position shared to Quality Assurance committee with 12 month deep dive - Reports monthly to Quality Assurance Committee via SPC chart - Audit of PPH Feb-Sept 2024 completed. Actions underway and updated actions included below.
Robson Group 2	The Trust continues to report a high rate above the upper confidence level. A review of CQIM+ dashboard data shows that the Trust is above national performance and is clustered around the top of the average. Whilst data for December 24 reports an increase, provisional data for January 25 reports the same rate as for November 24.	Trust to submit audit findings to the LMNS to inform the cause of variation and confirm actions in place to address the high rate - for review by the LMNS Clinical Team	Formal audit of Robson 2 underway alongside deeper dive of IOL and ELCS in primigravid women	- IOL project group already in place with detailed action plan. - Learning from latest audit to be incorporated into this once complete and shared with LMNS clinical team

Apgar Score < 7	The Trust reported a high spike in November 24 – the LMNS note that this was twice as high as LWH (Level 3 unit). A review of CQIM+ dashboard data shows that the Trust has reported a high rate for both December 24 and January 25 (provisional data). review of Quarter 4 NWNODN Dashboard data also shows that the Trust has been flagged as red for Term Admissions.	Trust to confirm the cause of the high rate and actions in place to address - for review by the LMNS Clinical Team The LMNS also request that the Trust present the findings to QSSG for discussion and assurance – date of QSSG to be confirmed by the LMNS	• Review of data completed and discussion with LMNS team to check WHH data collection processes as not highlighted internally • Position - November 2024 per 1000 births - 26.3/1000, similar rates to Aug, Sept and October • Position - October- December 2024 per 1000 births 23/1000 • Position - Jan-March 2025 per 1000 births 22.3/1000 • Position - March 2025 per 1000 births 30/1000 • Outlier compared to C&M (14 per 1000) • Detailed audit underway. Once complete, learning will inform actions	• Once audit process complete and actions identified these will shared with the LMNS and presented to QSSG as requested.

PPH actions update:

Actions since previous full audit

- A QI project was set up as part of the actions from the previous audit
 - Task and Finish group for PPH meeting on a 2-weekly basis
 - Risk assessment reviewed and changed to an abbreviated version to be more representative of risk
 - Walkthroughs of scenarios completed
 - Driver diagram (opposite) completed (actions paused due to introduction of regional guideline)
- New regional guideline has been developed and is being rolled out in 2025.
- In-situ simulations of PPH and simulations on PROMPT training days
- Training videos on how to fill out the PPH proforma on BadgerNet



Actions following audit of PPH Feb-Sept 2024

Reminders in safety brief of the need for ongoing PPH risk assessment throughout labour

In-situ scenarios to continue for PPH, specifically focussing on instrumental deliveries

Review of the EMCS cases to identify common threads for learning

Single point lesson on management of the PPH in an instrumental

Dissemination of audit to the unit for information and learning

Implementation of the regional PPH guideline

Liaise with Transfusion lead to cross reference the audit patients with the transfusion activation times

Repeat audit for period October 2024 – March 2025



Maternity Self-Assessment tool

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Directorate/care group infrastructure and leadership	Clinically-led triumvirate	Trust and service organograms showing clinically led directorates/care groups	G	Organograms in place
		Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes	G	Quadrumvirate in place comprising CBU Business Manager, Director of Midwifery, Lead Nurse for Gynaecological and Paediatric Services and Clinical Director. All share responsibility for attending specialty, operational and governance meetings within the CBU and Trust wide.
	Director of Midwifery (DoM) in post (current registered midwife with NMC)	DoM job description and person specification clearly defined	G	Director of Midwifery job description clearly defines the professional accountability for midwifery.
		Agenda for change banded at 8D or 9	G	Position currently filled
		In post	G	Position currently filled
	Direct line of sight to the trust board	Lines of professional accountability and line management to executive board member for each member of the triumvirate	G	In place
		Clinical director to executive medical director	G	In place
		DoM to executive director of nursing	G	In place
		General manager to executive chief operating officer	G	In place

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Maternity services standing item on trust board agenda as a minimum three- monthly. Key items to report should always include: • SI Key themes report, Staffing for maternity services for all relevant professional groups. • Clinical outcomes such as SB, NND HIE, ATAIN, SBLCB and CNST progress/Compliance. • Job essential training compliance • Ockenden learning actions	G	Monthly Quality & Safety report provided for Quality Assurance Committee for: - • Governance Overview (including Complaints, Patient Safety events) • Maternity Safety & Experience (including Safety Champion themes, FFT, MVP Feedback) • MNSI cases • Key safety risks and workplans e.g. PPH, IOL, diabetes • Workforce metrics and training compliance • Coroner Regulation 28 position Quarterly report: • Transitional care • PMRT • ATAIN Monthly report provided for Quality Assurance Committee for: - • MIS including SBLCB progress. Quarterly Staffing Paper provided to Strategic People Committee including NICE red flags audit, workforce metrics. All papers are also taken to Trust Board
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]	G	DoM presents to Board at each Board meeting as per Perinatal quality surveillance model as per above
		There should be a minimum of three PAs allocated to clinical director to execute their role	G	In place. 2 PAs for Clinical Director role, 1 PA for Assoc Clinical Director role.
	Collaborative leadership at all levels	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team	G	Yes.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	in the directorate/ care group	Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate. Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave	G	HR Business Partner for W&C CBU is Jo-Ann Murphy Matron/Ward Manager 1:1 meetings in place to monitor recruitment, retention, sickness, vacancy, and maternity leave. HR support as per Sickness and Absence Policy.
		Adequate senior financial manager is in place to support clinical triumvirate and wider directorate	G	Senior Business Accountant for W&C CBU is Denise Dugdale.
		Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area	G	Monthly meetings in place with Finance.
		Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways	G	Senior operational support in place: Planned Care Group triumvirate consisting of Associate Medical Director, Associate Director and Associate Chief Nurse
		From governance and senior management meetings that all clinical decisions are made collaboratively by multiprofessional groups	G	Monthly Women's Health and CBU Governance meeting. Meetings consist of multiprofessional groups to discuss and agree collaboratively on all clinical decisions. Other regular MDT meetings where governance and safety matters are discussed and decisions made: • Intrapartum Review Group • ATAIN Review group • Guideline Review group • Audit meetings

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, e.g. senior midwifery leadership assembly	G	- Incident Reporting Group, Audit, PMRT are all multidisciplinary and have identified Chairs. - Matrons chair ward Manager & Specialist Midwives meeting.
		Leadership culture reflects the principles of the '7 Features of Safety'. 7 features of safety in maternity units 1. commitment to safety and improvement at all levels, with everyone involved. 2. technical competence, supported by formal training and informal learning. 3. teamwork, cooperation, and positive working relationships. 4. constant reinforcing of safe, ethical and respectful behaviours. 5. multiple problem-sensing systems, used as basis of action. 6. systems and processes designed for safety, and regularly reviewed and optimised. 7. effective coordination and ability to mobilise quickly.	G	Various forums for MDT working in place with a focus on safety and improvement (ATAIN, PPH, IRG, ORG). Programme of formal training in place complemented by informal training opportunities such as C Shop, Trainer train and schedule of SIMs Formal workstream in place to support improved culture and further develop working relationships. PSIRF model fully embedded and tools such as cluster review, SEIPS used as routine. Triangulation of data and themes from learning responses completed to inform new workstreams and to ensure a holistic approach to safety.
	Leadership development opportunities	Trust-wide leadership and development team in place	G	Senior leaders are visible to frontline staff. Listening opportunities are provided to staff from both the Quadrumvirate Team and also the Chief Nurse and Non Exec Safety Champion.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Inhouse or externally supported clinical leadership development programme in place	A	Ward Managers attend monthly Trust Ward Managers Meeting and also attend a Maternity Managers and Specialist Midwives Meeting facilitated by Maternity Matrons. Matrons attend Trust Nursing and Midwifery Forum. Matron opportunities to attend ad hoc leadership and development training days. Opportunities to complete external leadership educational programmes. Midwifery workforce development guideline to be launched Q1 2025/26 which will provide overview of development pathways for midwives from band 5 to aspiring senior leaders. Project to implement national Labour ward (Birth Suite) Coordinator framework underway. Formal leadership programme for aspiring managers band 6 and below or those in senior leadership positions in process of being developed Development of Deputy Manager Band 6 roles for aspiring Band 7. Trust Matron development programme to be launched July 2025
		Leadership and development programme for potential future talent (talent pipeline programme)	A	Formal leadership programme for aspiring managers band 6 and below or those in senior leadership positions in process of being developed
		Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship	G	Coaching and mentoring are available on an individual need's basis. Service supportive of leadership programmes such as masters level study, nominations to the Florence Nightingale programmes.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Accountability framework	Organisational organogram clearly defines lines of accountability, not hierarchy	G	Trust/CBU organograms in place to demonstrate lines of accountability.
		Organisational vision and values in place and known by all staff	G	Trust values are published and well understood by staff. Values merit badges are awarded to staff who have demonstrated a high standard for an individual Trust value. Trust wide vision and values strategy is in place. Ward Accreditation programme is used to monitor staff understanding of the Trust vision and values.
		Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]	G	Contractual Code of Conduct HR Policies and Process in place. HR full support for advice and escalation where needed.
	Maternity strategy, vision and values	Maternity strategy in place for a minimum of 3–5 years	G	In place
		Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan	G	In place
		Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.	G	Maternity and neonatal strategy was developed with input from staff, MNVP and experts by experience.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services [Ockenden Assurance]	G	MNVP in place. Meets quarterly with rep from Midwifery SLT at each meeting. Consultant Midwife works closely with MNVP on key projects. MNVP workplan in place which includes regular 15 Steps challenge. From October 2024 MNVP invited to following: • Monthly Safety Champions Walkaround • Quarterly NED/Quad Meeting • Guideline Review Group • LMNS MNSOG
		Maternity strategy aligned with trust board LMNS and MVP's strategies	G	Complete
		Strategy shared with wider community, LMNS and all key stakeholders	G	Complete
	Non-executive maternity safety champion	Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor	G	Jayne Downey is the nominated Non Executive Maternity Safety Champion
		Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor	G	Director of Midwifery and Neonatal Safety Champion participate in the Safety Champions walk arounds. Director of Midwifery and Obstetric Safety Champions attend WH Governance Meetings.
		All Safety champions lead quality reviews, e.g. 15 steps quarterly as a minimum involving MVPs, service users, commissioners and trust governors (if in place)	G	Programme of 15 Steps Challenge in place Monthly Safety champion walkaround sin place which now include MNVP co-chairs
		Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services	G	Maternity Safety Champion (Director of Midwifery) attends QAC. Agenda item to present Maternity update report of achievements and challenges. Discussion and actions are recorded in the QAC minutes.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Multiprofessional team dynamics	Multiprofessional engagement workshops	A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks. [MIS]	G	Organogram available
		Planned schedule of joint multiprofessional engagement sessions with chair shared between triumvirate, i.e. quarterly audit days, strategy development, quality improvement plans	G	Quarterly audit days, Obs & Gynae away days and other senior maternity meetings all in place.
	Multiprofessional training programme	Record of attendance by professional group and individual	G	In place and reported monthly to Quality Assurance Committee
		Recorded in every staff member's electronic learning and development record	G	In place
		Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see	G	In place
		A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority	G	In place.
		All staff given time to undertake mandatory and job essential training as part of working hours	G	Yes
		Full record of staff attendance for last three years	G	Yes
		Record of planned staff attendance in current year	G	Yes
		Clear policy for training needs analysis in place and in date for all staff groups	G	Yes

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Compliance monitored against training needs policy and recorded on roster system or equivalent	G	Yes – recorded in ESR. Compliance for training not accessible in ESR is monitored by the Practice Development Midwife.
		Education and training compliance a standing agenda item of divisional governance and management meetings	G	Yes, Exception Report provided for CBU Governance meeting and discussed at management meetings.
		Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]	G	Yes – PROMPT training. Skills and Drills. MAMU 2 (CTG training).
	Clearly defined appraisal and professional revalidation plan for staff	Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal	G	Training meets all current NMC revalidation requirements and supports GMC educational requirements.
		All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation	G	Trust standard job descriptions and role profiles in place.
		Compliance with annual appraisal for every individual	A	Trust standard in place for all staff to have annual appraisal. PDR compliance is reviewed by Line Managers and levels of compliance monitored at CBU Management meetings. Current compliance is below 85% threshold. PDR trajectory to achieve full compliance in place.
		Professional validation of all relevant staff supported by internal system and email alerts	G	HR process in place to support monitoring of compliance and notification when professional registration has lapsed, or validation is overdue.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities	G	HR guidelines in place to support monitoring of capability and performance in the workplace. Staff supported to identify opportunities for professional education and development as part of PDR process. Senior Managers and Leaders accessible at clinical level for staff to discuss training and development opportunities. Rotational midwifery posts support maintenance of midwifery clinical skills
	Multiprofessional clinical forums	Schedule of clinical forums published annually, e.g. labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings	G	Dates set annually for GRG, PMRT, WHGG, WACHGG, Departmental Audit
	Multiprofessional inclusion for recruitment and HR processes	HR policies describe multiprofessional inclusion in all processes where applicable and appropriate, such as multiprofessional involvement in recruitment panels and focus groups	G	Interviews for senior leadership posts are conducted with an MDT interview panel
		Organisational values-based recruitment in place	G	All job descriptions and interview processes follow values based principles
		Multiprofessional inclusion in clinical and HR investigations, complaint and compliment procedures	G	Investigation panels have an MDT review process for incident claims and complaints. External representation requested as appropriate. Families are included in investigations where there has been a suspected poor outcome.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Standard operating procedure provides guidance for multiprofessional debriefing sessions following clinical incidents or complaints	A	No SOP however staff have access to support from Health and Wellbeing Department, Mental Health First Aiders and Counselling Services. Senior Managers and Clinicians offer debriefing opportunities for staff in group settings or on an individual basis following incidents and complaints. Develop local guidance on multiprofessional debriefing of staff. Provide debriefing training for senior leaders and managers who lead formal debriefing sessions.
		Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy	G	Process in place as part of implementation of PSIRF framework
	Multiprofessional membership/ representation at Maternity Voices Partnership forums	Schedule of attendance from multiprofessional group members available	G	In place and evidence available
		Record of attendance available to demonstrate regular clinical and multiprofessional attendance.	G	In place and evidence available
		Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design	G	MNVP and service users have been consulted on development of relocation of Triage and IOL. CQC Maternity Service Survey report shared with MNVP, and actions/next steps discussed. MNVP leads invited to attend Safety Champion walkarounds, quarterly QUAD/NED meetings and Guideline Review Group.
	Collaborative multiprofessional input to service development and improvement	Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users	A	In progress, completion by end of July 2025.
		Roles and responsibilities in delivering the QIP clearly defined, i.e. senior responsible officer and delegated responsibility	A	In progress, completion by end of July 2025.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP	A	In progress, completion by end of July 2025.
		Identification of the source of evidence to enable provision of assurance to all key stakeholders	A	In progress, completion by end of July 2025.
		The organisation has robust repository for collation of all evidence, clearly catalogued and archived that has appropriate shared access	G	Trust Knowledge & Evidence Service in place. Includes quarterly Maternity, Obstetrics & Gynaecology Evidence Update Bulletin
		Clear communication and engagement strategy for sharing with key staff groups	A	In place but not formalised
		QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements	A	In progress, completion by end of June 2025.
	Multiprofessional approach to positive safety culture	Weekly/monthly scheduled multiprofessional safety incident review meetings	G	Initial Safety Review and Intrapartum review group meetings take place weekly led by Trust Governance and includes CBU Ward Managers, Senior Managers, Clinical Staff – Midwifery, Gynaecology and Neonatal. Monthly Operational Review Group established to review operational patient safety events.
		Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS	A	Quarterly Trust shared learning forum in place. Maternity included on agenda. Maternity also standing agenda item at Patient Safety & Experience Committee. LMNS to be invited to future shared learning sessions.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Positive and constructive feedback communication in varying forms	G	SCORE Survey completed and Perinatal Cultural Leadership action plan in place. Trust Values badges awarded for exemplary behaviour. Safety Huddle Meeting highlights areas of good practice to be shared trust wide. Weekly Safety Brief provided to staff via Ward Managers. DOM monthly update provided to all staff. Ward Managers and Senior Leaders provide written and verbal feedback to individuals. Case on a page tool used to share feedback along with patient stories
		Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach	G	All incident reviews have the opportunity to identify good practice. This is feedback to staff at the time of the review.
		Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience.	G	Line managers and Matrons will link in with more junior colleagues following complex cases.
	Clearly defined behavioural standards	Schedule of focus for behavioural standards framework across the organisation	G	
		Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month	A	In place. Need to capture evidence
		Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they do not become normalised.	G	In place.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Governance infrastructure and ward-to-board accountability	System and process clearly defined and aligned with national standards	All policies and procedures align with the trust's board assurance framework (BAF)	G	Yes
		Governance framework in place that supports and promotes proactive risk management and good governance	G	Dedicated Governance Lead for Women's and Children's Health Department. Obstetrics and Gynaecology Governance Leads in place. Trust wide governance strategy in place. Governance activities and outcomes at speciality and CBU level meetings.
		Staff across services can articulate the key principles (golden thread) of learning and safety	G	Monthly newsletter circulated to staff with maternity lessons learned. Single point lessons developed to support ad hoc learning for incidents. Action plans are developed in response to lessons learned from incidents claims and complaints. Action plans are monitored through departmental governance meetings. Our Wise Learning (OWL) and learning from MNSI case on a page shared with staff.
		Staff describe a positive, supportive, safe learning culture	G	CQC report provided positive evidence of this. Feedback from Safety Champion walkaround would further support this. Culture workstream will further embed this.
	Maternity governance structure within the directorate	Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams	G	Corporate Governance Team in place with identified WCH Governance Leads. Corporate governance systems and practices are followed at Departmental level.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Maternity governance team to include as a minimum: Maternity governance lead (Current RM with the NMC) Consultant Obstetrician governance lead (Min 2PA's) Maternity risk manager (Current RM with the NMC or relevant transferable skills) Maternity clinical incident leads Audit midwife Practice development midwife. Clinical educators to include leading preceptorship programme. Appropriate Governance facilitator and admin support	G	- Integrated Governance Lead in post (current RM with NMC pin) - Consultant Obstetrician governance lead in post - Specialist Midwife - Audit & Assurance in post - Specialist Midwife - Practice Development in post - Specialist Midwife Retention in post (supporting preceptorship programme) - Specialist Midwife - Practice education in post - MDT Intrapartum group in place to lead and review patient safety events. - Maternity risk manager - not in post however management of risk by the Deputy DoM and DoM (both NMC registrants)
		Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member	G	Governance responsibilities are clearly described in Job Plans. Individuals are allocated as leads in maternity specific improvement initiatives such as MIS, SBL, ATAIN.
		Team capacity able to meet demand, e.g. risk register, and clinical investigations completed in expected timescales	G	CBU and Corporate Governance monitoring systems in place to monitor compliance with deadlines and authorise extensions as required.
	Maternity-specific risk management strategy	In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF	A	Maternity Risk Management Strategy is included in the Trust Risk Management Strategy.
		Clearly defined in date trust wide BAF	G	Yes

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Clear ward-to-board framework aligned to BAF	Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board	G	Reporting templates are available for all trust wide meetings. Work plan in place to highlight when specific reports are required for meeting agendas.
	Proactive shared learning across directorate	Mechanism in place for trust-wide learning to improve communications	G	Learning shared via daily safety meeting and safety brief to all staff. Various meeting forums to share learning and good practice. .
		Mechanism in place for specific maternity and neonatal learning to improve communication	G	Various tools used: • SEE Boards • Our Wise learning • Single point Lessons • Training Train • Area specific safety briefs? • MNSI Case on a page • Face to face listening and learning sessions held following adverse events
		Governance communication boards	G	Safe, Effective, Experience (SEE) boards provided in all clinical areas by Integrated Governance Lead – sharing all information and learning relating to Governance.
		Publicly visible quality and safety boards outside each clinical area	G	All wards have quality safety boards visible.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Learning shared across local maternity system and regional networks	G	DoM, Dep DoM, and other members of the senior team will attend a variety of LMNS/regional quality/improvement meetings including: - LMNS Maternity and Neonatal safety Group with shared learning key aspect of meeting - WHAM operational group
		Engagement of external stakeholders in learning to improve, e.g. CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups	G	Maternity Service has participated in safety collaborative initiatives and learning events. Staff attend LMNS learning events and safety initiatives
		Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.	A	Overarching Trust communication plan in place but formal strategy paused due to Bridgewater transition process
Application of national standards and guidance	Maternity specification in place for commissioned services	Multi-agency input evident in the development of the maternity specification	G	ICB engagement meetings in place via CQFG to discuss maternity performance and quality outcomes.
		Approved through relevant governance process	G	In place
		In date and reflective of local maternity system plan	G	In place
	Application of CNST 10 safety actions	Full compliance with all current 10 standards submitted	G	Achieved full MIS Year 5 compliance in 2024. Year 6 declaration submitted following review by Board, LMNS. Awaiting formal outcome from NHSR.
		A SMART action plan in place if not fully compliant that is appropriately financially resourced.	N/A	
		Clear process defined and followed for progress reporting to LMS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance	G	Yes

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Clinical guidance in date and aligned to the national standards	Clear process for multiprofessional, development, review, and ratification of all clinical guidelines	G	Guideline Review Group in place with guidelines circulated for MDT comment prior to approval
		Scheduled clinical guidance and standards multiprofessional meetings for a rolling 12 month programme.	G	Multiprofessional meetings in place. Schedule available.
		All guidance NICE complaint where appropriate for commissioned services	G	Compliance is monitored as a governance function and reported through governance meetings. Where no compliance is reported a risk assessment and action plan to achieve compliance is developed.
		All clinical guidance and quality standards reviewed and updated in compliance with NICE	G	Compliance is monitored as a governance function and reported through governance meetings. Where no compliance is reported a risk assessment and action plan to achieve compliance is developed
	Saving Babies Lives care bundle implemented	All five elements implemented in line with most updated version	G	Saving Babies Lives Care Bundle v.3 (SBLCBv3) implemented.
		SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.	G	The latest external review took place of Saving Babies Lives Care Bundle v.3 in March 2025 Feedback confirmed 100% compliance overall for the 6 elements. Action plans and ongoing audits in place to sustain compliance
		Trajectory for improvement to meet national ambition identified as part of maternity safety plan	G	Action plans and ongoing audits in place to sustain compliance

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Application of the four key action points to reduce inequality for BAME women and families	All four key actions in place and consistently embedded	G	Local maternity systems are asked to increase support for at-risk pregnant women (Covid) – complete. Reach out and reassure pregnant BAME women with tailored communications (Covid) - complete. Minimise the risk of Vitamin D insufficiency – in place and monitored as part of Saving Babies Lives Care Bundle v.3
		Application of equity strategy recommendations and identified within local equity strategy	G	Equity and equity action plan in place as part of overarching maternity strategy and transformation action plan.
	Implementation of 7 essential learning actions from the Ockenden first report	All actions implemented, embedded and sustainable	G	Action Plan for the 7 essential learning actions from Ockenden first report complete.
		Fetal Surveillance midwife appointed as a minimum 0.4 WTE	G	Fetal Surveillance midwife post well established.
		Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs	G	In place
	A-EQUIP implemented	Plan in place for implementation and roll out of A-EQUIP	G	Advocating for Education and Quality Improvement (A-EQUIP). Full team of PMAs in place. 2025 workplan underway
		Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team	G	Advocating for Education and Quality Improvement (A-EQUIP). Full team of PMAs in place. 2025 workplan underway
		Training plan for transition courses and succession plan for new professional midwifery advocate (PMA) A-EQUIP model in place and being delivered	G	Advocating for Education and Quality Improvement (A-EQUIP). Full team of PMAs in place. 2025 workplan underway

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity bereavement services and support available	Service provision and guidance aligned to national bereavement pathway and standards	G	Regional Pathway in place.
		Bereavement midwife in post	G	7 day service in place
		Information and support available 24/7	G	Bereavement Champions have received training from Bereavement Midwife to ensure 24 hour support for staff and families.
		Environment available to women consistent with recommendations and guidance from bereavement support groups and charities	G	Dedicated Family Rooms available.
	Quality improvement structure applied	Quality improvement leads in place	G	Deputy Dom is lead within the Maternity service. Maternity team also work closely with the Trust Quality Academy.
		Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation	A	QI lead via Deputy Director of Midwifery Support provided from the Quality Academy. Formal plan underway. Completion by 31/7/2025
		Recognised and approved quality improvement tools and frameworks widely used to support services	G	Safety Collaborative focussed on QI methodology and some staff have attended the trust wide QI training sessions provided by the Quality Academy, utilising recognised and approved quality improvement tools and frameworks.
		Established quality improvement hub, virtual or otherwise	G	Trust wide Quality Academy in place, plus monthly Maternity QI meetings established.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	MatNeoSip embedded in service delivery	Listening into action or similar concept implemented across the trust	G	Trust engages with varied MatNeoSip project. NHSE Perinatal Cultural Leadership programme completed with included SCORE survey and implementation of action plan to support improved culture. Programme of ideas sessions completed with staff in Autumn 2024 to inform programme of improvement. Actions underway.
		Continue to build on the work of the MatNeoSip culture survey outputs/findings.	G	NHSE Perinatal Cultural Leadership programme completed with included SCORE survey and implementation of action plan to support improved culture.
	Maternity transformation programme (MTP) in place	MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan	A	QIP underway. Completion by 31/7/2025
Positive safety culture across the directorate and trust	Maternity safety improvement plan in place	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy)	A	Will be included as part of QIP underway. Completion by 31/7/2025
		Standing agenda item on key directorate meetings and trust committees	A	Once QIP in place will report quarterly to speciality governance and Quality Assurance Committee/Board. Completion by 31/7/2025
		Human factors training lead in post	A	External training completed. No formal human factors training lead
	Freedom to Speak Up (FTSU) guardians in post	FTSU guardian in post, with time dedicated to the role	G	Trust wide guardians in post with identifiable lanyards. Guardians receive time to support role Anonymous reporting system in place.
	Human factors training available	Human factors training part of trust essential training requirements	A	Human factors training programme is being implemented as part of the PSIRF implementation

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Human factors training a key component of clinical skills drills	G	Human factors included as part of Prompt training
		Human factors a key area of focus in clinical investigations and formal complaint responses	G	Key aspect within PSIRF. SEIPS methodology being used routinely.
	Robust and embedded clinical handovers in all key clinical areas at every change of staff shift	Multiprofessional handover in place as a minimum to include. Board handover with representation from every professional group: • Consultant obstetrician • ST7 or equivalent • ST2/3 or equivalent • Senior clinical lead midwife • Anaesthetist And consider appropriate attendance of the following: • Senior clinical neonatal nurse • Paediatrician/neonatologist? • Relevant leads from other clinical areas e.g., antenatal/postnatal ward/triage.	G	SOP in place, regular audits undertaken
		Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern	G	In place
	Safety huddles	A minimum of two safety huddles daily in all acute clinical areas to include all members of the MDT working across and in maternity services as well as the opportunity to convene an urgent huddle as part of escalation process's	G	In place
		Guideline or standard operating procedure describing process and frequency in place and in date	G	Need evidence to support

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Audit of compliance against above	A	In place, evidence to be collated
	Trust wide Swartz rounds	Annual schedule for Swartz rounds in place	R	Not yet in place
		Multiprofessional attendance recorded and supported as part of working time	R	As above
		Broad range of specialties leading sessions	R	As above
	Trust-wide safety and learning events	Trust-wide weekly patient safety summit led by medical director or executive chief nurse	G	Weekly safety Oversight meeting in place
		Robust process for reporting back to divisions from safety summit	G	Weekly meetings between Governance lead for Women's & Children's CBU and director of Midwifery including reporting back
		Annual or biannual trust-wide learning to improve events or patient safety conference forum	G	Quarterly Trust wide Shared Learning Forum in place
		Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes	G	In place
Comprehension of business/ contingency plans impact on quality. (i.e. Maternity Transformation plan, Neonatal Review, Maternity Safety plan and Local Maternity System plan)	Business plan in place for 12 months prospectively	In date business plan in place	G	Included in Trust business plan
		Meets annual planning guidance	G	Included in Trust business plan
		Business plan supports and drives quality improvement and safety as key priority	G	Included in Trust business plan
		Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups	A	Mat workforce not included in Trust business plan but measures to ensure workforce needs are met and safe staffing is in place are included with the Maternity & Neonatal Workforce Strategy, reported to QAC and Strategic People Committee and included in assurance related to the Maternity Incentive Scheme.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Consultant job plans in place and meet service needs in relation to capacity and demand	G	Yes, monitored by CBU Business Manager
		All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans	G	Yes, monitored by CBU Business Manager
		Business plans ensures all developments and improvements meet national standards and guidance	G	Yes, monitored by CBU Business Manager/quadrumvirate
		Business plan is aligned to NHS 10-year plan, specific national initiatives, and agendas.	G	Included in Trust business plan
		Business plans include dedicated time for clinicians leading on innovation, QI, and Research	R	Formal plan will be developed for 2025/26
Meeting the requirements of Equality and Inequality & Diversity Legislation and Guidances.	That Employment Policies and Clinical Guidances meet the publication requirements of Equity and Diversity Legislation.	That service plans and operational delivery meets the maternity objectives of the Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.	G	Included as part of Maternity & Neonatal Strategy 2024-26
		Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.	G	Equity and equity action plan in place as part of overarching maternity strategy and transformation action plan.
		Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template.	G	Equity and equity action plan in place as part of overarching maternity strategy and transformation action plan including key workstreams related to pelvic health, infant feeding, smoking, and enhanced provision for BME women and women in the most deprived deciles.

STRATEGIC PEOPLE COMMITTEE

AGENDA REFERENCE:	SPCIC/25/07/077			
SUBJECT:	Biannual review of obstetric, anaesthetic, neonatal and Q4 midwifery staffing			
DATE OF MEETING:	16 th July 2025			
ACTION REQUIRED:	To note and submit to Trust Board			
AUTHOR(S):	Ailsa Gaskill-Jones – Director of Midwifery, Laura James CBU manager – WCH, Kath Watkins Lead Nurse Paediatrics and Gynaecology			
EXECUTIVE DIRECTOR SPONSOR:	Ali Kennah - Chief Nurse			
LINK TO STRATEGIC OBJECTIVE	SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	Patients	Workforce	Public
		x		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	Yes	No	N/A
	Further Information / Comments: The paper relates to care of pregnant people/those on the pregnancy continuum and provides oversight of staffing matters to ensure a safe service. The paper also relates to workforce measures, in a majority female workforce. In ensuring safe staffing this will support the service in maintaining staff wellbeing in this group.			
EXECUTIVE SUMMARY:	The purpose of this paper is to provide assurance in relation to workforce within the maternity and neonatal services, in particular with regard to the standards within the Maternity Incentive Scheme (MIS) year 7, specifically: - Safety action 3 - Can you demonstrate that you have transitional care services in place and are undertaking quality improvement to minimise separation of parents and their babies. - Safety action 4 - Can you demonstrate an effective system of clinical workforce planning to the required standard?			

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

The paper notes challenges with regard to neonatal staffing in particular medical and AHP staffing and in the provision of robust transitional (TC) care service.

MIS also requires the service to demonstrate the completion of a systematic, evidence-based process to calculate midwifery staffing establishment (Birthrate Plus®) within the last three years. The paper reports the outcome of the 2024 assessment with the following key matters to note:

- A total clinical requirement for face to face care of 131.57wte. WHH current total clinical establishment is 127.99wte. This has resulted in a shortfall of 3.58wte between the 2025 recommended Birthrate Plus® establishment and existing funded establishment.
- The total clinical establishment excludes the management, and the non-clinical element of the specialist midwifery roles needed to provide maternity services. For WHH this equates to an additional staff of 15.79wte. The current establishment for these roles is 14.50wte for these roles. This is a variance of 1.29wte.
- As a result, the 2024 Birthrate Plus® assessment suggests a total shortfall in registered midwifery posts of 4.87wte

Ongoing monitoring of safe staffing levels via the red flag process is a further requirement of the Safety Action 5, via 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.

The paper notes in Q4 2024/2025 there are no episodes recorded in SafeCare where the Birth Suite Coordinator is

	NOT supernumerary as per the technical standard. Furthermore, there are no episodes recorded in SafeCare where a woman in active labour is NOT receiving one-to-one care. The paper also provides details of key midwifery workforce metrics as follows: • The vacancy rate for registered staff as at 31st May 2025 is 2.41%. • Midwifery retention rates have reduced with turnover slightly above the Trust average 13.92%. • Sickness rates for May 2025 for registered midwifery staff were 9.9% The rolling 12 month rate is 9.22%, significantly above the Trust target albeit an improvement from the position in January 2025 when the rate was 11.69%.		
PURPOSE: (please select as appropriate)	Approval	To note X	Decision
RECOMMENDATION:	Strategic People Committee is asked to receive and discuss this report and for the report to be shared with the Trust Board.		
PREVIOUSLY CONSIDERED BY:	Committee	Choose an item.	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
NEXT STEPS: <i>State whether this report needs to be referred to at another meeting or requires additional monitoring</i>	Submit to Trust Board		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
	None		

STRATEGIC PEOPLE COMMITTEE

SUBJECT	Biannual review of obstetric, anaesthetic, neonatal and Q4 midwifery staffing	AGENDA REF:	SPCIC/25/07/077

1. BACKGROUND/CONTEXT

The purpose of this biannual paper is to provide assurance in relation to workforce within the maternity and neonatal services, in particular with regard to the standards within the Maternity Incentive Scheme (MIS) year 7, specifically:

- Safety action 3 - Can you demonstrate that you have transitional care services in place and are undertaking quality improvement to minimise separation of parents and their babies.
- Safety action 4 - Can you demonstrate an effective system of clinical workforce planning to the required standard?
- Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

The paper also provides details of the midwifery service's position for Q4 2024/25 against national recommendations for safe maternity staffing and triangulation against maternity red flag incidents. This paper will provide specific assurance in relation to safety standards as follows:

- 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.

This paper also provides an overview of other key midwifery workforce metrics. at as 31st May 2025.

2. OBSTETRIC/ANAESTHETIC MEDICAL WORKFORCE (MIS SAFETY ACTION 4a & 4b)

2.1 – Obstetric Workforce

Compliance with medical workforce standards is ensured through several specific measures and processes within the CBU. Medical resources rigorously verify all short-term locums on the middle-grade rota to confirm they hold a current RCOG Certificate of Eligibility for Locums (CEL), which guarantees they have completed the mandatory obstetric skills drills, fetal heart monitoring training, and relevant work-based assessments before commencing clinical duties.

The CBU maintains an up-to-date register of doctors who have worked in training posts within the last five years, exempting them from the CEL, as well as other short-term locums with valid CELs. Consultant locums at the Trust are either substantive consultants or hold a Certificate of Completion of Training (CCT), making them exempt from the CEL requirement, which applies only to middle grade staff. The Trust also uses the RCOG monitoring effectiveness tool to oversee engagement with long-term locums; notably, no long-term locums have been employed since 2022, demonstrating adherence to workforce planning standards. An audit to assess compliance will be conducted by the service for the period from February to August 2025, in line with MNSI technical guidance.

To safeguard patient safety, the Trust has a standard operating procedure (SOP) in place to ensure that consultants working non-resident on-call shifts receive adequate rest before undertaking further clinical responsibilities. This SOP is aligned with the RCOG Roles and Responsibilities of a Consultant in Obstetrics and Gynaecology, which mandates prospective rest periods after on-call shifts, including weekends.

If a consultant works beyond midnight and therefore has less than 12 hours of rest, they can notify management to have their afternoon sessions cancelled or covered by colleagues, ensuring safe workload management. Currently, the only SAS doctor performing on-call duties at the Trust is part of the middle grade rota and works 12-hour shifts, consistent with rest and safety requirements. Compliance is monitored through feedback from these clinicians regarding their ability to obtain compensatory rest following busy night shifts.

Strategic People Committee are asked to note the position against safety action 4a.

2.2 Anaesthetic workforce

MIS standards require a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times.

This is in place in the service as follows::

- There is a suitably trained on-call duty Anaesthetist allocated 24 hours/7 days per week.
- There is resident Consultant presence from 08:00 to 17:00 weekdays, and 24-hour consultant on-call cover for the remaining hours.
- In addition, there is an allocated Consultant covering the elective caesarean section lists.

This meets the standard for MIS year 7. Strategic People Committee are asked to note the position against safety action 4b.

3. NEONATAL WORKFORCE (MIS SAFETY ACTION 4c & 4d)

3.1 Neonatal medical workforce

The neonatal workforce presently adheres fully to the standards set by the British Association of Perinatal Medicine (BAPM) at Tier 2 and Tier 3 levels. Nevertheless, the coverage at Tier 1 is only partially compliant, with current provisions operating from 09:00 to 21:30 on weekdays and from 09:00 to 16:00 on weekends. The existing staffing levels are inadequate to provide the required 24/7 Tier 1 coverage essential to meet BAPM standards.

This shortfall is primarily attributable to the insufficient allocation of speciality trainees from the Deanery. Currently, only one ST1 speciality trainee has been assigned, alongside one F2 trainee scheduled to be funded from August 2024. General Practice (GP) trainees are responsible for the remaining segments of the Tier 1 rota. It should be emphasised that the current funding for the Tier 1 paediatric team does not support a dedicated, compliant, 24/7 Tier 1 rota. To attain full compliance, the existing Tier 1 medical workforce would necessitate at least a twofold increase in staffing levels.

3.2 Neonatal nursing workforce

To ensure compliance with Maternity Incentive Scheme (MIS) Year 7 Safety Action 4d, the NNU staffing model is expected to adhere to the BAPM neonatal nursing standards. If the standards are not currently being met an action plan is required, with an update on any previous action plans. Any action plans should be shared with the LMNS and Neonatal ODN.

The Neonatal Nursing Workforce Tool (2020) has been used to ensure a consistent method of calculating the nursing establishment in relation to National Standards including BAPM (2010) for direct clinical care. The NWNODN have used this tool using the occupancy for Warrington NNU year 1/4/24-31/3/25, (awaiting verified data from the network, currently taken from BAPM).

Currently the neonatal workforce is compliant for direct clinical activity to the BAPM national standards of nurse staffing as per the technical guidance in Safety Action 4. This is detailed in table 1:

Table 1: Neonatal nursing position

Nursing workforce (WTE) Direct Patient Care Only (April 2025)					
<i>Total nurse staffing required to staff declared cots= 42.49, of which 29.74 (70%) should be QIS</i>					
	Budget	In post	Required to meet activity at average 80% occupancy	Variance: Budget against required	Variance: in post against required
Total nursing staff	31.42	27.40	27.91	3.51	-0.51
Total registered nurses	26.20	23.26	25.04	1.16	-1.78
Total QIS	26.20	17.50	18.33	7.87	-0.88
Total non-QIS	0.00	5.76	6.70	-6.70	-0.94
Total non-registered	5.22	4.14	3.84	1.38	0.30
Registered nurse as % nursing staff	83.4%	84.9%	89.7%		
QIS as % reg nurses	100%	75.2%	73.2%		

This is in contrast of the previous year's data where there was a shortfall in the nursing establishment of 1.65wte compared to the BAPM requirements based on acuity and activity for 2023/24.

Compliance against these standards does not however reflect further guidance as part of the NHS England service specifications for Neonatal Critical Care, the Toolkit for High Quality Neonatal Services (as part of BAPM) and recommendations from the Neonatal Nurse Association, which advises a minimum of one nursing co-ordinator per shift, which is supernumerary and additional to the staff caring for the babies on each shift. Whilst the WHH neonatal service aims to achieve this, this not always feasible due to acuity on the unit.

For units not meeting the standard, MIS guidance requires the Trust Board (and sub-committees of Board) to agree the action plan and monitor progress against any previously developed plans to address deficiencies.

A copy of the updated action plan, detailing progress against each action, is attached, there has been an additional action regarding the supernumerary shift co-ordinator.

3.3 Neonatal AHP workforce

Around 1 in 13 babies born in the UK are born early, very small or have a medical condition that requires admission to the NNU. Although advances in neonatal care have improved the survival of premature infants born at lower gestations, infants born prematurely are at risk of neurological, gastrointestinal, respiratory and cardiac problems during their neonatal course. They are also at risk of long term neurodevelopmental problems which have significant implications for the wider health economy.

AHPs play an essential role in the neonatal MDT, providing advanced, discipline specific knowledge and skills in order to optimise care and outcomes for babies and their families.

Timely and early intervention by AHPs in this complex and vulnerable population can impact on length of stay, reduces costs, improve family experiences, help to identify neonates at risk and impact longer term neurodevelopmental and other health outcomes. AHPs have a range of common core skills and professional overlap.

Alongside unique clinical skills that enable the provision of targeted pathways of care and specialised individualised care plans, they have the skill set to lead and support universal quality improvement projects such as UNICEF Baby Friendly Initiative (BFI) neonatal standards, Bliss Baby Charter and FICare as integral members of the multi-disciplinary team.

The NHS Long Term Plan, the Neonatal Critical Care Review and the Getting it Right First Time report recommend that a multidisciplinary team of Neonatal AHPs be established on the NNU. This team would consist of speech & language therapy, occupational therapy, physiotherapy and dietetics, in addition to psychology and pharmacy. Each speciality has developed specific staffing recommendations which provide a model for embedded AHP service provision as part of the wider MDT.

The NNU at WHH comprises of 2 intensive care (IC) 4 high dependency (HD) 8 Special care (SC), accordingly a full AHP team would comprise the following:

Table 2: Recommended AHP MDT v current provision

Role title	WTE Inpatient	In post	Outpatient/Clinic/follow up
Dietician	0.66	0.4	0.15 per ½ day clinic
Physiotherapy	0.7	0.2	0.15 per ½ day clinic
Occupational therapy	0.7	0	0.15 per ½ day clinic
Speech and language	0.42	0	No recommendation specified
Psychology	0.6	0	
Pharmacist	0.4	0	

As the table shows, neonatal services at WHH do not meet the requirements for AHP provision. WHH received 0.6WTE funding from NHS England following the Ockenden report. This funding was spilt initially between Dietetics and psychology provision. The psychology position has undergone two recruitment attempts and was not successfully filled; consequently, following the 2024 NNU NWNODN annual visit, its funding was reallocated to physiotherapy support based off their recommendation.

Due to the vacancies and lack of other provision, infants do not receive occupational therapy or psychology support. Infants who require speech and language input are required to attend Alder Hey children's hospital, this results in an ambulance transfer, separation from parents which impacts patient experience. These transfers put pressure on the neonatal transport service and are often delayed or cancelled due to pressures within this service. As a critical area, the NNU does receive support from Pharmacy on weekdays (Monday to Friday) however the designated hours are not included in this post.

3.4 Summary

Following completion of the neonatal nursing staffing review, medical, nursing and AHP this risk this poses has been formally documented in the CBU risk register, with appropriate mitigation measures established. Additionally, the issue was escalated and discussed with the North West Neonatal Operational Delivery Network (ODN) during their annual review on June 24, 2025, with an agreed-upon action plan under development to address the identified workforce deficiencies. The current risk rating is 15. The action plan is included in appendix 1.

Strategic People Committee are asked to note the position against safety action 4c & 4d.

4. TRANSITIONAL CARE STAFFING (MIS - SAFETY ACTION 3)

As in previous years, MIS years 7 has a clear expectation for services to provide a sustainable transitional care service within the maternity and neonatal services to minimise separation of parents and their babies.

WHH remains committed to delivering safe, high-quality care for babies on the Transitional Care (TC) pathway, while optimising the deployment of available staff resources. While the long-term aspiration remains the implementation of a dedicated TC staffing model, the service currently operates under an *in-reach model* whereby neonatal staff support the postnatal ward.

This arrangement is interim and was highlighted as a concern in the recent North West Neonatal Operational Delivery Network annual review visit on 24th June 2025, which noted the service was not fully meeting Safety Action 3 (MIS) and Neonatal critical care service specifications and were unable to provide Transitional care to 14 babies, between Jan 25-Mar 25, which equates to 86 care days.

This data excludes babies who receive IV antibiotics, if these babies were included the number of TC eligible babies who did not receive TC would rise to 49 between January and March 2025. This is a significant increase and a safety concern as these babies are not receiving the correct level of care. These babies have not previously been captured, however in BAPM Transitional Care Framework, these babies should be cared for in a TC setting.

To mitigate risks during this interim period, consistent clinical oversight is maintained through hourly rounding when on-site coverage by neonatal staff is unavailable. Additional assurance is provided via regular audits, which monitor outcomes to ensure the existing staffing model continues to meet the needs of babies on the TC pathway as per safety action 3.

To provide a 24/7 service with a band 5 staff nurse the costings are detailed below.

Enhancements	Band	WTE	Cost
	13% Band 5	2.54	£123,847.54
	34% Band 5	2.54	£147,155.85
		5.08	£271,003.39

Work is ongoing with regard to other models which could be implemented to provide a more robust TC service. Regular TC meetings take place to review and progress the action plan. Staffing levels are subject to ongoing review, and any instance where TC services are unavailable is recorded via the Datix system, enabling senior oversight and facilitating transparent reporting on the impact of staffing on TC service availability. Furthermore, access to TC pathways and the impact of staffing are considered during all Avoiding Term Admissions to NNU (ATAIN) reviews. Data

suggest the implementation of a more robust TC service would improve the service's ATAIN rates. The Trust is currently an outlier for its ATAIN rates when compared to other providers in the region.

TC staffing is included on the CBU risk register, the current risk rating is 12.

5. MIDWIFERY WORKFORCE (MIS SAFETY ACTION 5)

5.1 Background

The 2025 Birthrate Plus assessment was commenced in January 2025 and as per the established Birthrate Plus® methodology took a three months' casemix sample for the months of November and December 2024 and January 2025. This casemix data was obtained from the maternity EPR by the midwifery team with additional scrutiny provided by the Birthrate Plus consultant.

5.2 2025 assessment results - casemix

The final Birthrate Plus® report was received in March 2025. The full report is attached as appendix two. It is evident within the assessment there has been a significant increase in the complexity of women being cared for at WHH. There has been a 20.3% increase in the % of women in categories IV and V. Factors impacting upon the casemix include more co-morbidities such as diabetes, mental health, high BMI, increased induction rates usually in line with national clinical guidance, increase in operative deliveries, neonatal factors are some of the contributing reasons. The increase in acuity is evident in all maternity units within the past 4 years although the increase for WHH is in the higher %.

The change in the WHH casemix between the 2021 and 2025 reports is detailed in Table 3:

Table 3 – Casemix split 2021 v 2025

Casemix	%Cat I	%Cat II	%Cat III	%Cat IV	%Cat V
2024	1.5	8.6	19.0	32.0	38.9
	29.1%			70.9%	
2021	9.1	18.1	22.2	28.6	22.0
	49.4%			50.6%	

This intrapartum casemix is also an indicator of postnatal needs for mothers and babies with average hours being applied to the 5 categories, rather than specifically a length of stay. An adjustment is made to the %s in categories IV and V so some women are stepped down a category. As a result, the increased complexity will affect the requirements for midwifery inpatient care.

The assessment also considers the staffing requirements for 'extra care' babies. These cases are those that have a postnatal stay longer than 72hrs for either clinical or social reasons. The increase in babies that require frequent monitoring is also covered in the casemix as more hours are allocated to women in the higher categories IV and V.

Within the 2025 assessment, there were 432 women with safeguarding needs that may not have reached the threshold for formal intervention but required significant input from the community midwives, such as increased surveillance, support and signposting to other services. This would include woman with safeguarding needs, perinatal mental health, drug and alcohol dependency, who, whilst the actual labour and birth can be straightforward, their category will often be IV or V which results in more hours being allocated for the intrapartum and postnatal care. There may be adverse effects on the baby which again means additional care during the postnatal period. Additional hours are added into the community staffing to cover the work involved which will be over and above the routine ante and postnatal care.

An allowance of 24.0% uplift have been calculated for registered staff and maternity support workers, with 12.5% community travel included in the staffing figures. As with many Trusts, due to the increasing need for training and updating, some of which has arisen out of the Ockenden Report and compliance for MIS, an adequate allowance is required to fulfil the training requirements for midwives and maternity support workers.

5.3 2025 assessment results – clinical workforce

The results of the 2025 Birthrate Plus® assessment detail the total clinical midwifery workforce requirement to provide care across the maternity pathway and identify a total requirement of 131.57wte. The breakdown of this requirement is included in table 4.

Table 4: Total clinical requirement

Warrington and Halton Teaching Hospitals WTE	
Birth Suite and The Nest (core)	28.78wte RMs
Triage and Telephone Line	13.42wte RMs
C23 Maternity Ward • Antenatal activity • Postnatal activity	4.15wte RMs 28.38wte RMs and PN MSWs
Outpatient Services (Antenatal Clinics)	7.27wte RMs
Day Unit	3.24 RMs
Total for Hospital (core)	85.24wte RMs and PN MSWs
Community WTE	
Community (home births, ante and/or postnatal care, attrition and safeguarding)	16.65wte RMs and PN MSWs
Caseload Teams	29.68wte RMs.
Total Clinical WTE	131.57wte RMs and PN MSWs

This 131.57wte is comprised of 117.24wte midwives and 14.33wte MSWs. Most maternity units apply a skill mix of 90/10 so that 10% of the clinical wte are suitably qualified MSWs (Band 3s) working in postnatal services in the ward and on community.

For WHH, the current contribution has been agreed as 14.33wte comprising 7.01wte on the postnatal ward and 7.32wte in the core community. This equates to 11.2% of the current funded total clinical establishment. In addition, 4.7wte (35.6%) of specialist and management midwives wte is also allocated to the clinical total.

Applying the same methodology to the current workforce establishment shows a current clinical establishment of 127.99wte comprised as per table 5.

Table 5: Current clinical funded establishment

RMs Bands 5–7	Specialist Midwives	PN MSWs	Current Total Clinical wte
108.96	4.70	14.33	127.99

This shows an overall variance of -3.58wte between the 2025 recommended Birthrate Plus® clinical establishment and existing funded clinical establishment.

5.4 2025 assessment results – specialist/management workforce

The total clinical establishment excludes the management, and the non-clinical element of the specialist midwifery roles needed to provide maternity services. These posts are those which reflect the recommendations from national reports such as the Ockenden Report, Maternity Incentive Scheme and the manifesto produced by the RCM in August 2019 which sets out seven steps to strengthen midwifery leadership.

To reflect this specialist requirement, the Birthrate Plus® methodology applies a 12% uplift for midwifery establishment. For WHH this equates to an additional staff of 15.79wte.

The 2025 Birthrate Plus® assessment notes a current establishment of 14.50wte for these role, therefore a variance of -1.29wte, mainly within the diabetes and perinatal mental health specialisms.

5.5 Summary of results

The 2025 Birthrate Plus® assessment indicates the current baseline establishment has a total shortfall of 4.87wte when combining clinical and additional roles.

Strategic People Committee are asked to note the results of the 2025 Birthrate Plus® assessment, particularly the establishment shortfall of 4.87wte midwifery posts.

- Strategic People Committee are also asked to note the requirement within year 7 of the Maternity Incentive Scheme for Trust Board's to evidence midwifery staffing budget reflect establishment as calculated through the Birthrate Plus® evidence-based tool.
- The risk of not being able to demonstrate a safe model of midwifery staffing and the associated risk of not achieving MIS year 7 to be added to the CBU risk register.
- A risk benefit analysis be completed 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.

6. MIDWIFERY RED FLAGS

6.1 Background

A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing with associated risk to the women and babies. If a midwifery red flag event occurs, the midwife in charge of the service should be notified, who should then determine if midwifery staffing is the cause and the action needed. Monitoring staffing red flags is recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings' (2015).

NICE Midwifery Red Flags include:

- Delay in induction of labour
- Delay in administration of analgesia
- Delayed or cancelled time critical activity
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)
- Missed medication during an admission to hospital or midwifery-led unit.
- Delay of more than 30 minutes in providing pain relief
- Delay of 30 minutes or more between presentation and triage
- Full clinical examination not conducted when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process
- Delayed recognition of and action on abnormal vital signs
- Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

6.2 WHH Midwifery Red Flags

Staffing red flags across the maternity service are recorded within the SafeCare module of the health roster. Recording the midwifery red flags in SafeCare was introduced and implemented across the maternity service on 7 June 2021.

In addition to the NICE recommended criteria for midwifery red flags, WHH local red flags have been added to include:

- Delay in ongoing IOL
- Shortfall in RM time
- Birth Suite Coordinator NOT Supernumerary
- NEST Divert – Acuity
- NEST Divert – Staffing
- AMBER Alert – Acuity
- AMBER Alert – Staffing
- Red Status (Deflect)
- Homebirth Service unavailable

- Delay in review of a CTG
- Delay in Medical review in triage >30min
- Delay in triage >15mins

6.3 WHH Midwifery Red Flags reported

Red Flag Reason	Red Flags raised		
	Jan 2025	Feb 2025	Mar 2025
Delay in med review triage >30min	8	16	16
Delay in review of CTG	0	0	1
Delay in triage >15min	0	2	3
Delay in triage >30min	0	0	2
Delayed IOL	3	4	1
Delayed MEOWS	0	1	2
Delayed >30min Pain relief	0	0	0
Full clinical examination not conducted when presenting in labour.	0	0	0
Inadequate Triage	0	0	0
Missed Medication	0	0	0
Delay in administration of analgesia	0	0	0
Missed/Delayed Observation	0	0	1
Delayed recognition of and action on abnormal vital signs	0	0	0
Any occasion where 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0	0
Delay in ONGOING IOL	15	14	8
Delay of 2 hours or more between admission for induction and beginning of process	0	0	0
Shortfall in RM Time	16	42	19
Birth Suite Coordinator NOT supernumerary	3	2	2
AMBER Alert - Staffing	1	4	0
AMBER Alert - Acuity	0	0	0
IOL Handover to C23	0	1	0
Time critical activity	0	0	0
Unable to provide Transitional Care	0	0	0

Where a red flag is raised, this is escalated to the bleep holder and appropriate mitigation/support is provided to resolve the issue. There have been no harm events as a result of issues within the red flag escalation process.

3.3.1 Birth Suite Coordinator NOT Supernumerary

Monitoring of Safe Staffing levels is a requirement of the NHSLA Maternity Incentive Scheme for Safety Action 5.

The midwifery coordinator in charge of Birth Suite has supernumerary status (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.

Within safety Action 5 the requirement is that a supernumerary coordinator must be allocated for every shift and must start each shift with protected supernumerary status.

It is accepted that there may be short periods when the coordinator is temporarily unavailable due to rapidly changing acuity on the labour ward/Birth Suite to ensure safety for women, families and staff in the department. The co-ordinator should exercise professional judgement and escalate, if covering for breaks creates a safety risk to other women on labour ward/Birth Suite.

As long as there is clear evidence that the local escalation policy has been initiated in these circumstances, and this is not a recurrent daily event, Trusts may declare compliance with this standard.

The Birthrate Plus® acuity tool is used to monitor the supernumerary status of the Birth Suite Coordinator every 4 hours. If there is an occasion when the Birth Suite Coordinator does not have supernumerary status this is escalated to the Matron and mitigating action is taken to address the issue.

In the period 1st January 2025 – 31st March 2025 there were no occasions where a Birth Suite coordinator was not allocated at the beginning of the shift. There are 5 episodes recorded in BR+ where the Birth Suite Coordinator is NOT supernumerary. These were all for short periods and the escalation policy was initiated.

- 4th January - Caring for IOL bay - 0.35 BR+- high acuity – coordinator supporting induction of labour bay for two hours. Amber escalation enacted and relief provided.
- 7th January - for short period due to late notice sickness absence/adverse weather conditions – amber escalation enacted whilst cover identified. Coordinator not providing 1:1 care in labour.
- 8th January – Providing oversight to woman undergoing ECV.
- 6th February - Coordinator supporting induction of labour for short period at handover whilst staff redeployed to support.
- 29th March – Coordinator supporting Butterfly Suite

6.3.2 One-to-one care and support to a woman during established labour

If there is an occasion where a woman in active labour is NOT receiving one-to-one care the Birth Suite Coordinator will escalate to the Maternity Bleep Holder and

mitigating action is taken to address the issue. A red flag is recorded on SafeCare. In the period 1st January 2025 – 31st March 2025 there were 0 episodes recorded in SafeCare where a woman in active labour is **NOT** receiving one-to-one care.

7. MIDWIFERY WORKFORCE METRICS

7.1 Vacancy rate

The vacancy rate for registered staff as at 31st May 2025 is 2.41%, below the Trust target of 9%.



7.2 Retention rate

Midwifery retention rates have deteriorated in the five months of 2025 and at the end of May 2025 are above the Trust target at 13.92%. Some of this increase is due to retirement but there have also been resignations due to dissatisfaction. Exit interviews have been completed and a deep dive to explore this further is underway, the findings of which will report to SPC in August 2025.



7.3 Sickness absence

Sickness rates for May 2025 for registered midwifery staff were 9.9% The rolling 12 month rate is 9.22%, significantly above the Trust target albeit an improvement from the position in January 2025 when the rate was 11.69%.

Top five reasons for sickness absence in the last 12 months for registered midwifery staff are as follows:

- Anxiety/stress depression – 19.58%
- Gastrointestinal problems – 14.09%
- Other causes – 12.14%
- Musculoskeletal – 10.21%
- Benign and malignant tumours/cancer – 7.04%

As at 31st May 2025, seven registered staff were absent on a long term basis. Reasons for absence are not work related and relate to diagnosis of cancer, musculoskeletal injuries, pregnancy complications, chronic health condition and bereavement. Proactive absence management is in place. A wider deep dive of midwifery sickness absence to provide assurance is underway led by the Deputy Director of Midwifery with the support of workforce/HR colleagues.

8. RECOMMENDATIONS

Members of the Strategic People Committee are requested to receive and discuss the findings of this paper for information and to share with Trust Board.

QUALITY ASSURANCE COMMITTEE

Maternity Service - Review of harm events – September 2024-February 2025

Ailsa Gaskill-Jones – Director of Midwifery

Lisa Davies – CBU Governance Quality Lead



Working
Together



Excellence



Inclusive



Kind



Embracing
Change

Grading of harm – Context

- Changes in the way providers record patient safety through guidance published in August 2023 as part of the implementation of the learning from patient safety events framework (LFPSE)
- This includes assessing the degree of harm which relates to the actual impact on a patient from the particular incident being reported.
- This builds on the previous assessment guidance in the National Reporting and Learning System (NRLS) and maintains the principle.
- Patient safety incident harm definitions should always be applied based on the best information about the actual impact of the incident at the time of recording.
- The new addition in the policy guidance in relation to patient safety incident data in the LFPSE service relates to specific capture of information on psychological harm.
- Previously in the NHS, harm grading included psychological harm as well as physical harm within one measure, in the new guidance and reporting these are now split out into two separate measures.

New physical harm grades	New psychological harm grades
No physical harm	No psychological harm
Low physical harm	Low psychological harm
Moderate physical harm	Moderate psychological harm
Severe physical harm	Severe psychological harm
Fatal	n/a



Grading of physical harm

No physical harm

No physical harm

Low physical harm is when **all of the following** apply:

- minimal harm occurred – patient(s) required extra observation or minor treatment.
- did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit.
- did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication.
- did not or is unlikely to affect that patient's independence.
- did not or is unlikely to affect the success of treatment for existing health conditions.

Moderate physical harm is when **at least one** of the following apply:

- has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention
- has limited or is likely to limit the patient's independence, but for less than 6 months
- has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm.

Severe harm is when **at least one** of the following apply:

- permanent harm/permanent alteration of the physiology
- needed immediate life-saving clinical intervention
- is likely to have reduced the patient's life expectancy
- needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment
- has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions
- has limited or is likely to limit the patient's independence for 6 months or more.

Fatal (previously documented as 'Death' in NRLS)

- You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death, including stillbirth or pregnancy loss. You will have the option later to estimate to what extent it is considered a patient safety incident contributed to the death.



Grading of psychological harm

No psychological harm

- No specific psychological harm that meets the description of 'low psychological harm' or worse. Pain should be recorded under physical harm rather than psychological harm.

Low psychological harm is when **at least one** of the following apply:

- distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit
- distress that did not or is unlikely to affect the patient's normal activities for more than a few days
- distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition

Moderate psychological harm is when **at least one** of the following apply:

- distress that did or is likely to need a course of treatment that extends for less than six months
- distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months

Severe psychological harm is when **at least one** of the following apply:

- distress that did or is likely to need a course of treatment that continues for more than six months
- distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months



WHH harm events Sept 24-Feb 25

Harm	LFPSE grading	WHH position	Assurance pathway
Neonatal mortality (refers to the number of babies which have died within the first 28 days of life)	Fatal	➤ WHH Neonatal mortality rate Q4 23/24-Q3 24/25 0.4 per 1000 live births. ➤ Office for National Statistics rate for England in 2023 was 3.0 per 1000 births.	➤ All moderate/severe/fatal harms reported as part of monthly QAC Quality & Safety paper ➤ All cases reported to MBRRACE ➤ Select criteria referred to MNSI for investigation (>37weeks following labour and died within the first 7 days) ➤ Comparator rates and learning from cases reported via quarterly PMRT to QAC and Board
Intrauterine death (>24 weeks gestation)	Moderate	➤ WHH stillbirth rate rolling year Q4 2023/24-Q3 2024/25 is 2.41 per 1000 births. ➤ The Office for National Statistics rate for England in 2023 was 4.0 per 1000 births	➤ All moderate harms reported as part of monthly QAC Quality & Safety paper ➤ All cases reported to MBRRACE ➤ Intrapartum Term stillbirths referred to MNSI for investigation ➤ Comparator rates and learning from cases reported via quarterly PMRT to QAC and Board

MBRRACE-UK PERINATAL MORTALITY REPORT: 2023 BIRTHS

Metric	Recommendation	Progress
WHH stabilised & adjusted Neonatal mortality rate excluding deaths due to congenital anomalies is 0.73 per 1,000 live births. This is more than 5% higher than the average for similar Trusts & Health Boards.	The service should carry out an initial investigation of their data quality and possible contributing local factors that might explain the high rate.	➤ 4 cases in total ➤ 2 cases – poor prognosis in antenatal period ➤ 2 cases undergoing further review



WHH harm events Sept 24-Feb 25

Harm	LFPSE grading	WHH position	Assurance pathway
Babies transferred for cooling	Moderate	➤ 1 case Sept 24-Feb 25 ➤ 0.08% all births ➤ Improved position (0.2% of birth Sept 23-Aug 24)	➤ All moderate harms reported as part of monthly QAC Quality & Safety paper ➤ Intrapartum cases referred to MNSI for investigation ➤ Overview of MNSI referrals/investigations shared monthly to QAC and Board ➤ Annual review of MNSI to QAC
Dropped baby	Case dependent	➤ No cases Sept 24-Feb 25 ➤ Improved position. 1 case Sept 23- August 24	➤ All moderate/severe/fatal harms reported as part of monthly QAC Quality & Safety paper
Term admission to Neonatal Unit	Unavoidable - No harm Avoidable – Low harm	➤ 56 cases Sept 24-Feb 25 ➤ Improvement noted via ODN dashboard ➤ Q2 24/25 7.9%, Q3 24/25 6.2%	➤ Not meeting national/regional targets ➤ Quarterly reporting of position to QAC ➤ Action plan in place
Neonatal birth trauma	Case dependent	➤ 0 cases Sept 24-Feb 25 ➤ Improved position. 2 cases Sept 23-Aug 24	➤ All moderate/severe harms reported as part of monthly QAC Quality & Safety paper

WHH harm events Sept 24-Feb 25

Harm	LFPSE grading	WHH position	Assurance pathway
3 rd & 4 th degree tears	Moderate	➤ 29 cases Sept 24-Feb 25 ➤ 24 per 1000 births ➤ C&M rate 23 per 1000 births	➤ All moderate harms reported as part of monthly QAC Quality & Safety paper
PPH >1500mls	Low – occasionally moderate	➤ 50 cases Sept 24-Feb 25 ➤ All low harm ➤ 41.7 per 1000 births ➤ C&M 38 per 1000 births	➤ All moderate harms reported as part of monthly QAC Quality & Safety paper ➤ PPH workstream standing item within monthly QAC Quality & Safety paper
Maternal VTE	Low – occasionally moderate	➤ No cases Sept 24-Feb 25 ➤ Improvement noted Two cases Sept 23- Aug 24	➤ All moderate harms reported as part of monthly QAC Quality & Safety paper
Pressure Ulcer	Case dependent	➤ No cases Sept 24-Feb 25 ➤ Improvement noted - 5 cases Sept 23- August 24	➤ All moderate/severe harms reported as part of monthly QAC Quality & Safety paper
Maternity - Transfer to ITU	Moderate	➤ 1 case Sept 24-Feb 25 – moderate harm ➤ 0.08% all births	➤ All moderate/severe harms reported as part of monthly QAC Quality & Safety paper
Gynaecological interventions	Case dependent	➤ No cases Sept 24-Feb 25 ➤ Improved position. 1 case Sept 23-Aug 24	➤ All moderate/severe/fatal harms reported as part of monthly QAC Quality & Safety paper

QUALITY ASSURANCE COMMITTEE

DEEP DIVE: Maternity CTG (fetal surveillance) 08.07.2025

Ailsa Gaskill-Jones – Director of Midwifery



Working
Together



Excellence



Inclusive



Kind



Embracing
Change

Background

- CTG refers to Cardiotocography, and is used during pregnancy and labour to monitor the fetal heart rate and uterine contractions assessing the well-being of the fetus
- CTG is recommended for women with high-risk pregnancies, such as those with medical conditions, obstetric complications, or multiple pregnancies and for those undergoing induction
- Estimated in the UK, around 60% of term labours are continuously monitored using CTG reflecting current clinical practice where CTG is widely used to guide labour management, especially in cases with identified risk factors for fetal compromise
- Fetal surveillance is a key workstream within the Maternity Incentive Scheme through the Saving Babies Lives care bundle



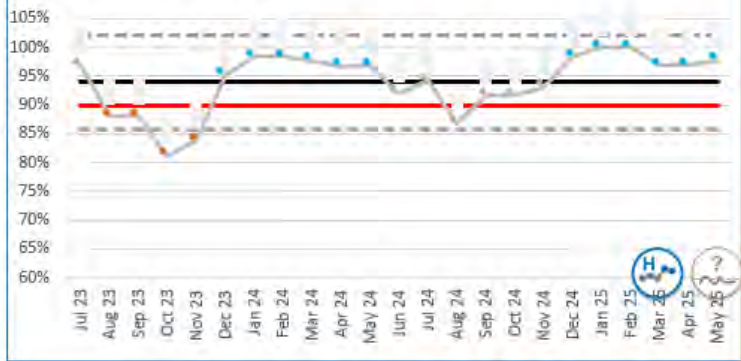
Position

- There is no comparator data in relation to CTG
- There is comparator data for Hypoxic Ischaemic Encephalopathy diagnosis and babies for cooling, but not all of these babies will have been monitored via CTG
- Cases of babies transferred for cooling are reported to MNSI who will complete an investigate and share learning
- Within the Saving Babies Lives care bundle there are standards in relation to:
 - Hourly peer review of CTG (has been removed for year 7 of MIS)
 - CTG training compliance
 - CTG competencies compliance

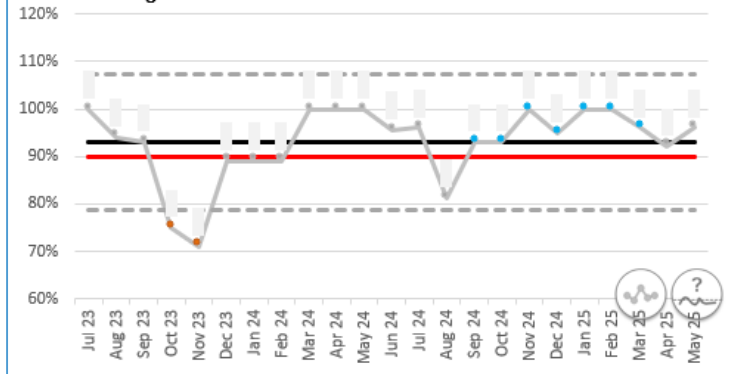


Position – Saving Babies Lives

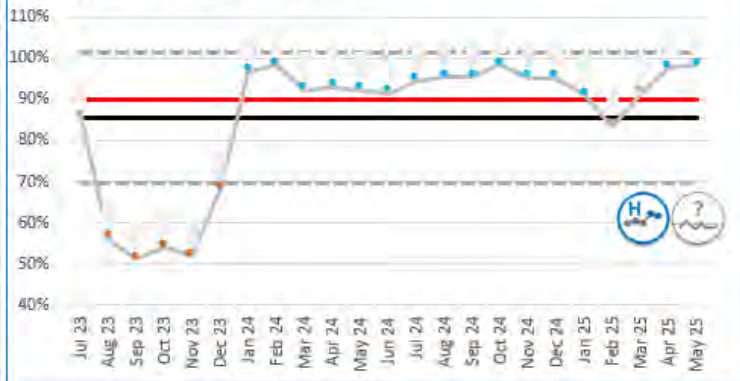
1. CTG Training - Midwives



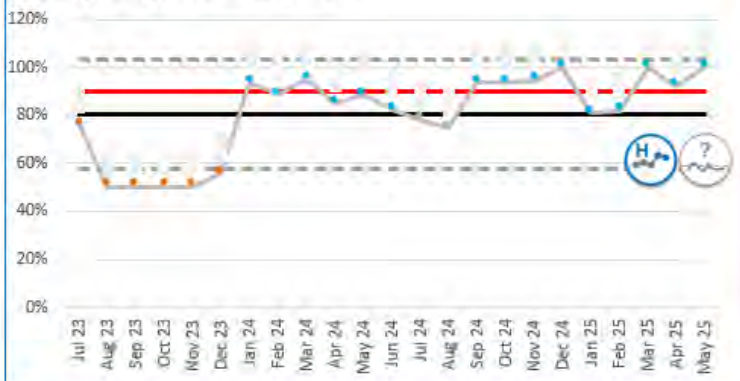
2. CTG Training - Doctors



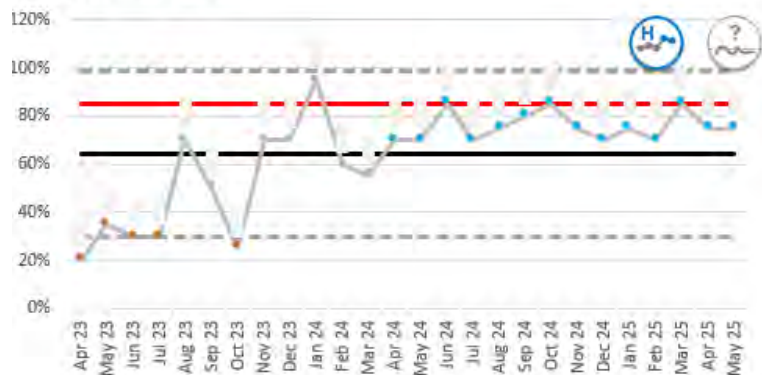
4. Competency Assessment - Midwives



5. Competency Assessment - Doctors



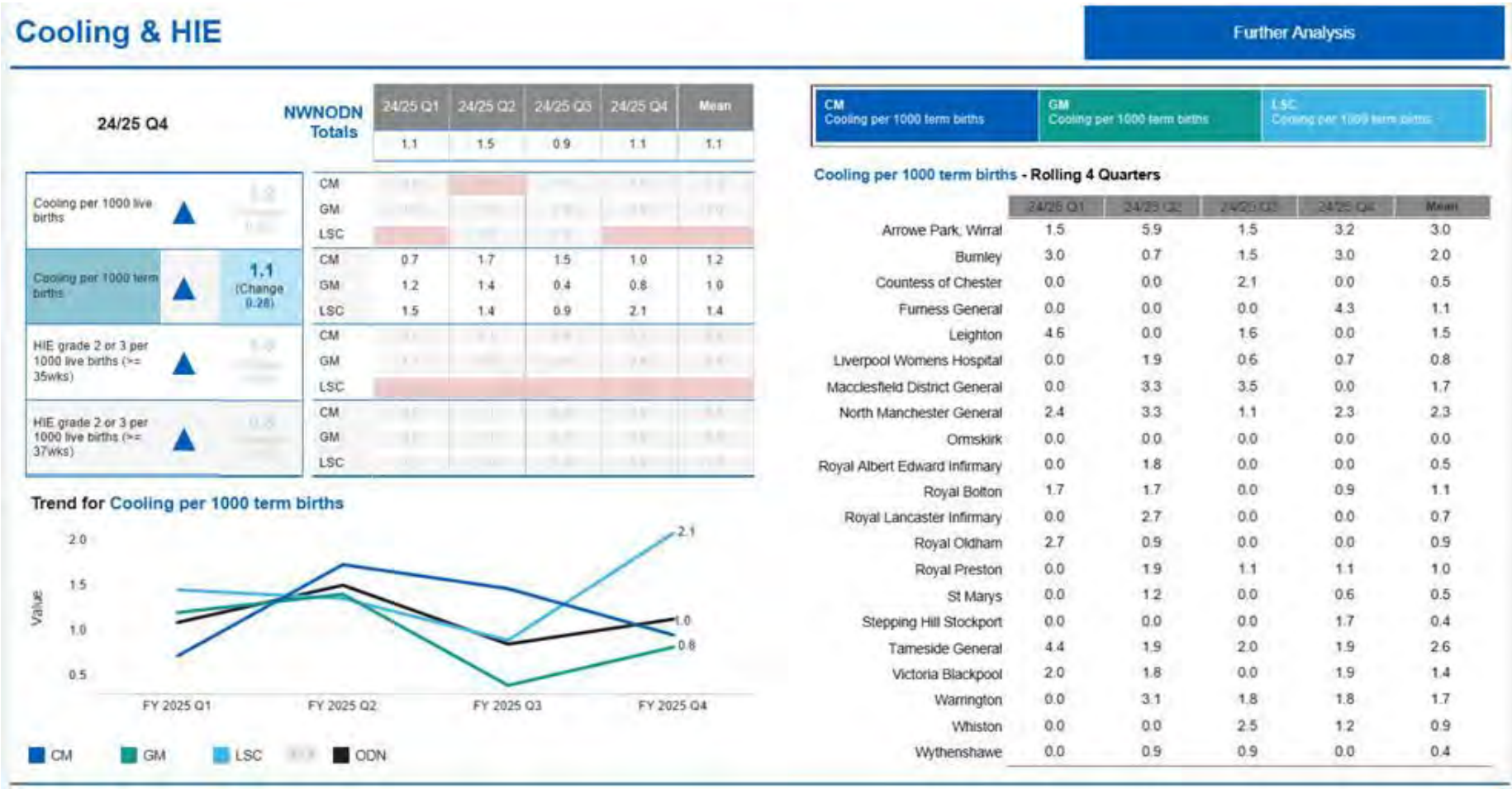
12. Peer review - CTG



Neonatal ODN feedback



Warrington and Halton
Teaching Hospitals
NHS Foundation Trust



- WHH – mean 1.7/1000 births
- ODN 1.0/1000 births
- Improved WHH position from Q2 24/25
- Not flagged as an outlier

MNSI recommendations:



*Based on the year of report publication. The number of top recommendations listed may vary depending on their frequency.

**2025/26 is not a full financial year (Apr-Mar).

Workstreams



**Warrington and Halton
Teaching Hospitals**
NHS Foundation Trust

Fetal surveillance

- MDT in place
- Fetal surveillance working group
- Weekly C-shop now re-established alongside opportunities for individual case review
- Monthly newsletter to the team
- Focussed work to improve position in relation hourly peer review of CTGs
- Review of training packages

Escalation

- Previously implemented the RCOG escalation toolkit
- Recognised this work not embedded
- New escalation QI project now initiated to review and refresh





**Warrington and Halton
Teaching Hospitals**
NHS Foundation Trust

**Any
questions**



REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/25/08/66																																						
SUBJECT:	Trust Mortality (SHMI) Analysis																																						
DATE OF MEETING:	6 August 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):																																							
LINK TO PUBLIC SECTOR EQUALITY DUTIES	<i>Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</i> <table border="1"> <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> </table> <table border="1"> <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> </table> <table border="1"> <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>			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:			
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):	Trust SHMI has demonstrated an increasing trend which has now stabilised (remaining in the expected range throughout) This paper explores the reasons for this and seeks to provide assurance with regards to the Trusts management of mortality data and its response when outlying mortality data is identified. A change in coding to Type 5 ED activity is identified as the cause for a rise in SHMI.																																						

PURPOSE: <i>(please select as appropriate)</i>	Approval	To note ✓	Decision
RECOMMENDATION:	Trust Board is asked to note the contents of this report and receive assurance that: 1. Trust SHMI remains within expected limits and is not an outlier 2. An increase in SHMI seen in the 12 months to April 2024 is due to a change to Type 5 activity coding rather than an increased risk of death in the organization. SHMI has now stabilised at a new baseline following this coding change – remaining within expected limits 3. The higher-than-expected Diagnosis Group SHMI for Acute Cerebrovascular Disease has been investigated with patient level mortality reviews and is driven by Stroke case-mix 4. The higher-than-expected Diagnosis Group SHMI for Fluid and Electrolyte Disorders is currently under investigation using the same methodology 5. In terms of non-SHMI mortality indicators – National Hip Fracture Database data has identified hip fracture mortality as a concern. Analysis and action plan to be presented to July 2025 QAC as a Deep Dive.		
PREVIOUSLY CONSIDERED BY:	Committee	Quality Assurance Committee	
	Agenda Ref.		
	Date of meeting	8/7/2025	
	Summary of Outcome	Proceed to Board for Assurance	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: <i>(if relevant)</i>	Choose an item.		

REPORT TO BOARD OF DIRECTORS

SUBJECT	SHMI ANALYSIS	AGENDA REF:	BM/25/08/66

1. BACKGROUND/CONTEXT

Trust SHMI has demonstrated an increasing trend which has now stabilised.

This paper explores the reasons for this and seeks to provide assurance with regards to the Trust's management of mortality data and its response when mortality alerts are received or outlying mortality data is identified.

2. KEY ELEMENTS

2.1 HIGH LEVEL SHMI SUMMARY – May HED Data

The NHS England (NHSE) SHMI for Warrington is 104.54 (January 2024 - December 2024). This result is in band 2, which means it is **as expected** using an over-dispersed funnel plot.

The Healthcare Evaluation Data (HED) HES SHMI for Warrington is 104.51 (February 2024 - January 2025).

This result is not an outlier using an over-dispersed funnel plot and **is not an outlier** based on the stricter Poisson method.

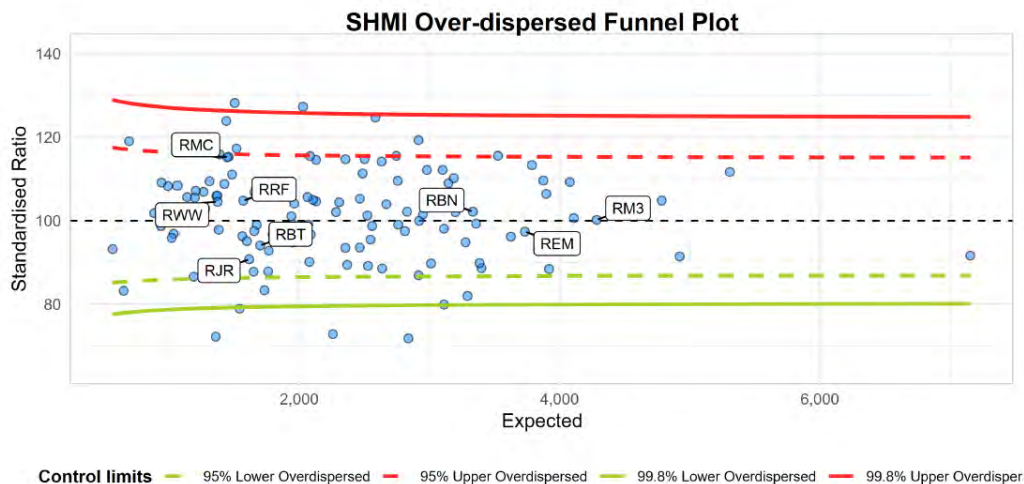
Additional SHMI variants calculated by HED using separate models are (for the period February 2024 - January 2025):

- In-Hospital SHMI is 105.25.
- Out-of-Hospital SHMI is 102.71.
- SHMI allowing for palliative care coding is 98.49.

Peer Comparison - SHMI Funnel Plot

HED has given the trust a green rating for this indicator with a SHMI value of 104.51 based on data spanning the 12 months leading up to and including January 2025.

This result is within expected levels based on 95% over-dispersed funnel plot limits:

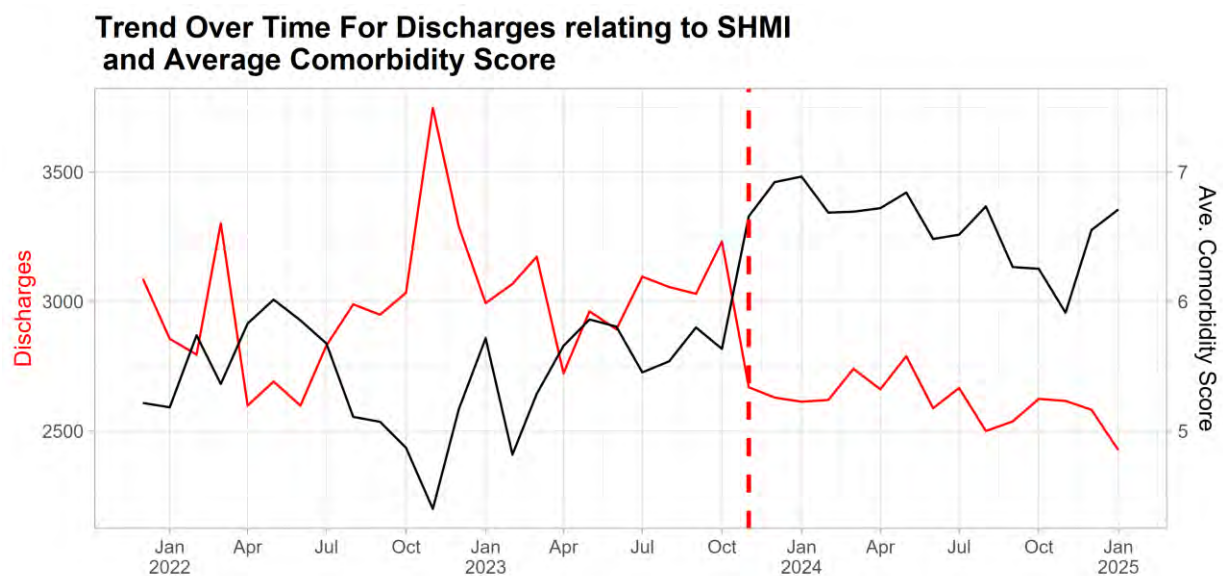


2.2 TRUST SHMI TRENDS

Warrington began including Short Day Emergency Care (SDEC) data in the Emergency Care Data Set (ECDS) as a Type 5 ED attendance instead of the Inpatient Data Set – Non-Elective Short Stay (NES) in November 2023. Subsequently other assessment areas have been added to Type 5 reporting.

This removal of low mortality risk patients from the SHMI data set would be expected to reduce the number of spells per month but raise the average comorbidity score.

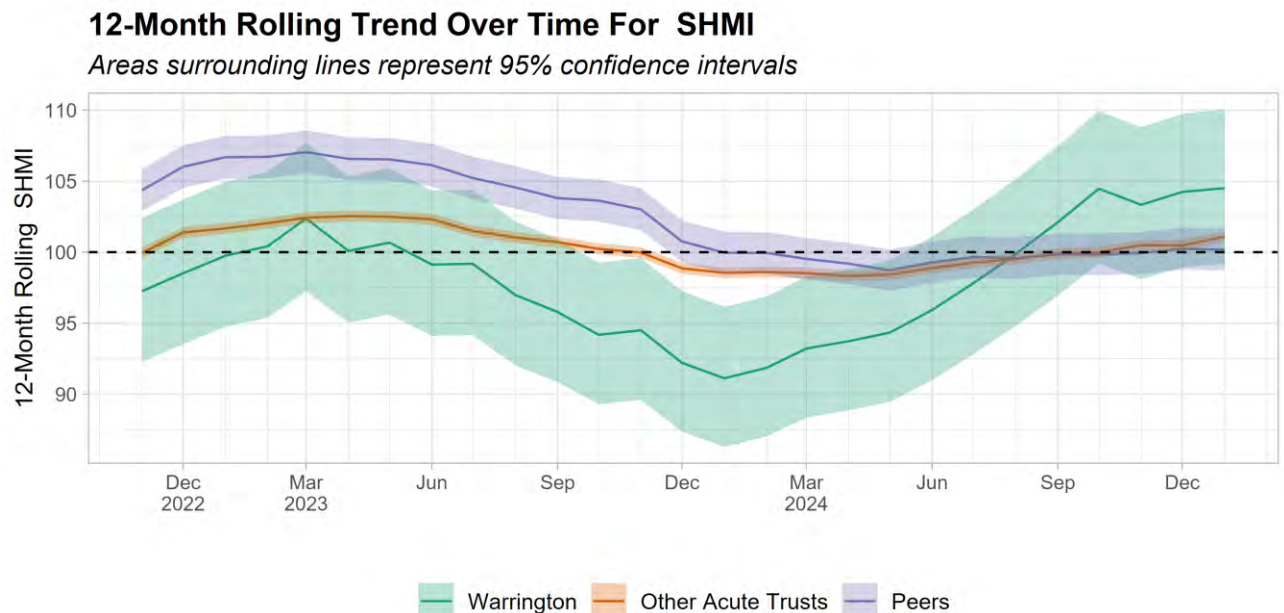
There is now sufficient data to see a clear and sustained change in these metrics in line with that expectation beginning in November 2023:



This change in coding has resulted in a higher SHMI value for the Trusts as:

1. Large numbers of low risk and low complexity admissions have been removed from the SHMI denominator
2. Though Trusts have been expected to submit SDEC to ECDS using version 3 since July 2024, many are not yet achieving this, and so coding inconsistencies between Trusts continue to further compound the effects of type 5 reporting on SHMI. The national deadline for reporting SDEC as ECDS activity using ECDS version 4 was initially July 2024 but has been delayed to July 2025.

The impact of these changes is apparent in the Trust's 12 month rolling trend for SHMI:



SHMI begins to increase from January 2024 as increasing volumes of activity are coded as Type 5

This increase continues as pre-type 5 recording months drop out of the 12 month rolling dataset, before stabilising at a new higher baseline in October 2024 as the dataset moves to only contain mortality data from the post-Type 5 implementation period.

The changes in SHMI that have been observed have been driven by a move to Type 5 coding (rather than an increased risk of death in the organisation) and compounded by other Trusts not adopting this mandated reporting standard in a timely fashion.

Throughout Trust SHMI has remained within the expected range

2.3 KEY DIAGNOSIS GROUPS WITH A HIGHER SHMI THAN PREDICTED

To further provide assurance with regards to mortality in the Trust, the Mortality Review Group as part of its mortality surveillance function reviews SHMI diagnosis groups with a higher-than-expected SHMI, there are 144 SHMI diagnosis groups used within the SHMI definition.

In the last 12 months, 2 diagnosis groups have been identified with a higher-than-expected SHMI which falls outside an over-dispersed poisson funnel plot (95% limit):

Key Diagnosis Groups with a higher than predicted SHMI using the last 12 months data			
SHMI Diagnosis Group	Observed Deaths	Expected Deaths	SHMI
37: Fluid and electrolyte disorders	37	21.03	175.96
66: Acute cerebrovascular disease	55	36.30	151.50

Acute Cerebrovascular Disease

Following identification of SHMI Diagnosis Group 66: Acute Cerebrovascular Disease as an outlier the Mortality Review Group has undertaken a deep dive case level clinical review of this cohort of patients.

This process reviewed all patients in this diagnosis group who died in January 2024 (the month with the greatest number of observed deaths) and undertook a Structured Judgement Review on each.

The output of this review is contained in appendix 1.

The SJR process concluded that 8 of the 9 patients received good care, with the remaining patient receiving adequate care.

The review concluded that the higher-than-expected SHMI for this diagnosis group at WHH was very likely to be driven by case mix:

- WHH does not have an acute stroke service, thus low risk, low severity patients who present with Stroke are not included in its case mix
- WHH repatriates patients from the acute stroke unit who have had more severe strokes and are often frailer – this case mix is at higher risk of death
- The Stroke patients that WHH does directly admit are generally those with catastrophic strokes, for supportive care, with high risk of death

Fluid and Electrolyte Disorders

More recently SHMI Diagnosis Group 37 Fluid and Electrolyte Disorders has been identified as a SHMI outlier.

This diagnosis group consists of a single CCS group consists of a single CCS group:

CSS 55 - Fluid and electrolyte disorders

Which contains a heterogenous group of fluid and electrolyte disorders with many causes, these disorders include:

Volume depletion / dehydration
 Hypernatraemia
 Hyponatraemia
 Metabolic acidosis
 Hyperkalaemia
 Hypokalaemia
 Fluid overload

A Clinical Coding Service, Mortality Review Group Coding Review of coding associated with the group has been undertaken, reporting in June 2025. This is not shared here as it contains patient identifiable data.

This review has demonstrated that the Group 37 conditions in each case were varied, unrelated and often associated with significant comorbidity. No major Clinical Coding concerns were identified

The Mortality Review Group will now undertake a focused clinical case review and report this to PSCEC.

2.4 OTHER NON SHMI MORTALITY INDICATORS OF CONCERN

On the 21st May 2025 the Trust received a mortality alert from the National Hip Fracture Database as Case mix adjusted and crude mortality for #NOF have moved out of predicted range in the reporting quarter Q4 2024/25 and are above the 95% control limit.

Latest data reported (Q1 2025) shows 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

Analysis and plan has been presented to QAC in July 2025 as a Deep Dive.

3. MONITORING AND REPORTING ROUTES

Mortality statistics will continue to be monitored and interrogated by the Mortality Review Group which reports to PSCEC monthly, with subsequent escalation to QAC as required.

SHMI will remain a key metric reported to the Board in the IPR

4. RECOMMENDATIONS

Trust Board is asked to:

QAC is asked to note the contents of this report and receive assurance that:

1. Trust SHMI remains within expected limits and is not an outlier
2. An increase in SHMI seen in the 12 months to April 2024 is due to a change to Type 5 activity coding rather than an increased risk of death in the organization and has now stabilised at a new baseline – remaining within expected limits
3. The higher-than-expected Diagnosis Group SHMI for Acute Cerebrovascular Disease has been investigated with patient level mortality reviews and is driven by Stroke case-mix
4. The higher-than-expected Diagnosis Group SHMI for Fluid and Electrolyte Disorders is currently under investigation using the same methodology
5. In terms of non-SHMI mortality indicators – National Hip Fracture Database data has identified hip fracture mortality as a concern in Q4 2024/25, mortality has improved in Q1 2025/26. Analysis and action plan has been presented to July 2025 QAC as a Deep Dive, and will return monthly.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/25/08/67																																						
SUBJECT:	Communications and Engagement Update (bi monthly) May to June 2025																																						
DATE OF MEETING:	6 August 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	<i>Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</i> <table border="1"> <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> </table> <table border="1"> <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> </table> <table border="1"> <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>			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:			
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 May to June 2025. Please note this report is now covering a two-month period (rather than quarterly) to ensure alignment of communications and engagement activity reporting with the Board meeting cycle. It incorporates reporting on the Working with People and Communities Strategy and elements of the previous Communications and Engagement Dashboard into one report. The report consists of:																																						

	• Overview of communications and engagement activity from May and June 2025 • Updates on Experts by Experience activity and involvement • Key communications campaigns and highlights from the period • Working with People and Communities Strategy May to June 2025 update Details of the current plan of upcoming engagement events which the Trust is hosting or planning to attend during 2025		
PURPOSE: <i>(please select as appropriate)</i>	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of this update on Communications and Engagement activity during the quarter.		
PREVIOUSLY CONSIDERED BY:	Committee	n/a	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: <i>(if relevant)</i>	None		

Communications and engagement update

Bi-monthly report (May to June 2025)

Trust Board

6 August 2025



Working
Together



Excellence



Inclusive



Kind



Embracing
Change

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 (May to June 2025) the Communications and Engagement Team...

- processed and allocated **28** communications 'job requests' for design, film, photography and communications campaign support
 - issued **7** Trust media releases (plus **1** WHH Charity media release and contributed to **1** Warrington and Vale Royal College media release)
 - published **19** stories across our main Trust website, charity website and breast screening services website
 - prepared / issued **2** media statements
 - handled **2** enquiries from local, regional and national print and broadcast media
- 

May / June activity and achievements overview

- Supported communication and public engagement to name the new Runcorn Health and Education Hub (due to open early 2026)
- Celebrated WHH's annual Thank You Awards 2024-25
- Continued to create content, success stories and case studies, for various communications channels around the Better Care Together integration programme. Progressed work to bring more communications channels together, with ongoing joint good morning messages and monthly Team Brief
- Celebrated Volunteers Week 2025 (1 to 7 June) with a press release and social media feature
- Provided communications coverage (internal and external) for the new AI dermatology service at Halton Health Hub
- Supported the opening of the new Warrington and Halton Diagnostics Centre at Halton Hospital, an £11 million project - part of a three-phase £16 million Community Diagnostic Centre (CDC) programme
- Re-launched the Trust-wide roll out of Martha's Rule and the Call for Concern service
- Continued to work on improving accessibility of the Trust website in response to a Government Digital Service audit



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

Media

Media releases issued during May and June 2025, including:



AI technology to speed up diagnosis of skin cancer in Warrington

[Read the release](#)



Vital estates funding awarded to Warrington and Halton Teaching Hospitals

[Read the release](#)



Online portal transforms patient experience at Warrington and Halton Teaching Hospitals

[Read the release](#)



WHH patch party spreads joy to young patients with sight condition

[Read the release](#)

All media releases / news items can be viewed on our [website](#).

Production of Patient Information (PINFO)

From May to June the Communications and Engagement Team:

- Supported clinical teams in putting **4** new leaflets through the PINFO process
- Reviewed and edited **8** existing leaflets to ensure content remains clinically appropriate and reflects WHH style guidelines
- Identified a total of **127** expired leaflets
- Archived **11** leaflets
- Introduced more frequent reminder email to authors and CBUs about expired leaflets (increasing frequency from quarterly to bi-monthly)



4. Communication tactics

Help yourself

- **Be open** – tell people about your hearing loss. Ask them to get your attention before speaking.
- **Be observant** – watch for facial expressions, lip patterns and hand gestures. These all give clues to the conversation.
- **Be positive** – don't be afraid to ask the speaker to repeat themselves.

Hints and tips for friends and family

Minimise background noise	Attract attention before speaking
Speak clearly and not too fast	Face the person, be sure your mouth is visible
Get to the point. Make sure the topic of conversation is clear	Include people. Tell them what you are talking about or laughing about.
Speak one at a time	Be patient
Repeat, rephrase, or write it down	Remember: communication is a two-way responsibility

5. The environment

- **Lighting** – Make sure the speaker's face is well lit.
- **Furnishings** – Soft furnishings reduce echo, for example using tablecloths and mats can reduce cutlery / crockery noise.
- **Position** – Always try to minimise background noise:
 - Sit with your back to the noise, if possible, as this will enable the hearing aid's rear microphones to minimise these unwanted sounds.
 - Turn off the radio / television
 - The ideal distance is three to six feet. Your hearing aid(s) only have a small microphone, so the closer you are to the sound you are listening to, the better.

Engagement, involvement and insight

From May to June 2025 we recruited 15 Experts by Experience (EbyEs)

We received requests for engagement support for the following projects:

- Conversation cafes – to improve communication with patients
- WHH Charity website user testing
- Health literacy cardio-respiratory pilot - appointment letters and digital apps review
- Review of pulse advertising campaign materials for maternity products
- Runcorn Health and Education Hub naming survey
- Dying Matters awareness session



Experts by Experience (EbyE) projects

Project name	Overview	No of EbyEs req	Outcomes
Health literacy – cardio respiratory letters and digital apps review	Request for EbyE involvement in a review of vaccination invitation and appointment letters and digital apps (within ORCHA health app library)	6	6 EbyEs recruited to take part in a Task and Finish Group - Contact info shared with project leads
Pulse advertising campaigns – maternity	Request for EbyE feedback on two potential Pulse advertising campaigns (associated with maternity products)	2	2 EbyEs provided feedback on campaign materials - Feedback shared with project leads - Campaign declined
Dying Matters awareness session	Request for EbyE participation within a Lunch and Listen session on death, dying and bereavement, hosted by Halton and Warrington Dying Matters Group	9	6 EbyEs recruited (plus 3 staff EbyEs) to join a virtual Lunch and Listen session on 7 May 2025 - Positive feedback overall - participants felt the session helped them be more mindful about end-of-life planning

Experts by Experience (EbyE) projects

Project name	Overview	No of EbyEs req	Outcomes
Runcorn Health and Education Hub naming survey	Request for EbyE participation in survey to inform the name of Runcorn Health and Education Hub	N/A	213 survey responses received (EbyE participation not recorded) - Chosen name: WELL Runcorn (Wellbeing, Education, Lifelong-Learning)
WHH Charity website user testing	Request for EbyE involvement in user testing and information finding tasks on new website	9 (14 recruited)	9 EbyEs participated in user testing 100% positive feedback - Site launched 10 July 2025
Patient communication skills – Physiotherapy	Request for EbyE workshop involvement with physiotherapy degree students to develop patient communication skills	5	TBC - recruitment ongoing

Local / national campaigns shared with EbyEs: 4

- University of Chester: Motherhood ADHD study
- NHS C&M consultation: Proposed changes to fertility treatment policies
- Redeveloping the 2025 Cancer Patient Experience Survey
- 2025 Adult Inpatient Survey focus groups



**Warrington and Halton
Teaching Hospitals**

NHS Foundation Trust

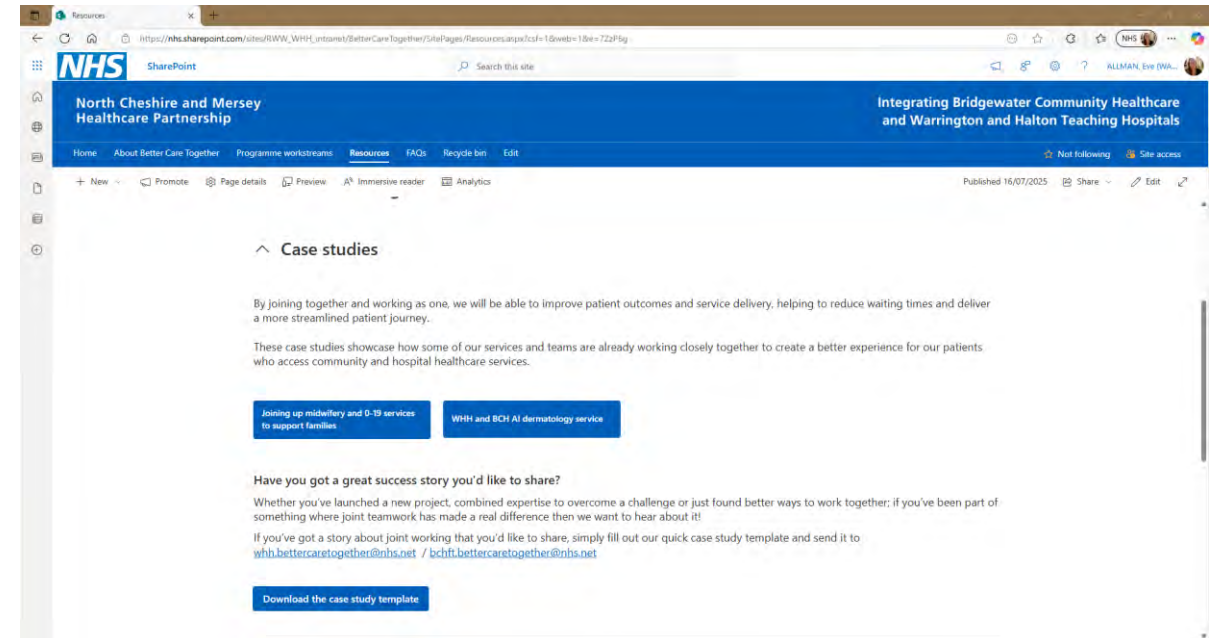


Key campaigns / highlights from May to June 2025

Better Care Together – integration update



- Created content for our staff engagement sessions including spotlight sessions and success stories.
- Published a new case study section on the Better Care Together microsite – featuring joint working on the AI Dermatology service and between midwifery and 0-19 services, with more joint working case studies to follow.
- Progressed work to bring more of our communications channels together including the development of a new external patient facing microsite and plan for internal digital channels.
- Continued to deliver joint good morning messages and a monthly Team Brief for WHH and Bridgewater colleagues.
- Communications and Engagement Delivery Group continues to meet monthly.



Better Care Together – public feedback



During summer engagement events, we asked the public to share their thoughts on the coming together of WHH and Bridgewater into a single Trust. Key themes from this feedback include:

What does integration mean to you?

- Improved convenience and accessibility
- Better communication and coordination
- Enhanced service efficiency and quality

How do you think care could be better provided closer to home?

- Central locations for multiple services
- More venue choice and provision
- Local venues with adequate parking / public transport links

What do you hope coming together will achieve?

- Operational improvements
- Improved patient experience
- Reduced waiting times
- Reduced travel time, costs and parking

Feedback also highlighted concerns around:

- Resources and funding limitations
- Staffing levels / workload pressures
- Implementation challenges

Overall, responses from both staff and the public are overwhelmingly positive, however, there are concerns about implementation, particularly around staffing and accessibility. Feedback suggests that though respondents understand potential benefits, they want assurance that the integration programme will be properly resourced and managed.

WHH Thank You Awards

Our annual staff awards ceremony was held at the Titanic Hotel, Liverpool on 16 May 2025.

- Over 300 guests (including sponsors) were in attendance
- 10 sponsors were secured
- £2,292 was raised on the night for WHH Charity
- Internal communications were shared via Team Brief, The Week and GMWHH
- Social media content shared pre / during / post event
- The team were delighted to be awarded Corporate Services Team of the Year
- Media releases produced to showcase our winners included:

[WHH celebrates outstanding contributions to healthcare at annual staff awards](#)

[Meet the inspirational health hero crowned your People's Choice Award winner](#)

- Planning is now underway for the first joint BCH and WHH Thank You Awards in 2026

**93.9% of guests
were satisfied
with the event
overall**



Shared Learning Forum

On 13 May the Head of Communications and Engagement and the Engagement and Involvement Officer presented the Trust website redevelopment project at WHH's quarterly Shared Learning Forum. The forum aims to support staff to learn from each other by sharing experiences, ideas and feedback to support quality improvement.

The website was developed over 10 months with ongoing Experts by Experience involvement, including surveys, website redevelopment sessions, accessible form testing and user testing tasks completed prior to launch on 18 September 2024.

Feedback from the session included:

"The website work has been phenomenal - it will make a huge positive difference, I'm sure!"
Anne-Marie Atherton,
Director / Founder, Digital Arts Box CIC

"Very informative presentation.
Very user friendly and easy navigation.
Fab work everyone!"
Lakshmi Senthilnathan,
EPR Training Lead / Product Specialist &
MESN Co-Chair

WHH Charity

Impact stories

- [Raising Smiles success thanks to community](#)
- [Garden opens in memory of much-loved staff members](#)

Newsletters

- One newsletter published - [CHARITY newsletter - May 2025](#)

Fundraising appeals

- Willow Tree Hub
 - [Consultant midwife laces up her trainers for Willow Tree Hub Appeal](#)
 - [Together, we took 250,000 steps of support for baby loss](#)
- Ophthalmology Sensory Garden - [Team take on marathon walk to raise funds](#)





**Warrington and Halton
Teaching Hospitals**

NHS Foundation Trust



Working with People and Communities Strategy

May to June 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 (15 from May to June). • 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	• 8 EbyE Projects delivered in 25/26 (plus 3 extended projects – health literacy, site map updates and Runcorn Health and Education Hub). • 31 EbyEs participating in May and June 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. Ward A8 redevelopment, Runcorn Health and Education Hub.	• Ongoing
4. Undertake consultation and engagement to enable effective support for services	• Inclusion of EbyE engagement from beginning of significant projects • Ongoing EbyE participation to be included in future Q2 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.	• 2025-26
2. Ensure website compliance with Web Content Accessibility Guidelines (WCAG) standards	• Processed 150 PDFs in response to Government Digital Service audit of our Trust website against The Public Sector Bodies (Websites and Mobile Applications) (No. 2) Accessibility Regulations 2018 to support greater accessibility. All technical fixes from the Government Digital Service audit have been implemented on the site. • Trust website accessibility recorded in the Silktide index, has maintained a rating of 'Great' at 90% and is currently 61st place in the NHS sector rankings (June 2025)	• Ongoing
3. Accessible content creation	• Close working between WHH and Bridgewater Communications and Corporate Governance teams has supported development of accessible templates for Committee in Common agendas, reports and minutes to support digital accessibility. • Work continues to ensure content produced is in accessible formats.	• Ongoing
5. Patient information	• The Production of Patient Information Policy includes references to making information accessible and a new Accessible Information and Communication Policy is being updated by Patient Experience and Communications teams	• 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: ✓ WHH Shared Learning Forum ✓ International Clinical Trials Day ✓ Warrington Armed Forces Day ✓ Warrington Pride	• 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 and ongoing promotion of Living Well Warrington continues via WHH communications channels.	• 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	• A focus in May and June has been on the promoted of the Supported Internships offered in partnership with Warrington and Vale Royal College – including internal communications, joint media release and production of case study templates. • 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 11 July 2025.	• Ongoing



**Warrington and Halton
Teaching Hospitals**

NHS Foundation Trust



Upcoming engagement events

Upcoming engagement events: 2025

Date	Event	Time	Venue	Event purpose
31 Aug 2025	Warrington Mela	11am to 4pm	Queen's Gardens, Palmyra Square, Warrington, WA1 1JN	Annual open event supporting cultural diversity and community inclusion.
1 Oct 2025	Annual Members' Meeting	3.30pm to 4.30pm	Lecture Theatre, Halton Education Centre, Halton Hospital, Runcorn, WA7 2DA	Annual Trust membership event, bringing together foundation trust members, governors and the Trust Board.



REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/25/08/68			
SUBJECT:	Emergency Preparedness Annual Report (EPRR)			
DATE OF MEETING:	6 August 2025			
AUTHOR(S):	Daniel Moore, Chief Operating Officer & Deputy Chief Executive / Rachel Clint – Head of EPRR			
EXECUTIVE DIRECTOR SPONSOR:	Daniel Moore, Chief Operating Officer & 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):	all			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	<i>Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</i>			
	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 aims to: • Provide an overview of the emergency preparedness arrangements within Warrington and Halton Hospitals NHS Foundation Trust. • Outline the work that has been undertaken in the area during the past 12 months. • Describe the trust response to incidents which have occurred during 2024-25.			

	Summarise the planned work streams and priorities for the year ahead.		
PURPOSE: <i>(please select as appropriate)</i>	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to note the annual report for Emergency Preparedness, Resilience and Response (EPRR)		
PREVIOUSLY CONSIDERED BY:	Committee	Finance + Sustainability Committee	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt		
FOIA EXEMPTIONS APPLIED: <i>(if relevant)</i>	Section 41 – confidentiality		

REPORT TO TRUST BOARD

SUBJECT	Emergency Preparedness Annual Report (EPRR)	AGENDA REF:	BM/25/08/68

1. BACKGROUND/CONTEXT

All NHS organisations are required to deliver their legal duties and responsibilities for Emergency Preparedness, Resilience and Response (EPRR) set out in The Civil Contingencies Act 2004. As a Category 1 responder under the Act, the trust has a duty to develop robust plans to prepare and respond effectively to emergencies, to assess risks and develop plans in order to maintain the continuity of our services in the event of a disruption.

The demands on the EPRR function in acute trusts have continued to experience both significant disruption and major change. The demands of Accountable Emergency Officers (AEOs), EPRR Professionals and Boards in ensuring robust, resilient systems for patients and communities has never been greater.

Like most NHS organisations, WHH has had our resilience tested on several occasions over the last year, most notably in the form of the operational pressures associated with winter, but also through the occurrences of business continuity incidents. The Trust continues to engage with the ICB and system partners to collaborate on the responses to significant events such as winter pressures.

The trust plans and procedures, along with the commitment of WHH staff, have enabled WHH to manage incidents in a professional manner, helping to minimise disruption to patient care.

NHS England measure providers compliance with 62 Core Standards relating to emergency planning, response and resilience (EPRR). For the 2023/24 cycle, the Cheshire and Merseyside ICB conducted a review of all acute and community providers self-assessments across the system. In 2023, NHS England adapted the method of assessing providers self-assessments in relation to the Core Standards for EPRR.

2. KEY ELEMENTS

Purpose

The purpose of the annual report is to: -

- Provide an overview of the emergency preparedness arrangements within Warrington and Halton Teaching Hospitals
- Outline the work that has been undertaken in emergency planning during the past 12 months
- Describe the trust response to incidents which have occurred during 2024-25.
- Summarise the planned work streams and priorities for the year ahead
- Outline the continuous improvement work streams to support WHH compliance with Core Standards for EPRR.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

Emergency Preparedness Structure

The Trust has an Emergency Preparedness, Resilience and Response (EPRR) policy in place which outlines the approach to the principles of risk assessment, multi-agency co-operation, emergency planning, sharing information and communicating with public. In addition, key plans such as the Incident Response Plan, the overarching Trust Business Continuity Plan and Major Incident Plan underpin the plans outlining how critical services will continue to be provided in the event of a disruptive incident.

Lead Officers

- Daniel Moore- Chief Operating Officer and Deputy Chief Executive is the designated Accountable Emergency Officer with responsibility for Emergency Planning within the Trust
- The Lead Director is currently supported by Rachel Clint, Head of Emergency Preparedness
- In the absence of the AEO, The Director of Operations and Performance, Zoe Harris, deputises and would fulfil the role of the Strategic Commander in their absence
- John Somers is the Non-Executive Director with responsibility for Emergency Planning, all Non-Executive Directors have a responsibility for understanding and knowledge of the EPRR function
- Trust Board are updated on significant matters associated with EPRR

Committee Structure

To discharge our responsibilities effectively under the Civil Contingencies Act (2004), emergency preparedness arrangements have been embedded into the trust's Committee structure.

The EPRR Group, chaired by the Chief Operating Officer and Deputy Chief Executive, is charged with the responsibility of overseeing the development of emergency preparedness arrangements within the Trust. The group meets monthly and its membership includes senior managers from Planned Care, Unplanned Care and Clinical Support Services, there is clinical attendance and appropriate representation from corporate services.

In addition to Emergency Preparedness matters, the role of the EPRR Group is to anticipate and plan for forthcoming events which are likely to present a challenge to our services and resources and to develop co-ordinated plans. Minutes of the Group's meetings are produced, and high-level briefing reports are provided to the Finance and Sustainability Committee and to the Strategic Executive Group as and when it is appropriate. There are bi-annual updates shared with the Board.

EPRR External Structure:

The NHS England Area Team has lead responsibility for co-ordinating a local health response to an emergency. A Cheshire, Halton and Warrington Local Health Resilience Partnership (LHRP) exist to deliver National EPRR strategy in the context of local risks, this partnership is coordinated by the Cheshire and Merseyside Integrated Care Board (ICB). The LHRP brings together the health sector organisations involved in emergency preparedness and strengthen cross-agency working. The quarterly Strategic LHRP meetings are attended by The Chief Operating Officer or Deputy. The Head of EPRR attends the Tactical LHRP and task group meetings. This structure has recently evolved following the establishment of the Integrated Care Board in July 2022, with this structure becoming embedded into standard practice.

Bridgewater Community Healthcare Trust

The Head of EPRR continues to collaborate with the Associate Director of Estates and EPRR at Bridgewater Community Health Trust. Both leads attend EPRR Group meetings across the organisations. An additional focus will be placed on integrating appropriate policies and workstreams as the collaboration continues to strengthen.

4. IMPACT ON QPS?

As identified through the annual assurance process.

5. MEASUREMENTS/EVALUATIONS

Assurance Process

The Trust is required to undertake an annual self-assessment against the NHS England Core Standards for EPRR.

In 2024, the Trust self-assessment was finalised as 68% with a rating of non-compliant (42/62 standards fully compliant and 20/62 partially compliant). This was an improvement on the assessment score of 5% in the 2022-23 cycle of assurance.

The Head of EPRR has remained focused on addressing the standards that have been assessed as 'partial' and ensuring all trust plans are updated to reflect the requirements of the EPRR and Core Assurance Framework.

The two key areas for priority focus are within the domains of CBRN / Hazmat and Business Continuity. With targeted interventions and the establishment of sub-working groups, the gaps in the previous cycle should be addressed providing there is shared ownership beyond the EPRR function. All compliant plans will also be refreshed as part of the work programme for EPRR.

It is likely that the letter for the 2025 cycle will be received in July and there will be a submission of the self-assessment by the end of September 2025. FSC and the Board will be appraised of any self-assessment and subsequently agreed scores.

Compared to other Trusts in Cheshire and Merseyside and beyond, WHHFT is challenged and benchmarks less with only one dedicated lead. This will be reviewed as integration and partnership plans continue to be established.

MIAA audit

In December 2024, MIAA completed an assurance audit based in the Trust's EPRR profile. In their report on 21st January 2025, MIAA concluded that WHHFT measured highly across all areas considered with the strongest possible outcomes, *'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.'* There were very minor recommendations made and the areas identified have been addressed for completeness.

Incidents, Exercises & Learning

During 2024-25 the following significant incidents and exercises occurred:

Creamfields (22nd – 26th August 2024)

The Creamfields Music Festival occurred in Daresbury in August 2024.

The August Bank Holiday weekend has historically been a busy period for the Trust. Fluctuations in demand associated with bank holiday periods exist, but the August Bank holiday weekend also coincides with the staging of the Creamfields Music Festival (CF) in Daresbury, of which Warrington Hospital is the primary receiving hospital for the event.

Creamfields 2024 was held between Thursday 22nd August and Monday 26th August. A series of planning meetings with external organisations and partners took place, along with internal Bank Holiday weekend planning meetings.

Events Medical Service (EMS) was once again appointed as the main provider of healthcare on site and worked in partnership with NWS. As far as possible, it was planned that patients would be treated on site or referred direct to admitting specialities.

Predictions for attendances, admissions, discharges and occupancy were shared based upon the past 6-week trends, alongside previous Bank Holiday and Creamfields Festival weekend activity. Historically most activity associated with the festival occurs on the Saturday and the Sunday when the festival reaches a peak of circa 70000 attendees.

As the local receiving Trust to the festival, it was imperative for robust plans to be in place in advance of the event to ensure the capacity for safe, patient-focused care across the Bank Holiday period and in the days that followed.

Representatives from clinical, nursing and operational teams met with the event organisers and medical team twice in advance of the festival weekend. There were monthly preparation updates through the EPRR Group and the Creamfields operational order and medical plans shared with senior operational and clinical colleagues. A bank holiday handover meeting took place on Friday 23rd August. The Creamfields Event Team invited the Trust to attend daily Silver Command meetings, the aim of these meeting was to coordinate any items to escalate or plans for mutual aid if required. On Friday 23rd August there were significant winds speeds and additional response meetings were stood up to establish multi-agency planning ahead of risk associated with the adverse weather.

A full event debrief took place after the event. It was agreed that learning from previous years festivals had been embedded and there were minimal impacts on services at WHHFT during the festival weekend. There were in total 20 festival related hospital attends and 1 ITU admission. There was less pressure on the Trust in comparison to previous years.

Communications Exercises

All NHS organisations are required to undertake a communication exercise every six months to test the ability to contact key staff 24 hours a day, seven days a week in the event of a Business Continuity, Critical, or Major Incident. This is applicable to NHS Cheshire and Merseyside and all Trusts within Cheshire and Merseyside.

There have been several tests of the Trust Major Incident communication cascade in the past 12 months. There have been two ICB led communications exercises (Exercise Calliope on 29th August 2024 and Exercise Gabriel conducted out of hours on 25th February 2025) and one NHS England test (Exercise Toucan on 12th May 2025). The trust has also exercised its own communications tests twice in the past year (Exercise Toto on 19th June 2024 and Exercise Ariel on 27th November 2024). These communications exercises have demonstrated improved efficiency and ensured the appropriate colleagues have been reached during the exercises.

Major Incident Exercise

The Trust has a plan that provides a framework for WHHFT to respond to a major incident declaration. Exercise Ariel was carried out to test the trusts major incident plan on 27th November 2024. This was a tabletop exercise with the aim to review the trust Major Incident Plan and tests the action cards. This exercise was designed to test processes and roles during a Major Incident. It was designed to support the validation of the NHS EPRR Core Standards. Wider standards affiliated with Training and Exercising, Duty to Maintain Plans, Command and Control and Response were considered as part of this exercise.

A group of Executives, Associate Directors, Manager, nursing representatives, a representative from the ICB and one from the Northwest NHS England EPRR team attended the exercise. Lessons identified from the exercise were incorporated into the review of the major incident plan.

ED Major Incident Exercise

On 14th August 2024, senior clinical, operational and nursing colleagues in UEC attended a tabletop exercise to test the Major Incident Plan and the management of casualties in the event of an incident. This formed a provisional review of the trust plan ahead of the later Exercise Ariel.

Mass Casualty Exercise

On 25th February 2025, the trust conducted a tabletop exercise, Exercise Creta to determine the capacity for mass casualties as per the system distribution plan.

NHS England is asking all health systems in the North to test their mass casualty arrangements so that this can inform the review of the national Mass Casualty Framework. Exercise Creta aimed to test the internal ability of Warrington and Halton hospitals to clear capacity to receive casualties from a mass casualty incident. Specifically to:

- oCreate 10% bed base in 6 hours.

- oCreate 20% bed base in 12 hours.

- oDouble level 3 capacity for 96 hours from incident declaration

This fed into the ICB led Exercise Forma on 6th March 2025, attended by the Head of EPRR and the Lead Nurse for UEC.

Infectious Disease Outbreak Exercise

On 3rd December 2024, the Head of EPRR and the Associate Director of Infection Prevention and Control attended a Cheshire and Merseyside ICS tabletop exercise infectious disease outbreak exercise, led by UKHSA and the ICB. This exercise was designed to review the arrangements of the ICS of an outbreak of a communicable disease. Learning from the system wide tabletop exercise has been embedded into trust plans.

Business Continuity

On 24th June 2025 the trust completed a tabletop exercise in preparation for the NHS England devised Exercise Kaus Australis. This was a business continuity exercise based on a national power outage. The aims of the exercise were to consider how the trust would manage a period of national power outage, on the day of the occurrence, 12 hours later and up to four days later. The Head of EPRR will represent WHHFT in the ICB led exercise Kaus Australis on 8th July 2025. A trust response plan for extended periods of loss of power will be established following on from this exercise.

The CrowdStrike IT incident on 19th July 2024 tested the trusts digital capabilities and the reliance on digital systems. WHHFT was impacted by this occurrence as the trust EPR system relied on the systems most affected by the national incident. A response was set up in line with the Trust Incident Response Plan and the incident was managed well across the core groups involved in the response with learning embedded into the refresh of the trust plan.

Following the tragic events of the incident in Southport on 29th July 2024, there were multiple pockets of civil unrest across the UK. There were fears that there would be activity in the Warrington and Halton boroughs. The trust acted on the formal intelligence received from external partners and adopted a proportional response based on the level of risk. The Head of EPRR worked closely with Operational and Corporate managers to provide a response and to support staff groups who felt anxious and vulnerable during the week of unrest. There were no notable impacts upon the trust.

As part of the development of the trusts business continuity capabilities, all services have been asked to review their business continuity plans annually and test the plans in accordance with national guidelines. The Head of EPRR has created resources to support this process.

A Winter Planning Exercise has been planned and will take place to test the trust and partners winter plans on 2nd September 2025.

The Trust Business Continuity Plan is attached as Appendix 1.

Decontamination, CBRNe and HazMat

The Trust agreed to hosted NWAS train the trainer courses in August 2024, assisting the resilience of our responses to CBRNe incidents and supporting the development of the Trust's CBRNE and HAZMAT Plans.

On 27th November 2024, there was a suspected hazmat incident at the trust. The incident was managed proportionally and there was no harm to the patient or staff. There were aspects of multi-agency work between the police, fire service and the decontamination tent supplier. Suspected contaminated waste was removed and replacement equipment has been ordered to ensure the trust has the fully complement of equipment required as per the expected standards.

On 4th December 2024, NWAS conducted an audit of the Trusts CBRN capabilities. The trust was able to provide some evidence to support the decontamination capabilities, meeting 18 of 28 standards. The action plan for addressing the gaps has been shared with UEC, with training and exercising identified as a priority along with the replenishment of suits to take the trust up to the expected compliance rating. The Head of EPRR has provided a risk assessment based on the outcomes and the Head of EPRR has requested increased ownership from the UEC CBU.

A CBRN Exercise has been planned and will take place as a live exercise on 21st October 2025.

Industrial Action

Ballots are open for Resident Doctors, Consultants and SAS doctors following the pay award announcement in May 2025. Other union groups have expressed disappointment with the pay announcements and have opened consultation with members of respective union groups. The situation is being monitored and the Trust Industrial Action Response Plan has been refreshed in preparation for any potential action as early as late-July (Resident Doctors).

Training

The Trust has an ongoing programme of exercises and training events to test and validate emergency plans. In 2024-25 there have been more opportunities to engage teams in training exercises and this programme will continue with routine training along with standalone tabletop exercises.

Tactical Manager on-call training has been enhanced through the delivery of bi-annual events to on-call managers, with thematic focus areas based on the needs of trainees. Training this year has occurred on 15th November 2024 and is scheduled to next take place on 19th September 2025 (training has been rescheduled from June to September to ensure full attendance). This training also supports the portfolio and CPD of Tactical Commanders.

National Occupational Standards were introduced by NHSE in 2022 for Strategic and Tactical Managers. All Executive's and Tactical Managers have been invited to attend the rolling training programme and are required to maintain evidence of their training standards.

As part of the revised EPRR Framework in June 2022, the minimal occupational standards were introduced and all Strategic and Tactical managers are expected to attend this every three years. Participation from WHH Strategic and Tactical managers has been very encouraging to date, with further opportunities identified for 2024, ensuring new personnel have access to the training too. 76% of Tactical Commanders have attended the POHC course, and all Strategic Commanders have attended or are booked on to training within the coming months.

The Head of EPRR has also attended a range of training events and is enrolled on the vocational Health Emergency Preparedness Resilience and Response course for this year.

A Training Needs Analysis and Exercise Schedule is in place to ensure appropriate training is available for all Tactical and Strategic Commanders. More consideration has been placed on wider training opportunities for operational commanders and for colleagues working in support services.

Public Health Commander Training (June 2022 – onwards)

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an infectious disease outbreak or a major transport accident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act

2004 (CCA), the Civil Contingencies Act 2004 (Contingency Planning Regulations) 2005, the NHS Act 2006 and the Health and Care Act 2022.

This work is referred to in the health service as 'emergency preparedness, resilience and response' (EPRR). The day-to-day management of people and patients in the NHS is subject to legal frameworks, duty of care, candour and moral obligation. This does not change when responding to an incident; however, these events can lead to greater public and legal scrutiny. If staff are planning for or responding to an incident, they need to have the tools and skills to do so in line with their assigned NHS command and/or incident response role.

The minimum national occupational standards that health commanders, managers and staff responding to incidents as part of an incident management team and other staff involved in EPRR must achieve to be competent and effectively undertake their roles. All staff with a command role in incident management must maintain continual professional development (CPD), maintaining personal development portfolios (PDPs) in accordance with NHS Core Standards for EPRR. All Strategic Commanders have attended the course and all Tactical Commanders (except one new to post) have completed this training within the past 3 years. A training log is appended at the close of this report.

Wider Training Opportunities

Utilising contributions from acute and community providers, Cheshire and Merseyside ICB shared opportunities for MACA (Military Awareness) training, Legal awareness training and Accountable Emergency Officer training in 2024/25. These opportunities assist the Trust's Strategic Commanders in their compliance with the National and Minimal Occupational Standards for EPRR, and their skills as strategic commanders. Records of those who have attended the training are appended at the end of this document.

EPRR Training

The Head of EPRR continues to ensure that appropriate training is attended to support the function in WHHFT. The Head of EPRR has attended the following 2024-2025;

- Legal Awareness Training 3rd September 2024
- Formal Debrief Training 11th February 2025
- EDI Considerations for EPRR 26th February 2025
- JESIP Awareness 25th April 2025
- Joint Decision-Making Model Awareness 25th April 2025
- Local Resilience Forum Awareness 25th April 2025

The Head of EPRR has also enrolled on the Diploma in Health Emergency Planning, Response and Resilience, this is funded through UKHSA and the qualification should be completed by August 2026.

Wider events / disruptions

Several events with potential implications on the Trust have been monitored following guidelines in the Trust Business Continuity Plan or Incident Response Plan.

These have included:

- IPC outbreaks
- National cybersecurity issues
- OPEL 4 – owing to operational pressures over winter, WHH declared OPEL 4 fewer occasions in 2024-25 compared to previous years
- Southport incident July 2024
- Halton kitchen fire November 2024
- Halton bleep failure April 2025
- Liverpool Water Street Incident May 2025
- Warrington fire May 2025
- Warrington Neighbourhood Weekender May 2025

Work undertaken in 2024/25

The following policies were created or refreshed and updated to reflect local and national developments during 2024-2025:

- Trust Escalation Plan
- Full Capacity Plan
- Adverse Weather Plan
- Tactical Commander Handbook
- Winter Plan
- Bank Holiday Plans
- Major Incident Plan
- Incident Response Plan
- Trust Debrief Guidelines
- Incident Coordination Centre SOP
- Business Continuity Plan
- CBRN/HazMat Plan
- Mass Casualty Plan
- Countermeasures Plan
- Lockdown Plan
- New and Emerging Pandemic Plan
- EPRR Policy

Engagement has continued with the following external groups:

- Cheshire Health Resilience Partnership
- EPRR network
- System Partners (Cheshire and Merseyside ICB, Warrington Borough Council, Halton Borough Council, Bridgewater)
- Close liaison has been maintained with partner agencies in planning for local mass gathering events i.e., Creamfields festival. Member of Creamfields Safety Advisory Group and liaison with NWAS
-

Single Point of Contact

The Head of EPRR has continued to act as the trusts Single Point of Contact (SPOC) when required. This includes the monitoring, storing and cascading of national and local guidelines or incident related information.

Learning and Lessons Identified

Learning from incidents and events is tracked through EPRR Group on a lessons identified tracker. Following on from an incident or exercise a debrief or exercise report details the learning, with an action plan to embed learning into policy reviews or to practice. Further information of this process is defined in the WHH Debrief Guidelines.

6. TRAJECTORIES/OBJECTIVES AGREED

NHS Core Assurance for EPRR

The Head of EPRR continues to work towards achieving at least substantial compliance (89-99%) with the submission of the core standards self-assessment this year. There are some inter-dependencies with the requirement for additional input from departments to ensure this can be achieved. There are also some national guidelines requiring updates in areas such as Evacuation and Shelter, Mass Casualties and Mass Countermeasures, the Head of EPRR will continue to refresh trust plans based on any updated guidance received.

Work programme for 2025/26

In 2024-25 the core focus has been to continue to refresh the emergency planning portfolio and embed lessons identified from the 2023/24 cycle of core assurance. Positive outcomes through the Core Assurance process and MIAA audit have been welcomes, however in EPRR the cycle of improvement is continuous.

For 2025-2026, the focus will include reviewing outcomes in line with the Core Assurance Framework and testing a number of WHH emergency plans. EPRR involves an ongoing cycle of planning, training, testing and improving. Although debrief activities have been carried out, it is prudent to continue to capture the learning through response and recovery to enable effective winter preparation for 2025-2026. This will include collaboration with key stakeholders involved in the responses, raising staff awareness, testing plans and identifying any areas for improvement. A winter planning exercise has been scheduled for September 2026.

The Board has previously expressed satisfaction with the Trust's EPRR resource. A benchmarking exercise carried out in April 2024 indicated that WHH does not have an equitable resource in comparison to neighbouring trusts, or trusts of a similar scale. With the changing requirements in EPRR it will be prudent to review the EPRR structure in the year ahead, especially through the integration process. The integration will require significant input with the likelihood of the need to complete another complete refresh of all EPRR documents and the requirement to increase the training programme to meet the requirements of the EPRR Framework 2022. Several priorities have been identified to address integration in the short, medium and long term, some of these are listed below:

- Develop a structure for the single delivery of EPRR and AEO functionality
- Refresh all policies and plans with consideration of different ways of working across acute and community settings
- Develop training and plans to amalgamate the on-call systems and processes
- Work in collaboration with Estates, Digital Services and Operational Managers to ensure resilience across Place
- Establish integrated on-call, business continuity and incident response arrangements.

In addition to resource, EPRR has historically not had a budget allocated. Despite this, annual servicing of PRPS Suits and the decontamination shelter takes place, utilising the UEC budget to cover costs incurred. There is the need to invest in additional training for instance for loggists and debrief trained personnel, as well as the requirement to offer training so commanders are up to date with the skills and education required as part of the minimal occupational standards. Furthermore, it is imperative that all incident control rooms are appropriately equipped with logbooks, tabards and such, this will require some funding to maintain the Trusts compliance with the EPRR Framework (2022).

In support of and in addition to the above, the following work plans will be undertaken:

- Continue to deliver training to key staff in Emergency Preparedness and Incident Management through Tactical Commander training, Strategic Commander training, Operational (Site) Manager training and ad-hoc events
- Continue to encourage and support opportunities for Strategic and Tactical on-call managers to attend the Public Health Commander training to ensure minimal occupational standards are met
- Test the Trust plans ensuring wider stakeholder input
- Continue to develop the UEC CBRN plans including further training and an exercise scheduled for October 2025
- Embed learning from 2024-2025 to support planning for winter pressures
- Continue as a full and active member of the Local Health Resilience Planning Group
- Update plans and procedures in line with any new national guidance
- EPRR education within care groups and the workforce to enhance resilience
- Review the Corporate Business Continuity Plan, embed the audit process and request all areas refresh and exercise their plans
- Monitor the lessons identified from other local, regional and national incidents.

7. MONITORING/REPORTING ROUTES

The ICB led LHRP meets quarterly and is attended by the Trust Head of EPRR; the outcomes are fed into the Trusts EPRR Group meeting.

The Strategic LHRP meets quarterly and is attended by the AEO.

Wider participation occurs with ICB exercise or task and finish groups, of which the Head of EPRR attends.

The EPRR Group meets monthly and reports updates through the Finance and Sustainability Committee and Strategic Executive Group meetings.

For any incidents or wide-scale events, Tactical Response meetings are established on an ad-hoc basis and follow the above reporting routes.

8. TIMELINES

This report is presented annually to the Finance and Sustainability Committee and subsequently to the Board. The Core Assurance submission will take place in September 2025. The Finance and Sustainability Committee and the Board will be appraised of the assessment and the outcomes of the core assurance self-assessment. EPRR updates occur bi-annual (and additionally following any significant incidents) as per the expectation from the EPRR Core Assurance Framework.

9. ASSURANCE COMMITTEE

The EPRR Manager regularly updates and escalates any prominent issues to the EPRR Group. This subgroup continues to report to the Finance and Sustainability Committee, and to the weekly Strategic Executive Group meetings when notable events are in place or incidents occur.

10. RECOMMENDATIONS

The Trust Board is asked to note the significant work and achievements undertaken during 2024-25 and the planned work programme for 2025-26 in support of improvements in EPRR and the Trusts objectives.

Appendix 1 – Trust Business Continuity Plan



Trustwide Business
Continuity Plan 2025.

Appendix 2 – Training records



EPRR Training
Log.xlsx

Appendix 3 – NHS Core Standards letter



NHS England »
Emergency preparedr

REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/25/08/69			
SUBJECT:	Bi-monthly Strategy Highlight Report			
DATE OF MEETING:	6 August 2025			
AUTHOR(S):	Megan Wainwright, Strategy Project and Team Support Officer			
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Chief Strategy & Partnerships Officer			
LINK TO STRATEGIC OBJECTIVE: <i>(Please select as appropriate)</i>	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): <i>(Please DELETE as appropriate)</i>	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	<i>Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</i>			
	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. The ICB have been asked to support this. • 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 64,000 views with the membership growing daily. The platform showcases over 600 activities that support living well across Warrington. • The full business case for development of the East Pathology Hub and has been developed and is presented to Trust Board in August for approval.		
PURPOSE: <i>(please select as appropriate)</i>	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to note this report for information.		
PREVIOUSLY CONSIDERED BY:	Committee	Choose an item.	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: <i>(if relevant)</i>	None		

Strategic projects update

May-June 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	Community diagnostic centre	Lefteris Zabatis/Stephen Bennett	
Slide 11-12	New hospitals programme and strategic estates	Carl Mackie	
Slide 13-14	Warrington Living Well Virtual Health & Wellbeing Hub	Rachel Moran/Stephen Bennett	
Slide 15	Completed projects	Strategy team	
Section 4 - Other trust strategic updates			
Slide 16-17	Summary of other Trust strategy related updates		
Section 5 - Cheshire and Merseyside strategic updates			
Slide 18	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 64,000 views with the membership growing daily. The platform showcases over 600 activities that support living well across Warrington.
- The full business case for development of the East Pathology Hub has been developed and is being presented to the Trust Board in August for approval.

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
Damian Nolan	Director Commissioning and Provision, Adult Social Care, Halton Borough Council	Urgent and Emergency Care System Improvement
Sally Yeoman	CEO, Halton And St Helen's Voluntary and Community Action	Wider determinants of health priorities and prevention programme in Halton
Marianne Loynes Peter Bryant	Mergers and acquisitions team, NHS England	Integration transaction support
Rob Cooper	CEO, Mersey and West Lancashire Teaching Hospitals	Pathology Collaboration
Phil Merrifield	CEO, Made Open Software	Future developments of Living Well Warrington digital platform
Mark Swift	CEO, Wellbeing Enterprises	Runcorn health and education hub
Wesley Rourke	Executive Director, Environment and Regeneration	Runcorn Shopping City, Levelling up, Runcorn Town Deal
Debbie Watson	Director of Public Health, Warrington Borough Council	Warrington Virtual Hub, Warrington poverty working group
Robert Woolf	Founder, Made Open Software	Future developments of Living Well Warrington digital platform
David Wilson	One Halton Clinical director	UEC Steering group
Sara Garratt Amanda Ridge	C&M ICB C&M ICB	Living Well Warrington digital platform

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	Chief Strategy and Partnerships Officer, Wirral University Teaching Hospitals	Integration, C&M strategy
Carl Marsh	Place Director, Warrington	Place development and Warrington neighbourhood health
Nick Armstrong	Cheshire and Merseyside ICB	Strategic estates planning, Warrington
Tim McPhee	Associate Director Integration, Transformation and Partnerships, Mersey Care	Runcorn Health and education Hub, One Halton delivery plan, Warrington neighbourhood health
Kate Clark	Director of Strategy MWL	Regional Pathology hub
Cathy Elliott	CEO, NHS Cheshire and Merseyside	Integration
Sarah Bowman-Jones Mathew Jones Asia Bibi Sunil Sharma	Alder Hey Children's Hospital, Paediatric Surgical team	Paediatric hub project team meeting
Mark Hogg	Finance, Mersey and West Lancashire NHS Trust	Pathology Hub
Dr Laura Mount Dr Ash Ahluwalia Dr Golam Choudhury Dr Mike Northey	Warrington PCN Clinical Directors	Warrington neighbourhood health
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
Paul Corless	Transformation and PCN Lead, ICB	Warrington neighbourhood health, Living Well Warrington digital platform

Integration – part 1



Programme Overview

Bridgewater Community Healthcare NHS Foundation Trust (BCH) and Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) are coming together and working as one to improve healthcare services for our communities. Warrington and Halton need strong and resilient clinical services, and our healthcare system must be sustainable for the future. We know that we can achieve more together for both our patients and staff.

The integration programme- “Better Care Together” has been established with 10 workstreams: Strategic Programme Development, Estates, Workforce, Finance, Corporate Service Integration, Clinical and Operational Services Integration, Digital Services, Communication and Engagement, Clinical Governance and Quality, and Corporate Governance. Each workstream 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:

- Strategic case for change now complete alongside a paper that sets out the rationale for accelerating the transaction with a view to creating a single.
- The documents will be submitted to both BCH and WHH Trust Boards in early July for approval and then to the Cheshire & Merseyside ICB board to secure support in late July.
- All clinical summits have now been held, and 6 priority clinical pathways have been agreed to be progressed initially.
- All corporate services have been requested to complete a pro-forma document to provide the next level of information to support the integration of the corporate teams asap.

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
Present proposal for acceleration of programme at Trust Boards and ICB	July 2025
Development of clinical model/clinical strategy	July/August 2025

Better Care Together
Home · Community · Hospital

Integrating community and hospital services provided by
Bridgewater Community Healthcare NHS Foundation Trust and
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Contact details

Lucy Gardner
Chief Strategy and Partnerships Officer WHH
Lucy.gardner5@nhs.net

Stephen Bennett
Head of Strategy and Partnerships WHH
Stephen.bennet@nhs.net

Runcorn town deal-part 1

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

- Hub naming survey carried out, with WELL Runcorn chosen as the name.
- Draining complete, structural steel installation finished and mezzanine floor built.
- Experts-by-Experience sessions carried out to confirm furniture choices and colours, through accessibility lens.
- Additional services from external organisations added to timetable following stakeholder session in April.

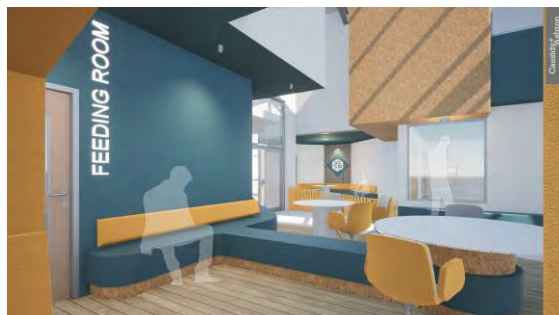
Runcorn town deal- part 2



**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	Oct 2025
Services go live	Jan 2026



Contact details
Viviane Risk
Strategic Project Manager
viviane.risk@nhs.net

Carl Mackie
Halton Healthy New Town and Strategy
Manager
carlmackie@nhs.net

Community diagnostic centre-part 1

Project Overview

- As part of the national strategic vision to create Community Diagnostics Centres (CDC) across England, the Trust is working alongside the regional team to develop a centre for outpatient diagnostics to serve the populations of Warrington and Halton. This will also be a regional resource.
- The final approved CDC Programme covers three phases:
 - Phase 1 (now complete) saw the development of a range of diagnostic services within the Nightingale Building at Halton.
 - Phase 2 (now complete) saw a range of diagnostic services established within the Halton Health Hub at Runcorn Shopping City.
 - Phase 3 (now complete) saw the development of a new build extension to the CSTM building on the Halton site to accommodate additional CT and MRI services.

What does this mean for WHH?

- Additional capacity to undertake diagnostic testing for patients of Halton and Warrington, and the wider Cheshire and Merseyside region.
- New estate at Halton General Hospital and at the Halton Health Hub in Runcorn Shopping City, which supports new hospitals plans and the estates strategy.

Progress since last report

- Over 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.

Community diagnostic centre- 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 ✓



Contact details
Lefteris Zabatis
Senior Strategic Project Manager
lefteris.zabatis@nhs.net

New hospitals and strategic estates planning- part 1

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

- Plans for an urgent treatment centre submitted to Cheshire & Merseyside ICB and NHSE North West
- Continued development of strategic estates planning work, including updated new hospitals masterplan and development of
- Strategic development of future estate programme as part of wider integration in discussion, including potential for shared corporate space to enable the transaction

New hospitals and strategic estates planning- part 2



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	March 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

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

- Continued stakeholder engagement and presentation at various meetings as part of communications plan.
- 657 new members to platform, 611 live activities, 12,000 active users, 64,000 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.

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-Sept 25
Launch test business membership model	Aug/ Sept 25
Sustainability and business proposal finalisation	Sept 25



Contact details

Stephen Bennett
Head of Strategy & Partnerships
stephen.bennett13@nhs.net

Rachel Moran
Strategic Project Manager
rachel.moran1@nhs.net

Completed Projects

Halton Health Hub

- Halton Health Hub Phase 1 was completed in November 2022, enabling the delivery of orthoptics, optometry, audiology, and dietetic therapy services from within the Runcorn Shopping City centre in Halton Lea.
- Services in Phase 1 have since been expanded to add MSK therapies, a GP out-of-hours service, public health services, including weight management and smoking cessation, and a Wellbeing Service delivered by Wellbeing Enterprises CIC.
- In November 2023, Phase 2 opened. Phase 2 comprises a Community Diagnostics Centre, offering residents improved access to range of diagnostics and treatments usually only accessible via an acute hospital.

Warrington Living Well Hub

- Attendances at the Living Well Hub are now approaching 25,000 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:
 - Mersey Care's Children & Young People's Mental Health appointments
 - Green Doctor (in partnership with Talking Point) – providing drop-in advice around energy usage and keeping household bills down
- The Living Well programme across the town has been entered into the 2025 HSJ awards as an exemplar programme of work demonstrating a high-quality integrated care approach and provider collaboration.

Other Trust strategic updates

Theatre 3 at Nightingale Building, Halton

- T1 & T2 operational from May 2025
- Recover and T3 currently in full construction
- WHH Project Team working closely with contractors to manage early warning notices and compensation events

Urgent and Emergency Care System Improvement

- The Urgent and Emergency Care System Improvement Programme continues. Workstreams have been revised to include Pre Hospital., In Hospital and Post Hospital and each are working to agreed delivery plans, reporting to the ICB regularly.
- The length of time patients are being nursed on the A&E corridor has reduced from 13 hours in April 2024 to 6.5 hours in June 2025.
- Bed occupancy rates remain a challenge as do the 4 and 12- hour waiting time targets for the emergency department. Targeted work is ongoing to address these issues and includes the development and expansion of hot clinics.

Other Trust strategic updates

Digital Projects

Electronic Patient Care and Management System (EPCMS)

- Pre marker engagement officially launched at 5pm on Thursday 26th of June 2025.

Federated Data Platform

- The FDP and NHS England transitioned to Business As Usual (BAU) on Friday, with ongoing efforts to embed the system.
- The transition has been challenging, particularly with the Patient Booking Management (PBM) system, which is not yet fully utilised.
- Theatres are using the system well for scheduling and list planning, with all information centralized in one place.
- The system now includes adjusted book utilisation figures, incorporating historic data and average anaesthetic times, aiding in informed decision-making

Patient Engagement Portal (PEP) Update (Stats from June 2025)

- All appointment, TCI and Radiology letters are now being sent digitally to the NHS App and the Patient Portal.
 - 72.4% of patient letters have been read digitally reducing the need for printing and postage of letters
- 62% of our local population are registered with the NHS App (60% Halton, 64% Warrington)
- In June 2025, 131k notification messages have been sent to our patients
 - 72k (55%) were sent via the NHS App
 - 56k were read on the NHS App –reducing SMS messages by 22%

Cheshire and Merseyside strategic updates

Laboratory Information Management System (LIMS)

- The Full Business Case for a unified LIMS across 5 healthcare organisations was approved by the Trust Board in June 2024. The contract has been awarded to the preferred supplier and implementation is planned to begin in 2027. The local WHH team are 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 has been developed and will be presented to the 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.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/25/08/70			
SUBJECT:	Strategy Bi-Annual Delivery Report			
DATE OF MEETING:	6 August 2025			
AUTHOR(S):	Carl Mackie, Halton Healthy New Town and Strategy Manager			
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.			
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):	In May 2023 Trust Board ratified governance and reporting arrangements for the updated Trust Strategy 2023-25. It was agreed that reporting against the delivery of the Strategy would be standardised, including a bi-annual			

	update of progress against the priorities within each of the strategic aims (Q, P, S) to the appropriate Board committee. There are a total of 58 strategic priorities within the refreshed 2023-25 Trust Strategy. These are broken down and monitored as below: There are 18 strategic priorities against the 3 objectives within the Quality aim of the Trust strategy. These are reported twice yearly through Quality Assurance Committee. H2 KPIs were reported to QAC on 10th June 2025 as per the Quality Priorities Quarter 4 (Q4) 2024 – 2025. There are 24 strategic priorities against the 4 objectives within the People aim of the Trust strategy. These are reported twice yearly through Strategic People Committee. H2 KPIs were reported to SPC on 16th April 2025 as per the WHH People Strategy Annual Report. There are 16 strategic priorities against the 4 objectives within the Sustainability aim of the Trust strategy. These are reported twice yearly through Finance and Sustainability Committee. H2 KPIs were reported to FSC on 2nd June 2025 as per the Sustainability Strategic Priorities Bi-Annual Report. As of this report, the Trust is on target to meet 34 priorities, 14 are behind expectations with mitigations and programmes in place to bring back in line with expectations, and 6 are behind expectations with limited or no mitigations. As noted in the Strategy Bi-Annual Delivery Report H1 delivered in February 2025, arrangements are in place to extend the validity of the current strategy to April 2026, in line with the integration programme. As such, the strategic priorities and objectives will remain consistent in 2025/26, with any updated metrics communicated via the appropriate committee(s) ahead of the next bi-annual update to Trust Board.		
PURPOSE: <i>(please select as appropriate)</i>	Approval ✓	To note ✓	Decision ✓
RECOMMENDATION:	The Trust Board is asked to note progress of the delivery of the Trust Strategy 2023-25 through the Strategic Priorities across Quality, People and Sustainability aims.		
PREVIOUSLY CONSIDERED BY:	Committee	Quality Assurance Committee; Strategic People Committee; Finance and Sustainability Committee	
	Agenda Ref.	Various	
	Date of meeting	Various as described	
	Summary of Outcome	Noted	

FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt
FOIA EXEMPTIONS APPLIED: <i>(if relevant)</i>	Section 43 – prejudice to commercial interests

REPORT TO TRUST BOARD

SUBJECT	Strategy Bi-Annual Delivery Report	AGENDA REF:	BM/25/08/70

1. BACKGROUND/CONTEXT

In March 2023, Trust Board approved a refresh of the Trust Strategy, which included a set of 12 strategic objectives underpinned by high level priorities. A summary of the refreshed Strategy is below.

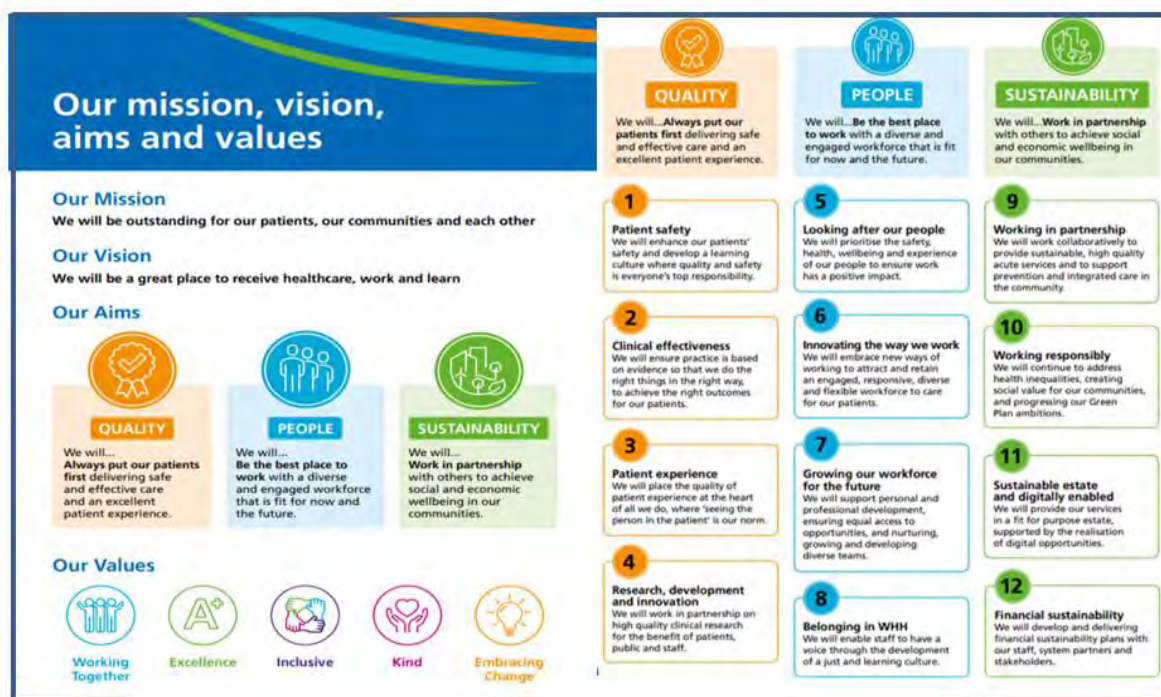


Figure 1: Summary of Trust Strategy 2023-25

In May 2023, Trust Board ratified the governance and reporting arrangements for the updated Trust strategy. This included the alignment of reporting across all aims of the strategy, and the approval of KPIs and / or Measures of Success aligned to each strategic priority.

As part of the alignment of reporting it was agreed that progress on the delivery of the strategy would be reported twice yearly, with the measures of success/KPIs relating specifically to Quality aims being monitored via Quality Assurance Committee, People aims being monitored via Strategic People Committee, and Sustainability aims being monitored via Finance and Sustainability Committee.

There are no changes to the Strategic Objectives as previously reported for H1 2024/25 as per the previous report to this board in February 2025.

2. KEY ELEMENTS

An update on progress of the Strategic Priorities for the Quality aims was reported to QAC on 10th June 2025 as per the Quality Priorities Quarter 4 (Q4) 2024 – 2025. Metrics are derived from this update and from the relevant Integrated Performance Report to Board (June 2025).

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar/Apr-25)	Target	RAG	Comments
1. Patient Safety: We will enhance our patients' safety and develop a learning culture where quality and safety is everyone's top responsibility	1.1 We will reduce avoidable harm and patient deterioration with a focus on Covid-19 elective recovery.	Delivery of 110% of pre-pandemic activity by the end of 2022/23.	100% (2019/20 activity)	April 2025: 99% of Daycase Procedures and 99% of Inpatient Elective Procedures against 2019 activity April 2025: 93.54% of Outpatient activity against 2019.	104%		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. 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.
		Potential Harm review panel will continue to undertake reviews where harm is suspected following a delay to treatment – feeding into wider governance processes					
	1.2 We will implement actions to deliver new standards required as a result of national reviews in Maternity care/provision, ensuring learning is acted upon.	Progress against action plans - Ockenden 1b:	94.91%	100.00%	100% compliant by Dec 23		A review of the Ockenden action plan has been completed the Quadrumvirate have agreed to close the Ockenden action plan. 4 actions from Ockenden 2 action plan have been transferred to an Ockenden Issues Log. These actions require further monitoring and some analysis of audit, and it was agreed to close on the action plan and transfer to an Ockenden Issues Log so that they remain under scrutiny.
		- Ockenden 2:	68.53%	100.00%	100% compliant by Nov 23		
		Change in practice as a result of learning being acted upon, evidenced through monthly tracking of improvements and impact of actions with triumvirate.					
	1.3 We will enhance timely patient recovery through therapy led initiatives, including work around deconditioning and rehabilitation.	Reduction in the number of patients who develop pressure ulcers.	10	19 (April 2025)	8		After Action Reviews are taking place and lessons are shared with ward teams and via Operational Patient Safety Group. Minimum category 3 and above will have an MDT review completed. Improvement plans in place for both Unplanned Care
		Patients participating in active movement and cognitive stimulation on the wards.					

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar/Apr-25)	Target	RAG	Comments
		Annual reduction in the number of inpatient falls & harm levels. Based on 590 falls in 2021/22	418 (2023/24)	There were 611 total falls in 2023/24. There have been 687 total falls in 2024/25 (an increase of 12%)	Fewer than 418		and Planned Care Groups overseen by the Associate Chief Nurses. Compliance/review meetings are taking place with the Deputy Chief Nurse/Director of Governance. Lessons learned shared. Purpose T (pressure ulcer risk assessment) launched 07 May 2025. Quality walk abouts are in place with the Chief Nurse, Deputy Chief Nurse/Director of Governance and associate Chief Nurses to assure on the quality of pressure ulcer prevention care. Quarterly Quality Summits in place with Chief Nurse, Deputy Chief Nurse/Director of Governance to monitor plans to improve quality metrics. Corporate Reviews initiated with Chief Nurse, Deputy Chief Nurse/Director of Governance for wards with higher incidence.
	1.4 We will improve recognition and response to deteriorating patients.	Reduce the number of Category 2 pressure ulcers by 20% with zero tolerance of Category 3 and Category 4 pressure ulcers.	For detailed performance information against this metric please see latest Quality Priorities update, shared twice annually at QAC for assurance				- Compliance for Q4 is 50.36% against the target of the (minimum) 70%. This is based on the following: - Pressure Ulcer Risk Assessment (Waterlow) completed within 6 hours of admission. (72.39%) - Pressure Ulcer Prevention Care Plan completed within 24 hours of admission (if Waterlow over 10). (33.09%) - Pressure Ulcer Risk Assessment (Waterlow) updated every 30 days during admission. (92.44%) - Outstanding actions from the concluded Task and Finish Group continue to be monitored through Operational Patient Safety Group. - Ward/department walk arounds commenced in April 2025 by Deputy Chief Nurse, Director of Clinical Governance and Associate Chief Nurses. - Quality Summits with the Chief Nurse commenced from May 2025
	1.5 We will reduce the number of category 2 hospital acquired pressure ulcers by 20%, with zero tolerance of category 3 and 4 pressure ulcers (aligned to 23/24 CQUIN)	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	For detailed performance information against this metric please see latest Quality Priorities update, shared twice annually at QAC for assurance				- DMO1 performance has recovered at an aggregate position in February 2025 which is a month earlier than planned. - Diagnostic Monthly Waiting Times and Activity Reporting (DMO1) is currently reporting at 96.65% (March 2025) at an aggregated position. - Equipment constraints in Urodynamics will be resolved with the purchase of an additional scanner.
	1.6 We will continue to evidence a culture of quality,	Ensure that all patients within the Emergency Department	For detailed performance information against this metric please see latest				The Manchester Triage Score (MTS) was rolled out within the Emergency Department, UTC (Urgent

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar/Apr-25)	Target	RAG	Comments
	safety and learning aligned to the National Patient Safety Framework.	receive timely assessment and treatment resulting in improved patient experience and improved clinical outcomes	Quality Priorities update, shared twice annually at QAC for assurance				Treatment Centre) and SDEC (Same Day Emergency Care) areas in April 2024. SDEC is not monitored nationally but is locally monitored, in the Trust. • At the end of Q4 (March 2025) 58.21% of Type 1 and Type 3 patients were assessed within the standard of 15 minutes. • There has been difficulty in measuring improvements due to the limited data that can be extracted from the Trust's Electronic Patient Record (EPR) system. The UEC Team are working with the Information Department to establish how this could be achieved. Opportunities to improve the way this activity is recorded continue to be explored.
2. Clinical effectiveness: We will ensure practice is based on evidence so that we do the right things in the right way, to achieve the right outcomes for our patients.	2.1 We will continue to utilise and evidence best clinical practice through the evidencing of compliance with guidance, such as the National Institute for Clinical Effectiveness.	NICE compliance	91.65%	94.11%	90%		
	2.2 We will continue to embed a positive risk management culture from ward to board.	Flexibility in risk appetite is recognised, this will be informed by the management of risk registers at service level, corporately and through the Board Assurance Framework.					The Risk Management Strategy provides a framework for managing risk across the Trust. The Strategy describes the process for managing risks and the roles and responsibilities of the Board of Directors, its Committees and that of all staff and provides a clear, structured and systematic approach to the management of risk to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the Trust. Local risk registers are monitored and maintained locally within the Clinical Business Units (CBU) which enables risk management decision-making to occur as near as practicable to the risk source. For those risks that cannot be managed locally these are escalated to the Corporate Risk Register and Strategic Risk Register where required. The Trust employs a number of systems to ensure that risk management is embedded within the organisation including business planning, performance management frameworks and clinical information systems. Regular reports are also available to the various committees responsible for aspects of risk

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar/Apr-25)	Target	RAG	Comments
							management. There are corporate policies and procedures in place to support risk management, covering the management of incidents, risk assessment and consent and general risk management arrangements. Risk appetite levels will depend on circumstances; for example the Trust will have a low tolerance to taking risks which may impact on patient or staff safety, but a greater appetite for opportunity risks such as major service developments which present significant challenges, but will ultimately bring benefits to the organisation. Expressing risk appetite can therefore enable an organisation to take decisions based on an understanding of the risks involved. It can also be a useful method of communicating expectations for risk-taking to managers and improve oversight of risk by the Board. Risk appetites are determined by the Trust Board. The Trust encourages stakeholder and partner organisations' participation and has developed an active Patient Experience Committee. Partners and Governors are encouraged to raise issues, be involved in determining solutions and input to all aspects of risk management. The Trust has a Board Assurance Framework in place which is reviewed by the Board of Directors and includes: the identification of the key risks to the achievement of the Trust strategic objectives and the systems in place to manage/mitigate these risks; the control systems in place to manage the key risks; the identification of sources of internal and external assurances evidencing the management of risk; and evidence of compliance with equality, diversity and human rights legislation. The Board Assurance Framework is reviewed by the Board of Directors at each of their meetings and the Audit Committee, and bi-monthly by the Board Committees, which provides additional challenge and scrutiny of the risks identified.

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar/Apr-25)	Target	RAG	Comments
	2.3 We will recover core services and improve productivity in line with targets set in the NHS Long-term plan.	% of plans on track to deliver annual operational improvement trajectories	0%	67%	100%		Elective / Daycase: 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. Diagnostics: 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 Outpatients: 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.
	2.4 We will improve a culture of quality, safety and learning through the consistent application of LOCSIPs, achieving >90% compliance in documentation and observational audits.	Improve Theatre Safety with a focus on improving safety culture and compliance with Safe Surgery Safety Standards	For detailed performance information against this metric please see latest Quality Priorities update, shared twice annually at QAC for assurance				• There has been 0 never events since January 2025. • All 11 recommendations which have been completed following the Theatre Safety Day with follow up actions being monitored via Procedural Safety Steering Group). • MIAA (Mersey Internal Audit Agency) external NatSSIPs 2 audit took place in December 2024 and was reported in January 2025. There were several key findings separated into 'High Risk' (3) and 'Medium Risk' (4). A response and detailed action plan against each action was presented at the Quality Assurance Committee on 8 April 2025.
	2.5 We will improve Clinical Pathway Optimisation through the 'Get it Right First Time' programme.	Delivery of the Trust wide improvement programmes across all Care Groups aligning to GIRFT recommendations to support timelier and more effective patient care	For detailed performance information against this metric please see latest Quality Priorities update, shared twice annually at QAC for assurance				UEC Internal and System Improvement Programme • There has been improvement in both 12- and 4-hour performance in March 2025. • 12 hour: 19.83% • 4 hour: 64.09% • WHH continues to consistently meet 80% Virtual Ward capacity target. Theatre Improvement Programme • Implementing the "Golden Patient" initiative is underway to reduce list order changes that impact timely starts with plans to commence with Urology and Trauma & Orthopaedics (May 2025) • A Working Group Meeting was held in April 2025 with representation from all key areas relating to Day Case

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar/Apr-25)	Target	RAG	Comments
							Arthroplasty. Outpatient Improvement Programme • A SOP (Standard Operating Procedure) is being developed to manage the appointment Type change within the outpatient appointment booking process. This is planned to be approved in Q1. • Training is to commence with Outpatient Central Booking Team first before wider roll out to all Outpatient Booking Teams.
	2.6 We will improve and embed a culture of Quality Improvement across the organisation (aligned to the Patient Safety Incident Response Framework).	Continue to embed Patient Safety Incident Response Framework by developing and maintaining effective systems and responses for responding to patient safety incidents across the Trust	For detailed performance information against this metric please see latest Quality Priorities update, shared twice annually at QAC for assurance				• The Patient Safety Syllabus Training is available to staff via the ESR platform and is mandated for staff who have been assessed as part of the Training Needs Analysis. Compliance is currently Level 1 at 97%, Level 2 at 86% and Senior Leaders at 94%. • 4 Patient Safety Specialists within the organisation have undertaken the level 3 and 4 Patient Safety Training Syllabus, with Loughborough University. Funding has been agreed for a further 5 members of staff to undertake this training during 2025.
3. Patient experience: We will place the quality of patient experience at the heart of all we do, where 'seeing the person in the patient' is our norm.	3.1 We will empower patients to be active participants in their care, giving consistent information, listening and discussing next steps in their care.	A reduction in both PALS and complaints in relation to communication as a key theme.	9.4% (Complaints with a primary theme of communication)		>9.4%		The Trust continues to sustain performance in the timely completion of complaints at 100% in time. At the time of reporting, there was 1 complaint over 6 months old. This was due to the patient's wishes to add further questions following review of patient records. All CBUs have a designated complaints case handler to ensure consistency. The Complaints Policy has been updated and is currently about to be circulated for consultation in Q1. This policy is expected to be ratified and Policy Review Group in early Q2. 7 PHSO cases were open at the time of reporting, these were not linked to a specific area or theme.
			22.75% (PALS with a primary theme of communication)		>22.75		
	3.2 We will ensure an inclusive communications method for each patient, taking into account their personal circumstances, using clear and easy to understand language.	Evidenced through improved use of interpreters for both people of whom English is not their first language and British sign language users					Language line call volumes have increased by 10%, with an average of 402 bookings made each month in 2024/25.

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-23)	Current Position (Mar/Apr-25)	Target	RAG	Comments
	3.3 We will create first and lasting impressions which contribute towards a positive experience of care.	Monitored by: - Ward accreditation - Leadership observations - Patient experience walk round - Governors walk rounds. - Feedback received at Patient experience sub committee					
	3.4 We will improve patient experience for those with mental health attendance.	Ensure that there are robust frameworks in place to care for patients with mental health challenges, evidenced through the implementation of a training package for nursing and medical staff and 95% compliance with the completion of Mental Health Act assessment and detention documentation	For detailed performance information against this metric please see latest Quality Priorities update, shared twice annually at QAC for assurance				• Training compliance is 97.59% (April 2025). • A rolling training programme is currently being planned, and the Associate Chief Nurse of Unplanned Care continues to work with the Mental Health Law Administrator and have scheduled monthly teaching sessions for frontline teams. • The Emergency Department is conducting a scoping exercise to examine having a Core 24 employee available when triaging mental health patients at the front door who could need assistance but might not need admission or additional assessment.
	3.5 We will reduce internal Hospital delays related to discharge planning to support safe and effective discharge, this will be evidenced	Evidenced through a reduction in failed discharges and a reduction in patients with 'no criteria to reside' averaged over 12 months	For detailed performance information against this metric please see latest Quality Priorities update, shared twice annually at QAC for assurance				• The Care Needs Assessment CDC updated form was piloted and evaluated during Q3. The pilot was not successful as the system did not pull through all the data required. A further test on this work is taking place during Q1 2025/26. • Transfer of Care Hub (TOCH) Nurses are now embedded across 5 wards as planned. 1 post remains vacant due to recruitment freeze. Improvements have been seen across the 5 inpatient wards in relation to the number of discharges, length of stay and the percentage of no criteria to reside.
	3.6 We will improve the compliance with the Nutritional Assessment of Adult inpatients utilising the Malnutrition Universal Screening Tool (MUST).	The overall target of the Trust is to achieve 95% compliance with assessment being completed within 24 hours of admission and then as a minimum every 7 days during their inpatient stay. With an aim to improve on current compliance in both metrics by 25% this year and to provide assurance that the appropriate level of intervention is provided to support patients in relation to their assessed needs and improve clinical outcomes.	For detailed performance information against this metric please see latest Quality Priorities update, shared twice annually at QAC for assurance				• MUST compliance in the 7-day assessment metric failed to meet the goal of a 25% improvement (Q4 – 20.3%). • The MUST has now been added to the Clinical Indicators Tab on Lorenzo and a further amber indicator prior to red will be added as a warning to allow staff sufficient time to ensure the MUST is completed. • Targeted training has been offered and provided to areas with compliance significantly below the Trust average.

Table 1: Quality Strategic Priorities and Measures of Success March 2025

An update on progress of the Strategic Priorities for the People aims was reported to SPC on 16th April 2025 as per the WHH People Strategy Annual Report.

Trust Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position (Mar 25)	Target	RAG	Comments
5. Looking after our people: We will prioritise the safety, health, wellbeing and experience of our people to ensure work has a positive impact.	5.1 We will ensure leaders have the skills, competencies, and behaviours to support staff health and wellbeing.	Reduction in sickness absence	5.60%	5.67%	4.2% supporting attendance		Development of WHH Leaders to Support Staff's Health and Wellbeing - 79% implemented
	5.2 We will support staff to remain in work and be present through the adoption of best practice, as evidenced through utilisation of the NHS Health and Wellbeing Cultural Framework.	Improved Retention	83.36%	87.28%	86% retention		Embed the NHS Health and Wellbeing Cultural Framework - 75% implemented
	5.3 We will provide bespoke health promotion programmes to our workforce to address population health inequalities impacting on their health and wellbeing.	Reduction in bank and agency reliance	17.00%	14.35%	9% reliance		Develop Bespoke Health Promotion Programmes to Address Population Health Inequalities - 67% Implemented
	5.4 We will equip line managers to use person centred engagement practices which improve employee experience.	Reduced turnover	15.98%	11.88%	13%		Empower Managers to Enhance Employee Experience - 38% Implemented
	5.5 We will implement employee recognition and appreciation schemes, which are accessible and valued by our staff.	Reduction in vacancy rate	11.53%	8.39%	9%		Promote Employee Recognition and Appreciation Schemes - 78% Implemented
	5.6 We will consistently apply onboarding process to the recruitment of our leaders, ensuring they have a personal priority to establish a great first impression for our patients and staff.						Onboarding - Create a Great First Impression - 65% Implemented
6. Innovating the way we work: We will embrace new ways of working to attract and retain an engaged, responsive, diverse and flexible workforce to care for our patients.	6.1 We will develop strategic workforce plans which are reflective of current and future needs.	Reduction in Vacancy Rate	11.53%	8.39%	9%		Development of Workforce Plans - 85% Implemented
	6.2 We will participate in system wide workforce planning.	Reduced Staff Turnover	15.98%	11.88%	13%		System wide approach to Education that enables Fair and Equitable access - 100% Implemented
	6.3 We will embed new roles within multidisciplinary teams, which harness available skill sets of a diverse workforce and promote adaptable ways of working and create agile teams.	Improved Retention	83.36%	87.28%	86% retention		Embed Agile Working Principles 100% Implemented
	6.4 We will attract and retain a transformed and flexible workforce that can deliver care to patients in new and different ways.	Reduction in bank/agency reliance	17%	14.35%	9% reliance		Equip the Workforce to review Models of Care - 75%
	6.5 We will equip our workforce with the skills to shape and deliver effective and changing models of care.						Enhance the Digital Capability - 85% Implemented

Trust Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position (Mar 25)	Target	RAG	Comments
	6.6 We will enhance digital capability, skills and leadership which embrace digitally enabled services.						Improve Attraction and Retention - 62% Implemented
7. Growing our workforce for the future: We will support personal and professional development, ensuring equal access to opportunities, and nurture, grow and develop diverse teams.	7.1 We will recruit and develop managers and leaders using the WHH Line Management standards within the Line Management Training Framework.	Improved mandatory training compliance	86.11%	90.14%	85% compliance for mandatory		WHH Leadership Development Programme - 100%
	7.2 We will develop a pipeline of career development opportunities aimed at nurturing and growing diverse teams from Kickstart Scheme recruits, work experience placements, apprenticeships, pre-registers multi professional students, inhouse training programmes and continuous professional development programmes (Further and Higher education) aligned to annual workforce plans.	Improved role-specific training compliance	84.21%	88.33%	85% compliance for role specific training		Widen Participation in Development Programmes - 100% Implemented
	7.3 We will maximise accessible development programmes including apprenticeship programmes, Continuous Professional Development programmes, role specific training and leadership development.	Reduction in Vacancy Rate	11.53%	8.39%	9%		Review Mandatory and Role Specific Training - 100% Implemented
	7.4 We will implement the NHS Talent Management and Succession Planning framework Scope for Growth to ensure line managers are clear about their responsibilities for their staff.	Reduced Staff Turnover	15.98%	11.88%	13%		Scope for Growth Appraisal Implementation - 100% Implemented
	7.5 We will provide a range of options for all staff seeking career progression, including professional education, training, shadowing, mentoring, coaching, and secondments.	Improved Retention	83.36%	87.28%	86%		WHH Career Development - 83% Implemented
	7.6 We will equip Team leaders to use structured tools and techniques to develop effective team working within their Care Groups, across Care Groups and with the wider health and social care system.	Reduction in bank/agency reliance	17.00%	14.35%	9%		Team Development - 100% Implemented
		Improved appraisal compliance	64.24%	79.22%	79%		
8. Belonging in WHH: We will enable staff to have a voice through the development of a just and learning culture.	8.1 We will ensure staff are able to speak up and feel heard, without fear of reprisal – including access to staff networks, Freedom to Speak Up channels and trade unions.	Reduction in Vacancy Rate	11.53%	79.48%	9%		Staff Able to Speak Up and Feel Heard - 78% Implemented
	8.2 We will ensure all leaders and line managers have the skills to create psychological safety and enable workforce recovery consistent with the principles of restorative and just cultures.	Reduced Staff Turnover	15.98%	11.88%	13%		Create a culture of Psychological Safety - 50% Implemented
	8.3 We will deliver compassionate interventions for individuals and teams who have experienced hurt due	Improved Retention	83.36%	87.28%	86%		Compassionate Leadership - 57% Implemented

Trust Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position (Mar 25)	Target	RAG	Comments
	to people practices, incivility, bullying, harassment, or discrimination.						
	8.4 We will ensure leaders and line managers have access to co-created resources designed to assist them to deliver compassionate and inclusive people practices.	Reduction in bank/agency reliance	17.00%	14.35%	9%		Access to Co-Created Resources to Assist in the Delivery of Compassionate and Inclusive People - 60% Implemented
	8.5 We will ensure principles of a restorative and just culture are evident in all workforce policies and procedures.	Reduction in sickness absence	5.60%	5.67%	4.20%		Adopt Principles of a Restorative and Just Culture - 25% Implemented
	8.6 We will embed a behavioural framework in WHH appraisal process for each Trust value which promotes civility, kindness, and respect for all staff.						Behavioural Framework Embedded for Each Trust Value which Promotes Civility, Kindness and Respect for all Staff - 86% Implemented

Table 2: People Strategic Priorities and Measures of Success March 2025

An update on progress of the Strategic Priorities for the Sustainability aims was reported to FSC on 2nd June 2025 as per the Sustainability Strategic Priorities Bi-Annual Report.

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
9. Working in partnership: We will collaboratively work to provide sustainable, high quality acute services and to support prevention and integrated care in the community	9.1 We will collaborate with local secondary care providers to help tackle care backlogs, reduce unwarranted variation in care access and service delivery, address health inequalities and deliver more efficient, sustainable services.	RTT – Number of patients patient waiting 65+ weeks will be 0 by March 2024	478	128	0		The Trust ended March 25 with 128 breaches, this was made up of 35 capacity breaches, 55 patient choice and 38 patients who were categorised as complex / not fit for surgery with a short-term illness.
		Volume and Impact of collaborative projects being delivered with partners to reduce care backlogs to reduce unwarranted variation in care access and service delivery, address health inequalities and deliver more efficient, sustainable services.					The capacity breaches were mainly across 3 specialties, Gynae, T&O and Pain services, the services are continuing working on reducing long waiting patients. 52 weeks continues to reduce in line with the Trust trajectory and recovery plans have been drawn up inline with the 25/26 operational planning guidance. An additional theatre will be opening in September as part of the Target investment fund which will support treating long waiting patients. A number of collaborative projects are ongoing, including: LIMS - 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

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
							the hub model continues to ensure alignment. Pathology collaboration - Work continues to develop the East Pathology Hub and an outline business case was approved by WHH Trust Board in November 2024. Detailed work is ongoing to develop a full business case which will be presented to the Trust Board in July The 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
	9.2 We will collaborate with primary care, community care, social care and all community partners, including the voluntary sector to support the provision of integrated care in the community and prevention of ill health. It is proposed that this includes relocation of appropriate secondary care into the community, following the principle of right service, delivered	Increased number of clinical appointments in off-site locations	87,582 (Total number of outpatient appointments, including DNAs & cancellations, 2022/23)	121,746 (28% increase)	5% increase		Trust embedded within a number of projects at place and region, including Prevention Pledge (ICB) and One Halton Wider Determinants of Health (Place) among others.
		Deliver Living Well Hub in 2023/24.					Living Well Hub delivered.
		Deliver Runcorn Town Deal Hub by end of 2025/26.					Runcorn Town Deal Hub construction programme underway. Building handover expected November 2025 and service go live early 2026.
		Deliver phase 1 and 2 of new Community Diagnostic Centre in 2023/24.					CDC Phase 1 and 2 complete.

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
	in the right place to deliver excellent patient care and experience and to improve access and address health inequalities.	Deliver phase 3 of new Community Diagnostic Centre in 2024/25. Actively contribute to delivery of projects at place and regional level which seek to improve access and address health inequalities					Phase 3 handover delayed to May 2025.
	9.3 We will review opportunities to provide services more locally for our residents who currently travel to specialist Trusts. This would be approached on a service by service basis to ensure the best outcomes for patients and our regional healthcare system.	Proactively review repatriation opportunities at service level.					Discussion of opportunities undertaken through strategic priority setting conversations. Opportunities including Paediatric Hub in partnership with Alder Hey in progress.
10. Working responsibly: We will continue to address health inequalities, creating social value for our communities, and progressing our Green Plan ambitions.	10.1 We will work in coordination with our system and place partners to prioritise the five strategic priorities for tackling health inequalities and improving population health, as outlined in the Core20PLUS5 approach.	Support both Warrington and Halton to develop place maturity. Deliver our Core20PLUS5 objectives. Deliver community spirometry services on behalf of Warrington and Halton.					Trust embedded within Place and ICB governance to support place maturity. This includes leading on a number of workstreams within both One Halton and Warrington Together. As part of a planned review of respiratory pathways across Halton and Warrington, been undertaking active case finding to identify potential undiagnosed cases of people with Chronic Obstructive Pulmonary Disease (COPD). Currently working with colleagues at Bridgewater to align our approaches to tackling health inequalities. The Director of Population Health and Inequalities is supporting both organisations.

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
							Integrated a health inequalities approach into our Trust's quality improvement priorities. Community spirometry now delivered via CDC, with more than 3,000 tests delivered across 2024/25.
	10.2 We will identify opportunities to reduce the Trust's consumption of resources in order to reduce CO2 emissions.	Heat decarbonisation plan in place by end of 2023/24 for Halton and Warrington sites.					The Trust has recently attracted £653,100 to undertake a scheme to replace 1,500 lights with LED alternatives. This will generate anticipated carbon savings of 223,633kg CO2e.
		Annual reduction in CO2 emissions	14,200tCO2e		5-10% reduction by 2025		
		Number of procedures/care pathways with carbon footprints calculated.	0	1	5		
	10.3 We will drive improved social value for our local population increasing the social and economic wellbeing in the communities we serve.	Maintain the number of local people employed by the Trust	77.00%		77.00%		3 local jobs supported through the creation of the Warrington Living Well Hub
			(staff with a Warrington or Halton postcode)				
		Prioritise spend with local suppliers In Cheshire and Merseyside.					
		Jobs created as a result of projects.					
	Increased Town centre footfall as a result of enhancing service provision within community locations, with 70% of clients attending Halton Health hub, the Living Well Hub and the Runcorn Health and Education Hub reporting that the presence of the Hub has encouraged them to come to the Town Centre.	In development via patient survey ready for Q1 reporting.		70%			

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
		Learning opportunities created and supported to support people into education and jobs					
	10.4 We will embed sustainability as part of our business-as-usual processes, making it a core consideration of the way the Trust operates, empowering staff to take action and delivering care in a way that supports NHS green ambitions of achieving a net zero National Health Service by 2045	Staff-led initiatives/Quality Improvement projects incorporating sustainability. Green ambitions included within corporate paperwork (job descriptions, Trust induction etc) Assessment criteria for environmental impact included in capital project proposals					Some sustainability initiatives identified by teams across the Trust, including Theatre Team, ICU team and IPC team. Information capturing complete. Funding opportunities being assessed when available. No live opportunities ongoing. Methodology for capturing information needed to calculate carbon/environmental impacts developed to ensure robust calculations and like-for-like comparisons. Plan for Green Plan refresh underway. To be shared with NHS C&M July 2025.
	10.5 We will deliver the commitments set out in the NHS Prevention Pledge and use data and digital technologies to inform care planning, to support the development and adoption of innovative, population-based models of care.	Delivery of prevention pledge action plan.					Prevention Pledge annual report submitted in March 2025. 2025/26 prevention pledge action tracker in development. Case study submitted to NHS Cheshire and Mersey ICB on preventative opportunities created through the creation of the Living Well Hub.
11. Sustainable Estate and digitally enabled service models: We will provide our services in an estate that is fit for purpose, supported by the realisation of digital opportunities and	11.1 We will continue to develop our plans for a new hospital in Warrington and a new hospital and wellbeing campus in Halton, seeking all investment opportunities to realise our new hospitals vision.	Submit bids at all available opportunities. Delivery of case of need communications plan. Explore alternative funding options to deliver new hospitals and estates enablers.					The Trust's New Hospitals programme continues to explore options to deliver against the vision for new estate. Phased redevelopment planning to commence. Alternative funding models and opportunities being pursued via partner organisations.

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
aligned to the needs of our patients, staff and populations							CDC phase 3, new build CT and MRI adjacent to CSTM due to complete May 2025.
	11.2 We will review how and where our services are delivered, investing wisely in existing estate to support long-term plans and make the most appropriate and effective use of clinical space, whilst we work towards our realisation of our new hospitals.	Deliver TIF Deliver CDC Deliver Living Well Hub Deliver Runcorn Health & Education Hub. Deliver Trust Capital Programme Refresh Trust Estates Strategy and develop opportunities. Work with partners at place and in C&M to maximise public sector estate utilisation.					TIF, CDC, and Runcorn Health and Education Hub project delivery is ongoing. Living Well Hub project complete. Trust estates Strategy ratified. Work now ongoing with Bridgewater as part of integration to assess estate and identify opportunities for efficiencies. Trust embedded within Place and ICB governance for strategic estate programmes. A review of all estate is ongoing as part of the integration programme. This is supported by, and aligned with, C&M ICB estates planning methodology, including site categorisation principles, and broader NHS guidelines on capital prioritisation.
	11.3 We will enhance our digital infrastructure to ensure it is reliable, modern, secure, sustainable and resilient, developing high performing multi-disciplinary digital teams to deliver major digital investments in electronic patient records and cloud migration.	WGLL Digital Maturity Assessment (DMA) - Smart Foundations.	DMA Overall 2.9	Smart Foundations – 3.6	Smart Foundations 4.6		The IT replacement programme is a Trust-funded capital scheme delivered over two years The 2024/25 period marks the successful completion of the programme's second year, which has delivered a full replacement of the Trust's wired and wireless local area network.

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
							Following this success, additional funding has been approved for a Phase 3 network refresh.
	11.4 We will transform care pathways and reduce unwarranted variation, using digital solutions to enhance services for patients, ensuring they can access services when and where needed, including remote care that is optimised through Patient Held Records (PHRs) and smartphone Apps, enabling patients to take an active role in their healthcare.	Empowering Citizens		Empowering Citizens 1.10	Empowering Citizens 4.1		The WHH Patient Engagement Platform (PEP) successfully went live on 10th June 2024, as planned. In conjunction with the NHS App, the PEP enables all WHH patients to securely receive electronic correspondence from the hospital and manage appointments easily online — helping to reduce DNAs and minimise telephone calls to Outpatients. All appointment and Radiology related appointment and details for WHH patients who choose to register via the App. Planning is already underway for Phase 2, which will extend the platform to include clinical correspondence. This will further enhance digital engagement while delivering additional savings through reduced printing and postage costs. There is growing interest in the use of AI tools. In 2025/26, we plan to pilot an Ambient Artificial Intelligence (AI) solution—best described as 'listening' software. This tool will be trialled in Outpatients, where it will listen to consultations between patients, carers, and clinicians. The aim is to reduce the need for manual note-taking by

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
							automatically generating a consultation record and a GP letter based on the conversation. iRefer – Clinical Decision Support (CDS) Tool for Radiology Tests: Now implemented across both Primary and Secondary Care, iRefer supports clinicians in selecting the most appropriate imaging tests. It is designed to reduce the number of incorrect or unnecessary test requests, helping to avoid unnecessary patient exposure to radiation.
	11.5 We will replace our Electronic Patient Records system to reduce paper use, minimising physical storage needs, and eliminate the dependency on paper records, reducing both material and disposal costs. It will facilitate better patient flow management reducing waiting times and allowing more efficient use of clinical resources. It will contribute greener healthcare infrastructure. The improved EPR will provide proactive alerts to enhance decision making by providing clinicians with real-time, evidence-based insights that support accurate diagnoses, treatment						Joint Procurement Delivery Group ToR and Partnership Procurement and Deployment Agreement endorsed. Both Trust agreed to work towards single Pre-Market Engagement (PME) in April. Following Exec to Exec and NHSE/ICB 10th March meeting work continues in finalising the procurement / deployment plans and finding a solution to funding issue. Bridgewater inclusion in EPR procurement Option 3 Two Phase ITT WHH/MWL Acute EPR ITT followed by WHH/BW Community EPR ITT.

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
	choices, and resource utilisation.						
12. Finance sustainability: We will act according to our duty to collaborate, by working with partners on shared financial objectives to achieve sustainability of the Trust and the wider Cheshire and Merseyside system.	12.1 We will deliver the Trust's agreed financial plan.	Achievement of CIP programme	£19.4m	CIP performance for 2024/25 was £18.5m against a £19.4m target (£12.6m recurrent)	£17.9m		Although the CIP target was not fully achieved for the 2024/25 financial year it was the highest in year and recurrent delivery to date. The Trust has recorded a deficit position of £16.8m subject to audit. This is a £5.5m variance against a revised deficit plan of £11.3m. The drivers of the variance are CIP not delivered (£0.9m), collaboration and cost pressures that have not been offset as in previous months (£4.3m) and PwC consultancy costs (£0.3m).
		Achievement of agreed financial plan	£27.8m deficit revised to £11.3m deficit following receipt of deficit support funding (£16.5m)	£16.8m deficit subject to audit for the year ended 31 March 2025	£15.7m deficit		
	12.2 We will participate, lead and contribute to system wide procurement to drive increased efficiencies and benefits.	Actively participate and contribute to the delivery of the ICS Procurement 34 Point Action Plan. Actively participate and contribute to the development of procurement within the ICS. Successful in leading on the introduction of a single Contract Management platform across the ICS.					The Trust is playing an active role in the development of the ICS procurement programme. Alison Parker is the Deputy Chief Procurement Officer. The Trust has now adopted Atamis, a centralised contract tender management system across the ICS to include trusts workplan's and contract registers. The C&M Procurement Community has developed a workplan to delivery increased savings and has appointed HealthTrust Europe to support Trusts in delivery of the workplan. There are also links with other ICS level networks to support collaboration (HR, IT, Estates etc.) A savings tracker has been developed to track savings a

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
							both Trust and ICS Level. Governance has been developed and introduced for the management of projects.
	12.3 We will deliver value for money by ensuring efficient use of resources	Amber or Green rating achieved in the Value for Money assessment undertaken by the Trust's external auditors and reported in the Auditor's Annual Report	Amber	Red – A risk of significant weakness with regard to the Trust's arrangements to secure financial sustainability was identified. The Trust recorded a deficit position worse than plan in 2024/25 and is in receipt of cash support from NHSE.	Amber or Green rating		Given the Trust recorded a deficit £5.5m worse than plan in 2024/25 and remains in receipt of cash funding, it is expected that the rating for Financial Sustainability will be red again for 2024/25. The report will be received in June 2025.

Table 3: Sustainability Strategic Priorities and Measures of Success March 2025

3. MONITORING/REPORTING ROUTES

The monitoring and reporting route for the Trust Strategy is described in the diagram below:

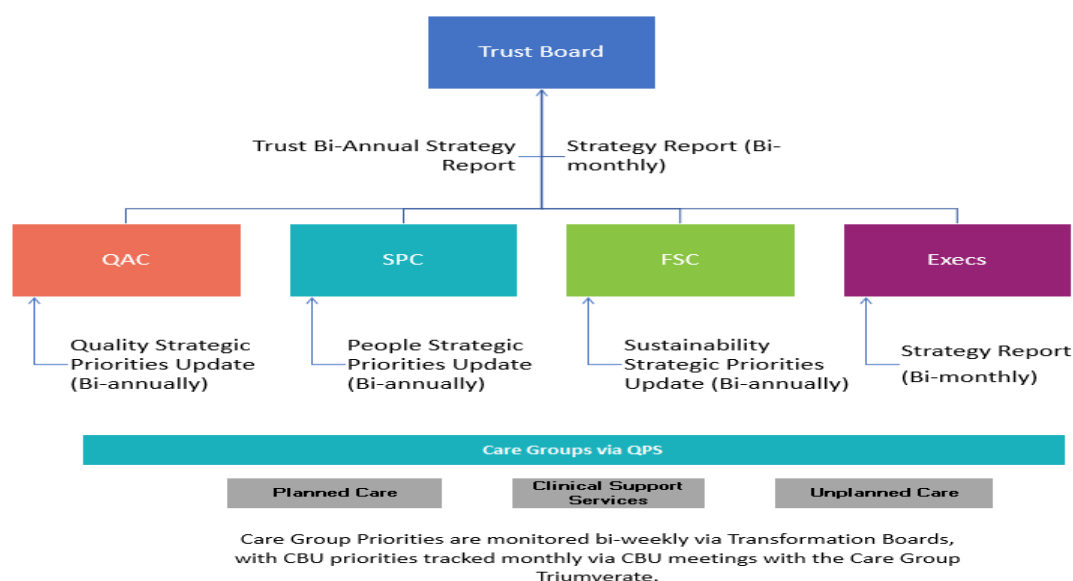


Figure 2: Monitoring and reporting arrangements for Trust Strategy 2023-25

4. TIMELINES

The Trust Strategy was due for refresh in 2025. As the Trust is undertaking a programme of integration with Bridgewater Community Healthcare NHS Foundation Trust, this full refresh of the strategy will take place as part of the integration programme, now expected in 2026.

Ahead of the development of an integrated strategy we have undertaken a relatively light touch review and refresh of the Strategic Objectives and their measures of success / KPIs to ensure progress against our strategic direction.

The updated objectives for 2025/26, agreed by the executive team and approved at Trust Board in February 2025 are presented overleaf.

Strategic Objectives – Quality	Overarching quality priorities
1. Patient safety: We will enhance our patients' safety and develop a learning culture where quality and safety is everyone's top responsibility.	1.1 We will keep our patients, service users and staff safe from harm through the delivery of harm free care.
	1.2 We will create a culture where the safety of patients, their relatives and our staff is our foremost priority
	1.3 Design and support safety programmes that deliver effective and sustainable change
2. Clinical effectiveness: We will ensure practice is based on evidence so that we do the right things in the right way, to achieve the right outcomes for our patients	2.1 We will make sure we 'get it right first time' by providing consistent care and supporting productivity improvement projects which deliver the best outcomes for our patients
	2.2 We will prioritise the application and embedding of QI methodology in linking with quality and safety programmes and to empower staff and achieve measurable improvement work with identifiable learning and sustainable results.
	2.3 We will work with our partners to understand and address the causes of health inequality to help people stay in control of their own health.
3. Patient experience: We will place the quality of patient experience at the heart of all we do, where 'seeing the person in the patient' is our norm.	3.1 We will ensure a positive patient experience, enhancing the experience of our patients and service users.
	3.2 We will maintain our focus on patients and their families' equality, diversity and inclusion.
	3.3 The patients and the publics' voice is integral in the decision-making process when making changes to services or care delivery.
4. Research, Development and innovation: We will work in partnership on high quality clinical research for the benefit of patients, public and staff.	4.1 We will continue to create opportunities for members of the public to gain access to clinical research trials contributing to the health of our population.
	4.2 We will further develop and grow our research capability through the application and selection for clinical trials.
	4.3 We will develop staff across a range of disciplines as Principle Investigators to grow research capability within our workforce.

Table 4: Updated Quality Strategic Priorities 2025/26

Strategic Objectives - People	Strategic Priorities - People
5. Looking after our people: We will prioritise the safety, health, wellbeing and experience of our people to ensure work has a positive impact.	5.1 We will ensure leaders have the skills, competencies, and behaviours to support staff health and wellbeing.
	5.2 We will support staff to remain in work and be present through the adoption of best practice, as evidenced through utilisation of the NHS Health and Wellbeing Cultural Framework.
	5.3 We will provide bespoke health promotion programmes to our workforce to address population health inequalities impacting on their health and wellbeing.
	5.4 We will equip line managers to use person centred engagement practices which improve employee experience.
	5.5 We will implement employee recognition and appreciation schemes, which are accessible and valued by our staff.
	5.6 We will consistently apply onboarding process to the recruitment of our leaders, ensuring they have a personal priority to establish a great first impression for our patients and staff.
	5.7 We will understand where there are workplace inequalities and take action address them.
	5.8 We will ensure that all individuals and teams have measurable objectives on equality, diversity and inclusion.
6. Innovating the way we work: We will embrace new ways of working to attract and retain an engaged, responsive, diverse and flexible workforce to care for our patients.	6.1 We will develop strategic workforce plans which are reflective of current and future needs.
	6.2 We will participate in system wide workforce planning.
	6.3 We will embed new roles within multidisciplinary teams, which harness available skill sets of a diverse workforce and promote adaptable ways of working and create agile teams.
	6.4 We will attract and retain a transformed and flexible workforce that can deliver care to patients in new and different ways.
	6.5 We will equip our workforce with the skills to shape and deliver effective and changing models of care.
	6.6 We will enhance digital capability, skills and leadership which embrace digitally enabled services.
	6.7 We will create continuous improvement processes, seeking feedback from staff networks and other groups.
	6.8 We will provide clear and inspiring pathways to address under-representation of our staff with protected characteristics.
7. Growing our workforce for the future: We will support personal and professional development, ensuring equal access to opportunities, and nurture, grow and develop diverse teams.	7.1 We will recruit and develop managers and leaders using the WHH Line Management standards within the Line Management Training Framework.
	7.2 We will develop a pipeline of career development opportunities aimed at nurturing and growing diverse teams from Kickstart Scheme recruits, work experience placements, apprenticeships, pre-registers multi professional students, inhouse training programmes and continuous professional development programmes (Further and Higher education) aligned to annual workforce plans.
	7.3 We will maximise accessible development programmes including apprenticeship programmes, Continuous Professional Development programmes, role specific training and leadership development.
	7.4 We will implement the NHS Talent Management and Succession Planning framework Scope for Growth to ensure line managers are clear about their responsibilities for their staff.

Strategic Objectives - People	Strategic Priorities - People
	7.5 We will provide a range of options for all staff seeking career progression, including professional education, training, shadowing, mentoring, coaching, and secondments.
	7.6 We will equip Team leaders to use structured tools and techniques to develop effective team working within their Care Groups, across Care Groups and with the wider health and social care system.
	7.7 We will recognise and sponsor high potential individuals from under-represented backgrounds to enable them to fulfil their potential with a clear development plan.
	7.8 We will use and monitor key equality, diversity and inclusion indicators to develop diverse teams.
8. Belonging in WHH: We will enable staff to have a voice through the development of a just and learning culture.	8.1 We will ensure staff are able to speak up and feel heard, without fear of reprisal – including access to staff networks, Freedom to Speak Up channels and trade unions.
	8.2 We will ensure all leaders and line managers have the skills to create psychological safety and enable workforce recovery consistent with the principles of restorative and just cultures.
	8.3 We will deliver compassionate interventions for individuals and teams who have experienced hurt due to people practices, incivility, bullying, harassment, or discrimination.
	8.4 We will ensure leaders and line managers have access to co-created resources designed to assist them to deliver compassionate and inclusive people practices.
	8.5 We will ensure principles of a restorative and just culture are evident in all workforce policies and procedures.
	8.6 We will embed a behavioural framework in WHH appraisal process for each Trust value which promotes civility, kindness, and respect for all staff.
	8.7 We will understand, encourage and celebrate diversity ensuring that we equip staff with the equality, diversity and inclusion knowledge to be inclusive allies, recognising that although staff may not be a member of a marginalised group(s), they are able to support others.
	8.8 We will develop leaders and managers to build on existing interventions and develop new mechanisms to support all staff to speak up and feel heard, without fear of reprisal.

Table 5: Updated People Strategic Priorities 2025/26

Strategic Objectives - Sustainability	Strategic Priorities - Sustainability
9. Working in partnership: We will collaboratively work to provide sustainable, high quality acute services and to support prevention and integrated care in the community	9.1 We will collaborate with local secondary care providers to help tackle care backlogs, reduce unwarranted variation in care access and service delivery, address health inequalities and deliver more efficient, sustainable services.
	9.2 We will collaborate with primary care, community care, social care and all community partners, including the voluntary sector to support the provision of integrated care across Halton and Warrington
	9.3 We will review opportunities to provide services more locally for our residents who currently travel to specialist Trusts, in line with local and regional opportunities
	9.4 We will realise opportunities to deliver excellent patient care and experience and to improve access and address health inequalities aligned to the principle of right service, delivered in the right place
	9.5 We will work with partners across our places to enhance the resilience of our Urgent and Emergency Care system, improving patient experience
	9.6 We will develop a programme of integration with our local community Trust to improve patient outcomes and experience, improve operational delivery and improve financial sustainability
10. Working responsibly: We will continue to address health inequalities, creating social value for our communities, and progressing our Green Plan ambitions.	10.1 We will work in coordination with our system and place partners to prioritise the five strategic priorities for tackling health inequalities and improving population health, as outlined in the Core20PLUS5 approach.
	10.2 We will identify opportunities to reduce the Trust's consumption of resources in order to reduce CO2 emissions.
	10.3 We will drive improved social value for our local population increasing the social and economic wellbeing in the communities we serve.
	10.4 We will embed sustainability as part of our business-as-usual processes, making it a core consideration of the way the Trust operates, empowering staff to take action and delivering care in a way that supports NHS green ambitions of achieving a net zero National Health Service by 2045
	10.5 We will deliver the commitments set out in the NHS Prevention Pledge and use data and digital technologies to inform care planning, to support the development and adoption of innovative, population-based models of care.
11. Sustainable Estate and digitally enabled service models: We will provide our services in an estate that is fit for purpose, supported by the realisation of digital opportunities and aligned to the needs of our patients, staff and populations	11.1 We will continue to develop our plans for a new hospital in Warrington and a new hospital and wellbeing campus in Halton, seeking all investment opportunities to realise our new hospitals vision.
	11.2 We will review how and where our services are delivered, investing wisely in existing estate to support long-term plans and make the most appropriate and effective use of clinical space, whilst we work towards our realisation of our new hospitals.
	11.3 We will enhance our digital infrastructure to ensure it is reliable, modern, secure, sustainable and resilient, developing high performing multi-disciplinary digital teams to deliver major digital investments in electronic patient records and cloud migration.
	11.4 We will transform care pathways and reduce unwarranted variation, using digital solutions to enhance services for patients, ensuring they can access services when and where needed, including remote care that is optimised through Patient Held Records (PHRs) and smartphone Apps, enabling patients to take an active role in their healthcare.

Strategic Objectives - Sustainability	Strategic Priorities - Sustainability
12. Finance sustainability: We will act according to our duty to collaborate, by working with partners on shared financial objectives to achieve sustainability of the Trust and the wider Cheshire and Merseyside system.	12.1 We will deliver the Trust's agreed financial plan.
	12.2 We will participate, lead and contribute to system wide procurement to drive increased efficiencies and benefits.
	12.3 We will deliver value for money by ensuring efficient use of resources
	12.4 We will pursue commercial and growth opportunities where in line with Trust strategy to improve the sustainability of the Trust and the services we provide
	12.5 We will deliver improvements to Trust productivity

Table 6: Proposed updated Sustainability Strategic Priorities 2025/26

5. ASSURANCE COMMITTEE

All as noted above.

6. RECOMMENDATIONS

The Trust Board is asked to note progress of the delivery of the Trust Strategy 2023-25 through the Strategic Priorities across Quality, People and Sustainability aims.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/25/08/71			
SUBJECT:	Code of Governance Compliance			
DATE OF MEETING:	6 August 2025			
AUTHOR(S):	Emily Kelso, Corporate Governance and Membership Manager.			
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	<i>Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</i>			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	Yes	No	N/A
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	Yes	No	N/A
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	Yes	No	N/A
				✓
	Further Information:			
EXECUTIVE SUMMARY (KEY ISSUES):	The Code of Governance for NHS Provider Trusts was most recently updated in April 2023 and sets out a common overarching framework for the corporate governance of trusts, reflecting developments in the UK corporate governance and the development of integrated care systems. Trusts must comply with each of the provisions of the code or, where appropriate, explain in each case why the trust has departed from the code. The provisions of the code, as best practice advice, do not represent mandatory guidance and accordingly non-			

	compliance is not in itself a breach of Condition FT4 of the NHS Provider Licence. The Annual Reporting Manual requires the Board of Directors to have considered the Trust's compliance/ non-compliance with the Code and to include a statement to this effect in the Annual Report. The Trust is declaring compliance with all elements of the code except: • C.4.3 – Explanation provided • D.2.1 – Explanation provided		
PURPOSE: <i>(please select as appropriate)</i>	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to note the content of the report.		
PREVIOUSLY CONSIDERED BY:	Committee	Audit Committee	
	Agenda Ref.	AC/25/06/033	
	Date of meeting	23 June 2025	
	Summary of Outcome	noted	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: <i>(if relevant)</i>	None		

REPORT TO TRUST BOARD

SUBJECT	Code of Governance Declaration 2024-25	AGENDA REF:	BM/25/08/71

1. BACKGROUND/CONTEXT

The Code of Governance for NHS Provider Trusts was most recently updated in April 2023 and sets out a common overarching framework for the corporate governance of trusts, reflecting developments in the UK corporate governance and the development of integrated care systems.

Trusts must comply with each of the provisions of the code or, where appropriate, explain in each case why the trust has departed from the code.

The provisions of the code, as best practice advice, do not represent mandatory guidance and accordingly non-compliance is not in itself a breach of Condition FT4 of the NHS Provider Licence.

The Annual Reporting Manual requires the Board of Directors to have considered the Trust's compliance/ non-compliance with the Code and to include a statement to this effect in the Annual Report.

2. KEY ELEMENTS

The Code of Governance for NHS Provider Trusts comprises of the following sections:

- Section A: Board leadership and purpose
- Section B: Division of responsibilities
- Section C: Composition, succession and evaluation
- Section D: Audit, risk and internal control
- Section E: Remuneration
- Appendix B: Council of Governors

The Trust Board has overall responsibility for the administration of sound corporate governance throughout the Trust and recognises the importance of a strong reputation. The purpose of the Code is to assist Foundation Trust Boards to ensure good governance and to improve their governance practices by bringing together the best practice of public and private sector corporate governance.

The Code imposes some disclosure requirements on Foundation Trusts and Boards are expected to observe the Code or to explain where they do not comply. It includes a number of main and supporting principles and provisions and Foundation Trusts are required to publish a statement in the Annual Report confirming how these have been applied.

Warrington and Halton Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in April 2023, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Trust is declaring compliance with all elements of the code except:

- C.4.3 – Explanation provided
- D.2.1 – Explanation provided

Details of compliance are described in **Appendix 1**.

3. RECOMMENDATIONS

The Trust Board is requested to note the content of the report

The NHS Foundation Trust Code of Governance – Compliance Checklist

A: Board Leadership and Purpose

A: Principles			
1.1 - Every Trust should be led by an effective and diverse board that is innovative and flexible, and whose role it is to promote the long-term sustainability of the Trust as part of the ICS and wider healthcare system in England, generating value for members in the case of Foundation Trusts, and for all Trusts, patients, service users and the public. 1.2 – The Board of Directors should establish the Trust’s vision, values and strategy, ensuring alignment with the ICP’s integrated care strategy and ensuring decision-making complies with 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. The Board of Directors must satisfy itself that the Trust’s vision, values and culture are aligned. All Directors must act with integrity, lead by example and promote the desired culture. 1.3 - The Board of Directors should give particular attention to the Trust’s role in reducing health inequalities in access, experience and outcomes. 1.4 - The Board of Directors should ensure that the necessary resources are in place for the Trust to meet its objectives, including the Trust’s contribution to the objectives set out in the five-year joint plan and annual capital plan agreed by the ICB and its partners, and measure performance against them. The Board of Directors should also establish a framework of prudent and effective controls that enable risk to be assessed and managed. For their part, all Board members – and in particular Non-Executive Directors whose time may be constrained - should ensure they collectively have sufficient time and resource to carry out their functions. 1.5 – For the Trust to meet its responsibilities to stakeholders, including patients, staff, the community and system partners, the Board of Directors should ensure effective engagement with them, and encourage collaborative working at all levels with system partners. 1.6 - The Board of Directors should ensure that workforce policies and practices are consistent with the trust’s values and support its long-term sustainability. The workforce should be able to raise any matters of concern. The Board is responsible for ensuring effective workforce planning aimed at delivering high quality of care.			
Ref	Code Provisions	Trust Position	Evidence
A.2.1	The Board of Directors should assess the basis on which the Trust ensures its effectiveness, efficiency and economy, as well as quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB and place-based partnerships.	Compliant	Board Assurance Framework, Performance reporting and Quality Report. Oversight through Integrated Performance report presented to Board Committees and Trust Board.

			Confirmed through annual governance statement, and external audit opinion.
A.2.1	The Board of Directors should ensure the Trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives.	Compliant	Active participant in the CMAST Provider Collaborative. Active participant in both Warrington and Halton Place based arrangements. Community Diagnostic Centre provider, serving Cheshire and Merseyside. Endoscopy hub provider on behalf of Cheshire and Merseyside. Partnership with Alder Hey to provide paediatric services locally in partnership. Lead for delivery of Living Well Hub, incorporating 25 providers. Active participant in pathology collaboration across Cheshire and Merseyside.
A.2.1	The Trust should describe in its Annual Report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	Compliant	Incorporated in Annual Governance Statement 2022/23.
A.2.2	The Board of Directors should develop, embody and articulate a clear vision and values for the Trust, with reference to the ICP's integrated care strategy and the Trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the Trust's purpose and intended outcomes, and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners and other decisions.	Compliant	The Trust's 2023-25 Strategy (Our mission is to be outstanding for our patients, our communities and each other) correlates with the ICP strategy published in 2021
A.2.3	The Board of Directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the Trust's vision, values and strategy, it should seek assurance that management has taken corrective action.	Compliant	The Board receives assurance reports from the Strategic People Committee who are the delegated Committee to received: • EDI Annual Report

			• WRES Report • WDES Report The Trust Board receives details of the annual staff survey. The Trust Board receives bi-annual Freedom to Speak Up (FTSU) reports and has appointed a Non-Executive Freedom to Speak Up Champion who undertakes regular triangulation with the FTSU Guardian and FTSU Exec Lead. The Board undertake regular observation visits across the Trust. A presentation on the development of a WHH Culture Plan drawing on the NHS People Promise themes from the NHS Staff Survey (2023 published in March 2024) was made to Trust Board on 6 March 2024, and final plan to be presented to Board Committees Monitoring to take place via a Culture Dashboard as part of the SPC Business Cycle
A.2.3	The Board of Directors should assess and monitor culture. The Annual Report should explain the Board's activities and any action taken, and the Trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	Compliant	The National staff survey results provide assurance on the culture at WHH through a range of measures using the NHS People Promise, Staff Engagement and Morale themes. In addition, the results provide information on PSIRF (19a, 19b,

			19c & 19d) and FTSU (Q 20a; 20b; 25e & 25f) Details included in the Annual Report 2023/24 NED Health & Wellbeing Champion appointed. Health and Wellbeing updates provided to Strategic People Committee including participation in a Deep Dive in 2023. The Board undertake regular observation visits across the Trust.
A.2.4	The Board of Directors should ensure that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners, and that risk is managed effectively. The Board should regularly review the Trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	Compliant	Oversight through Integrated Performance report presented to Board Committees and Trust Board. Financial and corporate performance reports received by the Finance & Sustainability Committee with escalation as appropriate to the Trust Board. We agree to consistent planning assumptions and CIP targets as part of annual planning, and this is outlined in the Annual Financial Plan submitted to the Board. BAF details risks in relation to quality, corporate and financial performance.

			Annual Governance Statement summaries arrangements.
A.2.5	The Board of Directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant.	Compliant	Integrated Performance Report regularly reported to the Board and Board Committees Separate workforce and patient Equality, Diversity & Inclusion Sub Committees in place reporting to Board Committees
A.2.5	Where appropriate, and in particular in high risk or complex areas, the Board of Directors should commission independent advice e.g. from the internal audit function, to provide an adequate and reliable level of assurance.	Compliant	Risk-based Internal Audit annual work-plan with oversight by the Audit Committee.
A.2.6	The Board of Directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health & Social Care, NHS England and the CQC.	Compliant	Quality Strategy. Annual Quality Report.
A.2.7	The Chair and Board should regularly engage with stakeholders, including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the Trust's vision.	Compliant	The Chair and Board engage directly with the Council of Governors via the Council of Governors meeting and informal Q&A sessions. Publication of the Chair's written report in the Trust Board papers. Regular observation visits by the Trust Board Involvement in system and national professional networks.
A.2.7	Committee Chairs should engage with stakeholders on significant matters related to their areas of responsibility.	Compliant	Committee Chair Assurance Reports provided to the Trust Board and Council of Governors and published on Trust website. Audit Chair meets with External and Internal Audit representatives.

			Increased NED involvement in CMAST meetings Regular observation visits by the Trust Board
A.2.7	The Chair should ensure that the Board of Directors as a whole has a clear understanding of the views of all stakeholders including system partners.	Compliant	The Chair is active within C&M through the ICB and CMAST meetings. Engagement is included in the Chair's briefings to the Trust Board and also the COG. External views also form part of the Trust's Quality Account.
A.2.7	NHS Foundation Trusts must hold a members' meeting at least annually.	Compliant	Annual Members Meeting held.
A.2.8	The Board of Directors should describe in the Annual Report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the Trust has entered.	Compliant	Annual report compliant with reporting guidance and includes some reference to stakeholders, system and place based partners and key partnerships for collaboration.
A.2.8	The Board of Directors should keep engagement mechanisms under review so that they remain effective.	Compliant	Working with People and Communities strategy approved and reported on quarterly to Board. Quarterly reporting to Board and CoG on communications and engagement activity, including Experts by Experience programme and engagement opportunities. Regular reporting on staff engagement, including NHS Staff Survey results to Board and SPC. Stakeholder engagement activity reported to Board as part of the Strategy highlight report.

A.2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The Board of Directors should routinely review this and the reports arising from its operation.	Compliant	Substantive FTSU Guardian (and Deputy) in place. Freedom to Speak Up Policy. FTSU NED Champion FTSU Exec Lead Biannual FTSU Reports to Board
A.2.9	Raising Concerns – the Board should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	Compliant	Substantive FTSU Guardian (and Deputy) in place. Freedom to Speak Up Policy. FTSU NED Champion FTSU Exec Lead Biannual FTSU Reports to Board
A.2.10	The Board of Directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement.	Compliant	Managing Conflicts of Interest Policy and reporting reviewed in year.
A.2.11	Where Directors have concerns about the operation of the Board or the management of the trust that cannot be resolved, these should be recorded in the Board minutes.	Compliant	Comprehensive minutes are produced of Board meetings. Board members can request that concerns are recorded.
A.2.11	If on resignation a Non-Executive Director has any such concerns, they should provide a written statement to the Chair, for circulation to the Board.	Compliant	Situation has not arisen to date.

B: Division of Responsibilities

B: Principles			
B.1.1 - The Chair leads the Board of Directors and, for Foundation Trusts, the Council of Governors, and is responsible for its overall effectiveness in leading and directing the Trust. They should demonstrate objective judgement throughout their tenure and promote a culture of honesty, openness, trust and debate. In addition, the Chair facilitates constructive Board relations and the effective contribution of all Non-Executive Directors, and ensures that Directors and, for Foundation Trusts, Governors, receive accurate, timely and clear information. B.1.2 - Responsibilities should be clearly divided between the leadership of the Board and the Executive leadership of the Trust's operations. No individual should have unfettered powers of decision. B.1.3 - Non-Executive Directors should have sufficient time to meet their Board responsibilities. They should provide constructive challenge and strategic guidance, offer specialist advice and lead in holding the executive to account. B.1.4 - The Board of Directors should ensure that it has the policies, processes, information, time and resources it needs to function effectively, efficient and economically. B.1.5 - The Board is collectively responsible for the performance of the Trust. B.1.6 - The Board of Directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the Trust, and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies. B.1.7 - All members of the Board of Directors have joint responsibility for every Board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the Chief Executive as the Accounting Officer.			
Ref	Code Provisions	Trust Position	Evidence
B.2.1	The Chair is responsible for leading on setting the agenda for the Board of Directors and, for Foundation Trusts, the Council of Governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	Compliant	Board approved Cycle of Business in place for both Board and CoG meetings with agendas for individual meetings subject to approval by the Chair.
B.2.2	The Chair is responsible for ensuring that Directors and, for Foundation Trusts, Governors receive accurate, timely and clear information that enables them to perform their duties effectively.	Compliant	Chair holds a monthly Q&A with Governors. Chair meets with the Lead Governor at least monthly.

			Annual induction and development sessions. Governor attendance at local and national conferences The Chair, via the Foundation Trust Office, ensures CoG agendas and papers are appropriate and shared in a timely manner.
B.2.2	A Foundation Trust Chair should take steps to ensure that Governors have the necessary skills and knowledge to undertake their role.	Compliant	Chair holds a monthly Q&A with Governors. Chair meets with the Lead Governor at least monthly. Annual induction and development sessions. Governor attendance at local and national conferences
B.2.3	The Chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of Non-Executive Directors in particular, and ensuring a constructive relationship between Executive and Non-Executive Directors.	Compliant	Chair encourages appropriate debate and ensures that all member of the Board have the opportunity to contribute effectively. Monitored in Chair's appraisal process
B.2.4	A Foundation Trust Chair is responsible for ensuring that the Board and Council work together effectively.	Compliant	Chair holds a monthly Q&A with Governors. Chair meets with the Lead Governor at least monthly. Chair encourages Governor observation of Board and Board Committees Lead Governor observes Private Board

			Chair ensures Board member attendance and contribution at CoG meetings.
B.2.5	The Chair should be independent on appointment when assessed against the criteria set out in provision B.2.6 below.	Compliant	Independence is confirmed as part of the appointment process. Annual NED declarations of independence.
B.2.5	The roles of Chair and Chief Executive must not be exercised by the same individual.	Compliant	Chair and CEO roles held separately.
B.2.5	A Chief Executive should not become Chair of the same Trust.	Compliant	The Chair has not previously been the Chief Executive of the Trust.
B.2.5	The Board should identify a Deputy or Vice Chair who could be the Senior Independent Director.	Compliant	Deputy Chair appointed. SID appointed
B.2.5	The Chair should not sit on the Audit Committee. The Chair of Audit Committee, ideally, should not be the Vice chair or Senior Independent Director.	Compliant	The Chair does not sit on the Audit Committee
B.2.6	The Board of Directors should identify in the Annual Report each Non-Executive Director it considers to be independent. Circumstances that are likely to impair, or could appear to impair, a Non-Executive Director's independence include, but are not limited to, whether a Director: ▪ Has been an employee of the Trust within the last two years; ▪ Has, or has had within the last two years, a material business relationship with the Trust either directly or as a partner, material shareholder, director or senior employee of a body that has such a relationship with the Trust; ▪ Has received or receives remuneration from the Trust apart from a director's fee, participates in the Trust's performance-related pay scheme or is a member of the Trust's pension scheme; ▪ Has close family ties with any of the Trust's advisers, directors or senior employees ▪ Holds cross-directorships or has significant links with other directors through involvement in other companies or bodies;	Compliant	Annual confirmation of independence as part of governance reporting included in annual report. Rationale for appointment beyond 6 years detailed within proposal to the Governor Nomination & Remuneration Committee and CoG prior to approval.

	- Has served on the Trust Board for more than six years from the date of their first appointment; - Is an appointed representative of the Trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the Board of Directors nonetheless considers that the Non-Executive Director is independent, it needs to be clearly explained why.		
B.2.7	At least half the Board of Directors, excluding the Chair, should be Non-Executive Directors whom the Board considers to be independent.	Compliant	Current composition is compliant. Seven NEDs & 6 voting Execs
B.2.8	No individual should hold the positions of Director and Governor of any NHS Foundation Trust at the same time.	Compliant	No individuals breach this requirement.
B.2.9	The value of ensuring that Committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding Chairs and members of Committees.	Compliant	Committee Terms of Reference are reviewed annually.
B.2.9	For Foundation Trusts, the Council of Governors should take into account the value of appointing a Non-Executive Director with a clinical background to the Board of Directors, as well as the importance of appointing diverse Non-Executive Directors with a range of skill sets, backgrounds and lived experiences.	Compliant	One Non-Executive Director has a clinical background. Diversity a key focus in NED recruitment process.
B.2.10	Only the Committee Chair and Committee members are entitled to be present at Nominations, Audit or Remuneration Committee meetings, but others may attend by invitation of the particular Committee.	Compliant	As per Terms of Reference.
B.2.11	In consultation with the Council of Governors, NHS Foundation Trust Boards should appoint one of the independent Non-Executive Directors to be the Senior Independent Director (SID); to provide a sounding board for the Chair and serve as an intermediary for the other Directors when necessary.	Compliant	SID appointed by Council of Governors
B.2.11	Led by the SID, the Non-Executive Directors should meet without the Chair present at least annually to appraise the Chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. The Chair Appraisal Framework published by NHS England refers.	Compliant	Chair appraisal process is led by the SID and is conducted in accordance with the Chair Appraisal Framework. Input provided by internal and external stakeholders.

B.2.12	Non-Executive Directors have a prime role in appointing and removing Executive Directors. They should scrutinise and hold to account the performance of management and individual Executive Directors against agreed performance objectives.	Compliant	Non-Executive Directors involved in all Executive Director appointments and provide input in Exec appraisals. Performance scrutinised via the IPR, Corporate Performance and Performance Assurance Frameworks in Trust Board and Committee meetings.
B.2.12	The Chair should hold meetings with the Non-Executive Directors without the Executive Directors present.	Compliant	NED only meetings held
B.2.13	The responsibilities of the Chair, Chief Executive, Senior Independent Director, Board and Committees should be clear, set out in writing, agreed by the Board of Directors and publicly available.	Compliant	Chair and CEO objectives and appraisal processes in place. Terms of Reference for Committees are published in Board meeting papers and are available on request. Board schedule of business in place. SID Role description in place.
B.2.13	The Annual Report should give the number of times the Board and Committees met, and individual Director attendance.	Compliant	Number of meetings and attendance included in Annual Report.
B.2.14	When appointing a Director, the Board of Directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on material additional external appointments without prior approval of the Board of Directors, with the reasons for permitting significant appointments explained in the Annual Report.	Compliant	All Directors are required to complete declarations of interest on appointment. This includes any other roles/ commitments and an indication of time involved. Any material appointments would be approved by the Board and explained in the Annual Report.
B.2.14	Full-time Executive Directors should not take on more than one Non-Executive Directorship of another Trust or organisation of comparable size and complexity, and not the Chair role of such an organisation.	Compliant	None of the Executive Directors currently hold Non-Executive roles.

B.2.15	All Directors should have access to the advice of the Company Secretary, who is responsible for advising the Board of Directors on all governance matters. Both the appointment and removal of the Company Secretary should be a matter for the whole Board.	Compliant	All Directors have access to the Company Secretary who advises the Board on all governance matters. Company Secretary appointed by the Board
B.2.16	All Directors, Executive and Non-Executive, have a responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.	Compliant	Chair encourages appropriate debate and ensures that all member of the Board have the opportunity to contribute effectively. Governor observation of the Board and Committees, with feedback to CoG & minutes of meetings demonstrate challenge.
B.2.16	Non-Executive Directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, request further information if necessary, and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	Compliant	Non-Executive Directors satisfy this requirement through participation in Board and Committee meetings.
B.2.17	The Board of Directors should meet sufficiently regularly to discharge its duties effectively.	Compliant	The Board is scheduled to meet six times a year with 6 additional development sessions
B.2.17	The Board should have a schedule of matters reserved specifically for its decisions. This schedule should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should also describe how any disagreements between the Council of Governors and the Board of Directors will be resolved.	Compliant	The Trust has a Scheme of Delegation in place. The Constitution describes how disputes between the COG and Board of Directors will be resolved.
B.2.17	The Annual Report should include this schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including a summary of the types of decisions to be taken by the Board, the Council of	Compliant	The narrative in the Annual Report reflects this requirement.

	Governors, Board Committees and the types of decisions that are delegated to the executive management of the Board of Directors.		

Section C: Composition, Succession and Evaluation

C: Principles			
C.1.1a - Appointments to the Board of Directors should follow a formal, rigorous and transparent procedure, and an effective succession plan should be maintained for Board and senior management. Appointments should be made solely in the public interest, with decisions based on integrity, merit, openness and fairness. C.1.1b - Appointments and succession plans should be based on merit and objective criteria and, within this context, should promote diversity of gender, social and ethnic backgrounds, disability and cognitive and personal strengths. C.1.1c - In particular, the Board should have published plans for how it and senior managers will in percentage terms at least match the overall black and minority composition of its overall workforce, or its local community, whichever is the higher. C.1.2 - The Board of Directors and its Committees should have a diversity of skills, experience and knowledge. The Board should be of sufficient size for the requirements of its duties, but should not be so large as to be unwieldy. Consideration should be given to the length of service of the Board of Directors as a whole and membership regularly refreshed. C.1.3 - Annual evaluation of the Board of Directors should consider its composition, diversity and how effectively members work together to achieve objectives. Individual evaluation should demonstrate whether each Director continues to contribute effectively.			
C2 Provisions for NHS Foundation Trusts Board Appointments			
Ref	Code Provisions	Trust Position	Evidence
C.2.1	The Nominations Committee or Committees of Foundation Trusts, with external advice as appropriate, are responsible for the identification and nomination of Executive and Non-Executive Directors.	Compliant	Nominations and Remuneration Committee (NARC) for Executive Director appointments. Governor Nominations and Remuneration Committee (GNARC) for Non-Executive Director appointments.
C.2.1	The Nominations Committee(s) should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the Trust, and the skills and expertise required within the Board of Directors to meet them.	Compliant	NARC Terms of reference include responsibilities for succession planning.
C.2.1	Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB,	Compliant	Interviews for Board position include ICB representation

	and the Foundation Trust should engage with NHS England to agree the approach.		
C.2.2	There may be one or two Nominations Committees. If there are two, one will be responsible for considering nominations for Executive Directors and the other for Non-Executive Directors (including the Chair).	Compliant	Nominations and Remuneration Committee (NARC) for Executive Director appointments. Governor Nominations and Remuneration Committee (GNARC) for Non-Executive Director appointments.
C.2.2	The Nominations Committees should regularly review the structure, size and composition of the Board of Directors and recommend changes where appropriate. In particular, the Nominations Committees should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the Board of Directors and, in light of this evaluation, describe the role and capabilities required for appointment of both Executive and Non-Executive Directors, including the Chair.	Compliant	Prior to any new appointment, an evaluation of the balance of skills, knowledge and experience on the Board is undertaken and then a description of the role and capabilities required for the particular appointment is prepared
C.2.3	The Chair or an independent Non-Executive Director should chair the Nominations Committees. At the discretion of the Committee, a Governor can chair the Committee in the case of appointments of Non-Executive Directors or the Chair.	Compliant	The Chair is the chair of both NARC and GNARC
C.2.4	The Governors should agree with the Nominations Committee a clear process for the nomination of a new Chair and Non-Executive Directors. Once suitable candidates have been identified, the Nominations Committee should make recommendations to the Council of Governors.	Compliant	As reflected in the GNARC Terms of Reference
C.2.5	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team is available for use by Nominations Committees to support the Council of Governors in the appointment of the Chair and Non-Executive Directors.	Compliant	To be incorporated in the recruitment process for Non-Executive Directors as required.
C.2.5	If an external consultancy is engaged, it should be identified in the Annual Report alongside a statement about any other connection it has with the Trust or individual directors.	Compliant	Use of external consultancy for NED appointments will be included in the Annual report as required.

C.2.6	The Nominations Committee responsible for the appointment of Non-Executive Directors should have Governors and/or independent members in the majority. Governors should also be in the majority on the interview panel.	Compliant	ToR confirms Governors should be in majority
C.2.7	When considering the appointment of Non-Executive Directors, the Council of Governors should take into account the views of the Board of Directors and the Nominations Committee on the qualifications, skills and experience required for each position.	Compliant	Governors are fully involved in NED appointments process including a specific Governor Focus Group. The interview panel includes both Governors and NED & Exec representation.
C.2.8	The Annual Report should describe the process followed by the Council of Governors to appoint the Chair and Non-Executive Directors.	Compliant	Included in Annual Report.
C.2.8	The main role and responsibilities of the Nominations Committee should be set out in publicly available written terms of reference.	Compliant	Nomination and Remuneration Committee TOR are available on request
C.2.9	Elected Governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of Governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.	Compliant	Governors terms of office are 3 years and subject to re-election. Biographies are provided. 3 year tenure confirmed in constitution.
C.2.10	A requirement of the National Health Service Act 2006 is that the Chair, the other Non-Executive Directors and, except in the case of the appointment of a Chief Executive, the Chief Executive are responsible for deciding the appointment of Executive Directors. The Committee with responsibility for Executive Director nominations should identify suitable candidates to fill Executive Director vacancies as they arise and make recommendations to the Chair, the other Non-Executive Directors and, except in the case of the appointment of a Chief Executive, the Chief Executive.	Compliant	Appointments are made with Chair, CEO and NED involvement. The Nominations and Remuneration Committee oversee this process.
C.2.11	It is for the Non-Executive Directors to appoint and remove the Chief Executive. The appointment of a Chief Executive requires the approval of the Council of Governors.	Compliant	This is set out in the Trust's Constitution.

C.2.12	The Governors are responsible at a general meeting for the appointment, re-appointment and removal of the Chair and other Non-Executive Directors.	Compliant	This is set out in the Trust's Constitution.
C.2.13	Non-Executive Directors, including the Chair, should be appointed by the Council of Governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a Director.	Compliant	Chair and Non-Executive Directors appointed and/or re-appointed for terms not exceeding three years.
C.2.14	The terms and conditions of appointment of Non-Executive Directors should be made available to the Council of Governors. The letter of appointment should set out the expected time commitment.	Compliant	Terms and conditions of NEDs are provided to Governors as part of the NED appointment process. Time commitment/ T&Cs detailed in offer letter.
C.2.14	Non-Executive Directors should undertake that they will have sufficient time to do what is expected of them. Their other significant commitments should be disclosed to the Council of Governors before appointment, with a broad indication of the time involved, and the Council of Governors should be informed of subsequent changes.	Compliant	Time commitments investigated during recruitment process. On appointment NEDs are required to complete declaration of interests including other significant commitments and time requirements.

C.4: Board Appointments – Applicable to both NHS Foundation Trusts and NHS Trusts			
Ref	Code Provisions	Trust Position	Evidence
C.4.1	Directors on the Board of Directors and, for Foundation Trusts, Governors on the Council of Governors should meet the “fit and proper” persons test described in the provider licence. For the purpose of the licence and application criteria, “fit and proper” persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a Director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged).	Compliant	Evidence to support Fit and Proper Persons (FPP) collated and reviewed for all Directors New FPP Policy approved Governors complete fit and proper persons declaration. Completion of Annual Exec FPP
C.4.1	Trusts should have a policy for ensuring compliance with the CQC’s guidance Regulation 5: Fit and proper persons: directors.	Compliant	Fit & Proper Persons (FPP) Policy in place and reflects the new NHS England FPPT Framework.
C.4.2	The Board of Directors should include in the Annual Report a description of each Director’s skills, expertise and experience. Alongside this, the Board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the Trust. Both statements should also be available on the Trust’s website.	Compliant	Director Biographies, balance, completeness and appropriateness included in Annual Report and published on Trust website
C.4.3	Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the Board of Directors and any decision to extend a term beyond six years should be subject to rigorous review.	Explain	The chair’s term of office was renewed for a fourth term by the Council of Governors in October 2022. The rationale for the extension was: 1. the number of changes amongst the non-executive directors in the preceding 12 months 2. the NHS was/is faced with the most significant pressures in its history resulting from COVID-19. Consequently, it was/is felt the

			Trust would benefit from securing greater stability of leadership during this period. The details of the extension have been shared with the North West regional director and chair of the ICS.
C.4.3	To facilitate effective succession planning and the development of a diverse Board, this period of nine years can be extended for a limited time, particularly where on appointment a Chair was an existing Non-Executive Director. The need for all extensions should be clearly explained and should have been agreed with NHS England. A NED becoming Chair after a three-year term as a Non-Executive Director would not trigger a review after three years in post as Chair.	Compliant	All NED terms are rigorously reviewed and reported. All current NED terms (with exception of the Chair – see above) are within 9 years.
C.4.4	Elected Foundation Trust Governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years.	Compliant	Constitution details that members are subject to re-election every 3 years.
C.4.4	The Governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.	Compliant	Biographies included in governor elections/ re-elections.
C.4.4	Best practice is that Governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.	Compliant	Governors do not serve more than 3 consecutive terms.
C.4.5	There should be a formal and rigorous annual evaluation of the performance of the Board of Directors, its Committees, the Chair and individual Directors.	Compliant	Annual evaluation of committees and Board in place and reported to the Board of Directors. Appraisals in place for Chair and individual directors.
C.4.5	For NHS Foundation Trusts, the Council of Governors should take the lead on agreeing a process for the evaluation of the Chair and Non-Executive Directors. The Governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the Chair.	Compliant	Chair and NED appraisal process approved by COG. The SID leads the evaluation of the Chair.

C.4.6	The Chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the Board of Directors. Each Director should engage with the process and take appropriate action where development needs are identified.	Compliant	Executive Director appraisal process in place Strong NED appraisal processes in place following NHSE approach. All members of the Board have completed an appraisal.
C.4.7	All Trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well Led Framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the Trust or individual Directors or Governors.	Compliant	External well led review undertaken by the Good Governance Institute between July and December 2022 with the final report published in February 2023.
C.4.8	Led by the Chair, the Council of Governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on: - holding the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors - communicating with their member constituencies and the public and transmitting their views to the Board of Directors - contributing to the development of the Foundation Trust's forward plans The Council of Governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in: <i>Your Statutory Duties: A Reference Guide for NHS Foundation Trust Governors and Addendum to Your statutory duties – A reference guide for NHS Foundation Trust Governors.</i>	Compliant	Annual evaluation of the Council of Governors in place. COG development session held in 2023 to evaluate effectiveness. Assessment against addendum to statutory duties completed. Governor Working Parties in place to support effective discharge of their duties. New Membership Strategy approved in 2023 to support communication and engagement with constituencies.
C.4.9	The Council of Governors should agree and adopt a clear policy and a fair process for the removal of any Governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest that prevents the proper exercise of their duties. This should be shared with the Governors.	Compliant	Included in Trust's constitution
C.4.10	In addition, it may be appropriate for the process to provide for removal from the Council of Governors if a Governor or group of Governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS	Compliant	Constitution details a comprehensive list of reasons why a Governor can be removed.

	Foundation Trust. NHS England's model core constitution suggests that a Governor can be removed by a 75% voting majority; however, Trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable.		
C.4.10	NHS England can only use its enforcement powers to require a Trust to remove a Governor in very limited circumstances: where it has imposed an additional condition relating to governance in the Trust's licence because the governance of the Trust is such that the Trust would otherwise fail to comply with its licence and the Trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a Trust to remove a Director under its enforcement powers than a Governor.	For information	
C.4.11	The Board of Directors should ensure it retains the necessary skills across its Directors and works with the Council of Governors to ensure there is appropriate succession planning.	Compliant	Succession planning is incorporated in Nominations and Remuneration Committee (EXEC) TOR. Both nomination and remuneration committees (EXEC and NED) receive papers regarding succession planning.
C.4.12	The Remuneration Committee should not agree to an Executive member of the Board leaving the employment of the Trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the Board first completing and approving a full risk assessment.	Compliant	The Nomination & Remuneration Committee agree dates of notice periods as part of their role in agreeing recruitment process and timelines as per the Committee ToR
C.4.13	The Annual Report should describe the work of the Nominations Committee(s), including: - the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline. - how the Board has been evaluated, the nature and extent of an external evaluator's contact with the Board of Directors, Governors and individual Directors, the outcomes and actions taken, and how these have or will influence Board composition	Compliant	The annual report describes the work of both nomination and remuneration committees (exec and NED) and appointments/ extensions or personnel changes within the current year.

	- the policy on diversity and inclusion, including in relation to disability, its objectives and linkage to Trust strategy, how it has been implemented and progress on achieving the objectives - the ethnic diversity of the Board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the Board reflects the ethnic diversity of the Trust's workforce and communities served - the gender balance of senior management and their direct reports.		The Annual report includes details of Board diversity and overall workforce profile.

Section D: Audit, Risk and Internal Control

D: Principles			
D.1.1 - The Board of Directors should establish formal and transparent policies and procedures to ensure the independence and effectiveness of internal and external audit functions, and satisfy itself on the integrity of financial and narrative statements. D.1.2 – The Board of Directors should present a fair, balanced and understandable assessment of the Trust’s position and prospects. D.1.3 – The Board of Directors should establish procedures to manage risk, oversee the internal control framework, and determine the nature and extent of the principal risks the Trust is willing to take to achieve its long-term strategic objectives. D.1.4 – Organisations should also refer to <i>Audit and assurance: a guide to governance for providers and commissioners</i>			
Ref	Code Provisions	Trust Position	Evidence
D.2.1	The Board of Directors should establish an Audit Committee of independent Non-Executive Directors, with a minimum membership of three or two in the case of smaller Trusts. The Board of Directors should satisfy itself that at least one member has recent and relevant financial experience. The Committee as a whole should have competence relevant to the sector in which the Trust operates.	Compliant	Audit Committee Terms of Reference – All Non-Executive Director members. The Audit Committee Chair has relevant financial experience.
D.2.1	The Chair of the Board of Directors should not be a member and the Vice Chair or Senior Independent Director should not chair the Audit Committee.	Explain	The chair of the Audit Committee is the senior independent director (SID). The chair of the Audit Committee (who is an experienced Audit Committee chair having held the role in a previous trust) was appointed to the role prior to being appointed as the SID at a time when there had been several new NEDs/associate NEDs joining the Trust. The member of the Audit Committee with relevant

			financial experience is the chair of the Finance and Sustainability Committee so is not appropriate to chair the Audit Committee too.
D.2.2	The main role and responsibilities of the Audit Committee should include: - Monitoring the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance, and reviewing significant financial reporting judgements contained in them - Providing advice (where requested by the Board of Directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; - Reviewing the Trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate Board risk committee composed of independent Directors, or by the board itself; - Monitoring and reviewing the effectiveness of the Trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the Board of Directors - Reviewing and monitoring the external auditor's independence and objectivity - Reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements - Reporting to the Board of Directors on how it has discharged its responsibilities.	Compliant	The Audit Committee TOR set this out.
D.2.3	A Trust should change its external audit firm at least every 20 years. Legislation requires an NHS Trust to newly appoint its external auditor at least every five years. An NHS Foundation Trust should re-tender its external audit at least every 10 years and in most cases more frequently than this. These timeframes are not affected by an NHS Trust becoming a Foundation Trust.	Compliant	External Audit service re-tendered in 22/23. Contract award approved by Council of Governors.
D.2.4	The Annual Report should include: - The significant issues relating to the financial statements that the Audit Committee considered, and how these issues were addressed. - An explanation of how the Audit Committee has assessed the independence and effectiveness of the external audit process and its approach to the appointment or	Compliant	Included in Annual Report.

	reappointment of the external auditor, length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans. An explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.		
D.2.5	Legislation requires an NHS Trust to have a policy on its purchase of non-audit services from its external auditor. An NHS Foundation Trust's Audit Committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.	Not applicable at present	The Trust does not procure non-audit services from the external auditor.
D.2.5	The Council of Governors is responsible for appointing the external auditor.	Compliant	Council of Governors approved award of External Audit contract in 2022/23.
D.2.6	The Directors should explain in the Annual Report their responsibility for preparing the Annual Report & Accounts, and state that they consider the Annual Report & Accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy.	Compliant	Included in Annual Report.
D.2.7	The Board of Directors should carry out a robust assessment of the Trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the Annual Report.	Compliant	Annual Governance Statement.
D.2.8	The Board of Directors should monitor the Trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the Annual Report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The Board should report on internal control through the Annual Governance Statement in the Annual Report.	Compliant	Internal Auditor undertakes an annual review of the core controls in place for Risk Management and reported to the Audit Committee. High Assurance provided for 2023/24. Details of the Trust's risk management and internal controls are included in Annual Governance Statement.
D.2.9	In the annual accounts, the Board of Directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and	Compliant	Included in the Annual Accounts and Annual Report.

	identify any material uncertainties regarding going concern. Trusts should refer to the DHSC Group Accounting Manual and NHS Foundation Trust Annual Reporting Manual, which explain that this assessment should be based on whether a Trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over a going concern are expected to be rare.		

Section E: Remuneration

E: Principles

E.1.1 - Levels of remuneration should be sufficient to attract, retain and motivate Directors of quality, with the skills and experience required to lead the Trust successfully and collaborate effectively with system partners. Trusts should avoid paying more than is necessary for this purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements. Trusts should follow NHS England's ***Guidance on pay for very senior managers in NHS trusts and foundation trusts***.

E.1.2 – Any performance-related elements of Executive Directors remuneration should be transparent, stretching and designed to promote the long-term sustainability of the NHS Foundation Trust. They should also take as a baseline for performance any required competencies specified in the job description for the post.

E.1.3 – The Remuneration Committee should decide if a proportion of Executive Directors' remuneration should be linked to corporate and individual performance. The Remuneration Committee should judge where to position its NHS Foundation Trust relative to other NHS Foundation Trusts and comparable organisations. Such comparisons should be used with caution to avoid any risk of an increase in remuneration despite no corresponding improvement in performance.

E.1.4 – The Remuneration Committee should also be sensitive to pay and employment conditions elsewhere in the NHS, especially when determining annual salary increases.

E.1.5 – There should be a formal and transparent procedure for developing policy on Executive remuneration and for fixing the remuneration packages of individual Directors. No Director should be involved in deciding their own remuneration.

E.1.6 – The Remuneration Committee should take care to recognise and manage conflicts of interest when receiving views from Executive Directors or senior management or consulting the Chief Executive about its proposals.

E.1.7 – The Remuneration Committee should also be responsible for appointing any independent consultants in respect of Executive Director remuneration.

E.1.8 – Where Executive Directors or senior management are involved in advising or supporting the Remuneration Committee, care should be taken to recognise and avoid conflicts of interest.

E.1.9 – NHS Trusts should wait for notification and instruction from NHS England before implementing any cost of living increases.

Ref	Code Provisions	Trust Position	Evidence
E.2.1	Any performance-related elements of Executive Directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. (Provisions to be taken into account by Remuneration Committees when such schemes are in place are detailed in the Code of Governance, Section E.2)	Compliant	All Executive Directors' pay reviewed and scrutinised by the Nominations and Remuneration Committee

E.2.2	Levels of remuneration for the Chair and other Non-Executive Directors should reflect the Chair and Non-Executive Director remuneration structure (published by NHS England Dec 2019).	Compliant	Levels of Non-Executive remuneration are consistent with the guidance.
E.2.3	Where a trust releases an Executive Director, for example to serve as a Non-Executive Director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the Director will retain such earnings.	Not applicable at present.	n/a
E.2.4	The Remuneration Committee should carefully consider what compensation commitments (including pension contributions and all other elements) their Directors' terms of appointment would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing Director's obligation to mitigate loss. Appropriate claw-back provisions should be considered where a Director returns to the NHS within the period of any putative notice.	Compliant	The current employment contracts for Directors allows compensation to be reduced to reflect a departing director's obligation to mitigate loss or appropriate claw-back provisions in case of a director returning to the NHS within the period of any putative notice. In addition, earn back is also applied to all directors with a salary over £150,000 up to the value of 10% subject to performance in line with NHS England requirements. The VSM Contract has been reviewed in line with FPPT (November 2023) recommendations and has been utilised with new appoints including Chief Finance Officer and Chief Nurse.
E.2.5	Trusts should discuss any Director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.	Not applicable at present	n/a
E.2.6	The Board of Directors should establish a Remuneration Committee of independent Non-Executive Directors, with a minimum membership of three. The Remuneration	Compliant	Nomination and Remuneration Committee comprises the Chair and

	Committee should make its Terms of Reference available, explaining its role and the authority delegated to it by the Board of Directors. The Board member with responsibility for HR should sit as an advisor on the Remuneration Committee.		all Non-Executive Directors with the Chief People Officer to provide HR advice and support to the committee.
E.2.6	Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the Trust.	Not applicable at present	n/a
E.2.7	The Remuneration Committee should have delegated responsibility for setting remuneration for all Executive Directors, including pension rights and any compensation payments.	Compliant	Incorporated in Nomination and Remuneration Committee (Execs) Terms of Reference.
E.2.7	The Remuneration Committee should also recommend and monitor the level and structure of remuneration for senior management. The Board should define senior management for this purpose and this should normally include the first layer of management below Board level.	Compliant	The Nomination & Remuneration Committee review VSM annually. The level below this is governed through Agenda for Change.

Appendix B: Council of Governors

Appendix B: Principles

1.1 – The powers and obligations of Governors of NHS foundation trusts are set out in the 2006 Act as amended by the 2012 Act. Appendix B describes the relevant areas of the Governors' role. In addition, ***Your statutory duties: A reference guide for NHS foundation trust governors*** (August 2013) examines how Governors can deliver their duties and an addendum to this document, ***System working and collaboration: The role of foundation trust Councils of Governors*** (October 2022) clarifies how Governors can continue to perform their duties within the context of system working.

1.2 - The Council of Governors has a duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. This includes ensuring the Board of Directors acts so that the foundation trust does not breach the conditions of its licence. It remains the responsibility of the Board of Directors to design and then implement agreed priorities, objectives and the overall strategy of the NHS foundation trust.

1.3 - The Council of Governors is responsible for representing the interests of NHS foundation trust members, the public at large and staff in the governance of the NHS foundation trust. Governors must act in the best interests of the NHS foundation trust and should adhere to its values and code of conduct.

1.4 – To discharge their duty to represent the public, Councils of Governors are required to take account of the interests of the public at large. This includes the population of the local system of which the Trust is part and the whole population of England as served by the wider NHS.

1.5 - Governors are responsible for regularly feeding back information about the Trust, its vision and its performance to members, the public at large and the stakeholder organisations that either elected or appointed them. The Trust should ensure Governors have appropriate support to help them discharge this duty.

1.6 - Governors should discuss and agree with the Board of Directors how they will undertake these and any additional roles, giving due consideration to the circumstances of the NHS foundation trust and the needs of the system and wider NHS and emerging best practice.

1.7 - Governors should work closely with the Board of Directors and must be presented with, for consideration, the annual report and accounts and the annual plan at a general meeting. The Governors must be consulted on the development of forward plans for the Trust and any significant changes to the delivery of the Trust's business plan.

1.8 - Governors should use their voting rights to hold Non-Executive Directors individually and collectively to account and act in the best interest of patients, members and the public at large. If the Council of Governors does withhold consent for a major decision, it must justify its reasons to the Chair and the other Non-Executive Directors, bearing in mind that its decision is likely to have a range of consequences for the NHS foundation trust, the system and the wider NHS. The Council of Governors should take care to ensure that reasons are considered, factual and within the spirit of the Nolan principles.

Ref	Code Provisions	Trust Position	Evidence
2.1	The Council of Governors should meet sufficiently regularly to discharge its duties. Typically the Council of Governors would be expected to meet as a full Council at least four times a year. Governors should make every effort to attend the meetings	Compliant	Incorporated in the Constitution.

	of the Council of Governors. The NHS Foundation Trust should take appropriate steps to facilitate attendance.		The CoG met on 4 occasions in 2023/24 with an additional working parties to support Governors in place. Attendance reported at each meeting to the CoG.
2.2	The Council of Governors should not be so large as to be unwieldy. The Council of Governors should be of sufficient size for the requirements of its duties. The roles, structure, composition, and procedures of the Council of Governors should be reviewed regularly.	Compliant	The CoG comprises 28 members plus Chair. The composition of the Council was most recently reviewed and updated in February 2023. Composition is considered when elections take place.
2.3	The annual report should identify the members of the Council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments.	Compliant	Included in Annual Report.
2.3	The annual report should also identify the nominated lead governor. A record should be kept of the number of meetings of the Council and the attendance of individual Governors and it should be made available to members on request.	Compliant	Annual Report. Records of attendance held and reported to each meeting of the CoG.
2.4	The roles and responsibilities of the Council of Governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the Council of Governors towards members and other stakeholders and how governors will seek their views and keep them informed.	Compliant	The Role of Governor is included in induction presentations given to new Governors and is included within the Governors Handbook. The Council of Governors Standing Orders form part of the Trust Constitution (Annexe 6)
2.5	The Chair is responsible for leadership of both the Board of Directors and the Council of Governors but the Governors also have a responsibility to make the arrangements work and should take the lead in inviting the Chief Executive and other Executives and Non-Executives, as appropriate, to their meetings. In these meetings other members of the Council of Governors may ask the Chair or their	Compliant	The Chief Executive, Executive Directors and Non-Executive Directors routinely attend Council meetings.

	deputy, or any other relevant Director present at the meeting, questions about the affairs of the NHS Foundation Trust.		Governors meet to agree the agenda for the Council of Governor meetings. The agenda includes a standing item for Governor questions for which Executive Directors routinely attend to provide a response alongside the Non-Executive Directors.
2.6	The Council of Governors should establish a policy for engagement with the Board of Directors for those circumstances when they have concerns about the performance of the Board of Directors, compliance with the provider licence or other matters related to the overall wellbeing of the NHS foundation trust and its collaboration with system partners.	Compliant	Policy for raising serious concerns included within the Annex 6 (section 9) of the Constitution.
2.6	The Council of Governors should input to the Board's appointment of a Senior Independent Director.	Compliant	The Board proposal for a new SID was approved through the CoG.
2.7	The Council of Governors should ensure its interaction and relationship with the Board of Directors is appropriate and effective. In particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and, where possible, using clear, unambiguous language.	Compliant	CoG Cycle of Business in place and formal calendar of meetings agreed and in place. Monthly Q&A session with the Chair in place CoG development sessions/ Working parties in place.
2.8	The Council of Governors should only exercise its power to remove the Chair or any Non-Executive Directors after exhausting all means of engagement with the Board of Directors. The Council should raise any issues with the Chair or with the Senior Independent Director in the first instance.	Compliant	The Trust Constitution along with the Board Standing Orders (Annexe 7) details the process for removal of the Chairperson or other Non-Executive Directors.
2.9	The Council of Governors should receive and consider other appropriate information required to enable it to discharge its duties, for example clinical statistical data and operational data.	Compliant	Agreed meeting Cycle of Business in place. Reports include Committee Assurance Reports. Strategy updates,

			Chair & Chief Executive Reports and complaints reports. Monthly Q&A with the Chair of the Trust. Governors observe Board Committees Lead Governor observes private Board Meetings. Assessment completed to ensure compliance with Addendum for Governors.
2.10	The Chair (and the Senior Independent Director and other Directors as appropriate) should maintain regular contact with the Governors to understand their issues and concerns.	Compliant	All NEDs routinely attend Council meetings. Executive Directors attend the CoG as required. Monthly Q&A with the Chair of the Trust.
2.11	Governors should seek the views of members and the public on material issues or changes being discussed by the Trust. Governors should provide information and feedback to members and the public at large regarding the Trust, its vision, performance and material strategic proposals made by the Trust Board.	Compliant	Governor and membership arrangements well established including the Governor Engagement Group New Membership Strategy agreed and implemented in 2023. Annual General Meeting in place at which Governors held a 'Marketplace' to engage with members and the public.
2.12	It is incumbent on the Board of Directors to ensure Governors have the mechanisms in place to secure and report on feedback that enables them to fulfil their duty to represent the interests of members and the public at large.	Compliant	Governor and membership arrangements well established. New Membership strategy approved in 2023.

			Governors observe Board Committees and submit written reports to the CoG. Governor Engagement Group in place. Monthly Q&A with the Chair of the Trust.
2.13	The Chair should ensure that the views of Governors and members are communicated to the Board as a whole. The Chair should discuss the affairs of the NHS Foundation Trust with Governors. Non-Executive Directors should be offered the opportunity to attend meetings with Governors and should expect to attend them if requested to do so by Governors. The Senior Independent Director should attend sufficient meetings with Governors to hear their views and develop a balanced understanding of their issues and concerns.	Compliant	The Chair will communicate views accordingly as part of the Chair's Report to Board. Non-Executive Directors, including the SID, are routinely in attendance at Council meetings to hear Governors' views. Monthly Q&A with the Chair of the Trust.
2.14	The Board of Directors should ensure that the NHS Foundation Trust provides effective mechanisms for communication between Governors and members from its constituencies. Contact procedures for members who wish to communicate with Governors and/or Directors should be clear and made available to members on the Trust's website and in the annual report.	Compliant	Contact procedures publicly available via Trust website, Annual Report and Newsletters. Members matters regular produced. Governor Engagement Group in place.
2.15	The Board of Directors should state in the annual report the steps it has taken to ensure that the members of the Board, and in particular the Non-Executive Directors, develop an understanding of the views of Governors and members about the NHS Foundation Trust, e.g. through attendance at meetings of the Council of Governors, direct face-to-face contact, surveys of members' opinions and consultations.	Compliant	Included in Annual Report.
3.1	The Council of Governors has a statutory duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.	Compliant	As set out in the Trust Constitution.

3.2	The 2006 Act, as amended, gives the Council of Governors a statutory requirement to receive the following documents. These documents should be provided in the annual report as per the NHS Foundation Trust Annual Reporting Manual: A) The annual accounts; B) Any report of the auditor on them; and C) The annual report	Compliant	Annual Report & Accounts published having been laid before Parliament. Documents received by the COG and presented at the Annual Members meeting.
3.3	The Directors must provide Governors with an agenda prior to any meeting of the Board, and a copy of the approved minutes as soon as is practicable afterwards. There is no legal basis on which the minutes of private sessions of Board meetings should be exempted from being shared with the Governors. In practice, it may be necessary to redact some information, e.g. for data protection or commercial reasons. Governors should respect the confidentiality of these documents.	Compliant	Agendas and minutes included in Board papers published on the Trust's website. Governors are encouraged to attend public Board meetings. The Lead Governor observes the Private Board Meetings and provides a report to the CoG.
3.4	The Council of Governors may require one or more of the Directors to attend a meeting to obtain information about the Trust's performance of its functions or the Directors' performance of their duties, and to help the Council of Governors decide whether to propose a vote on the Trust's or Directors' performance.	Compliant	Directors regularly attend the COG meetings as required. Governors meet to agree the agenda for the Council of Governor meetings. The agenda includes a standing item for Governor questions for which Executive Directors routinely attend to provide a response alongside the Non-Executive Directors.
3.5	Governors should use their rights and voting powers from the 2012 Act to represent the interests of members and the public at large on major decisions taken by the Board of Directors. These voting powers require: ▪ More than half the members of the Board of Directors who vote and more than half the members of the Council of Governors who vote to approve a change to the Constitution of the NHS foundation trust. ▪ More than half the Governors who vote to approve a significant transaction. ▪ More than half the Governors to approve an application by a trust for a merger, acquisition, separation or dissolution.	Compliant	Included in the Constitution

	- More than half the Governors who vote to approve any proposal to increase the proportion of the Trust's income earned from non-NHS work by 5% a year or more. For example, Governors will be required to vote where an NHS foundation trust plans to increase its non-NHS income from 2% to 7% or more of the Trust's total income. - Governors to determine together whether the Trust's non-NHS work will significantly interfere with the Trust's principal purpose, which is to provide goods and services for the health service in England, or its ability to perform its other functions.		
3.6	NHS Foundation Trusts are permitted to decide themselves what constitutes a 'significant transaction' and may choose to set out the definition(s) in the Trust's Constitution. Alternatively, with the agreement of the Governors, Trusts may choose not to give a definition, but this would need to be stated in the Constitution.	Compliant	Definition included in the Trust's Constitution; Clause 44.3 refers.
3.7	In taking decisions on significant transactions, mergers, acquisitions, separations or dissolutions, Governors need to be assured that the process undertaken by the Board was appropriate, and that the interests of the public at large were considered. A Council may disagree with the merits of a particular decision of the Board on a transaction, but still give its consent because due diligence has been followed and assurance received. To withhold its consent, the Council of Governors would need to provide evidence that due diligence was not undertaken.	Compliant	Transaction requirements included in constitution. Clause 44.1
3.8	The external auditors of a Foundation Trust must be appointed or removed by the Council of Governors at a general meeting of the Council.	Compliant	Appointment of external auditors approved by COG in 2022/23.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/25/08/72			
SUBJECT:	Fit and Proper Persons Test Annual Report			
DATE OF MEETING:	6 August 2025			
AUTHOR(S):	Emily Kelso, Corporate Governance and Membership Manager			
EXECUTIVE DIRECTOR SPONSOR:	Steve McGuirk, Chair			
LINK TO STRATEGIC OBJECTIVE: <i>(Please select as appropriate)</i>	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future		✓	
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	<i>Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:</i>			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	Yes	No	N/A
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	Yes	No	N/A
				✓
	Further Information:			
3. Foster good relations between people who share a protected characteristic and those who do not	Yes	No	N/A	
			✓	
Further Information:				
EXECUTIVE SUMMARY (KEY ISSUES):	The new NHS England Fit and Proper Persons Test Framework came into effect 30 September 2023, following this the WHH Fit and Proper Persons Policy was updated to comply with the framework. The framework has introduced a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC.			

	The purpose of this paper is to provide assurance to the Trust Board that all directors remain fit and proper for their roles and that the required evidence as per the NHS England Fit and Proper Persons Test Framework was submitted to the Regional Director NHS England, by the required deadline of 30 June 2025.		
PURPOSE: <i>(please select as appropriate)</i>	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to note the following: i. The Fit and Proper Persons Test has been conducted in accordance with the NHS England Fit and Proper Person Framework and the Leadership Competency Framework for Board Members. ii. The Trust can provide assurance that all current directors within scope meet the FPPT requirements. iii. The Annual NHS FPPT report was submitted to the Regional Director, NHS England, by the required deadline of 30 June 2025, following approval by the Audit Committee on the 23 June 2025.		
PREVIOUSLY CONSIDERED BY:	Committee	Audit Committee	
	Agenda Ref.	AC/25/06/034	
	Date of meeting	23 June 2025	
	Summary of Outcome	The Audit Committee approved the Fit and Proper Persons Test Annual Report for submission to the Regional Director of NHS England.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: <i>(if relevant)</i>	None		

REPORT TO TRUST BOARD

SUBJECT	Fit and Proper Persons Test Annual Report	AGENDA REF	BM/25/08/72

1. BACKGROUND/CONTEXT

The 'fit and proper persons' test set out in Regulation 5 of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014* (referred to as the 2014 Regulations) came into force on 27th November 2014 and aimed at making sure those individuals who have authority in organisations that deliver care, are responsible for the overall quality and safety of that care, and can be held accountable if standards of care do not meet legal requirements.

In 2019, a government-commissioned review (the Kark Review) of the scope, operation, and purpose of the Fit and Proper Person Test (FPPT) was undertaken. In response to the recommendations in the Kark Review, NHS England developed the [Fit and Proper Person Framework for board members](#) to strengthen/reinforce individual accountability and transparency for board members.

The framework has introduced a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC. This FPPT Framework came into effect from 30 September 2023.

The [WHH Fit and Proper Person Policy](#) was reviewed and updated in November 2024 to ensure alignment with the [NHS Leadership Competency Framework for board members](#) and the NHS Fit and Proper Person Framework for board members.

The FPPT is carried out on an individual board member basis, and in the annual submission to the NHS England regional director, the chair will provide a declaration of the FPPT outcomes for the board using the NHS FPPT submission reporting template – Appendix 6 of the NHS England fit and proper person test framework for board members.

FPPT data fields have been developed in ESR which enables the FPPT assessment elements to be recorded, along with some high-level detail where appropriate.

The purpose of this paper is to provide assurance to the Trust Board that all directors remain fit and proper for their roles and that the required evidence as per the NHS England Fit and Proper Persons Test Framework was submitted to the Regional Director NHS England, by the required deadline of 30 June 2025.

2. KEY ELEMENTS

The annual FPPT for WHH Board members and their deputies has been undertaken in line with, the:

- [Care Quality Commission \(CQC\) Fit and Proper Person Requirements \(FPPR\)](#)
- [NHS England Fit and Proper Person Test Framework for board members](#)
- [NHS Leadership Competency Framework for board members](#)
- [WHH Fit and Proper Person Policy](#)

Scope

The Fit and Proper Person Framework applies to the board members of NHS organisations. Within the framework the term 'board member' is used to refer to:

- both executive directors and non-executive directors (NEDs), irrespective of voting rights
- interim (all contractual forms) as well as permanent appointments
- those individuals who are called 'directors' within Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 201

The WHH Fit and Proper Person Policy specifies the scope as, all board appointments i.e., Executive and Non-Executive Directors. It also applies to those in a Deputy Director role, permanent, interim, irrespective of their voting rights and in addition; the Company Secretary and the Freedom to Speak Up Guardian.

Pre-Employment Checks

To confirm that an individual is of good character, the Trust undertakes pre-employment checks as determined by the NHS employment standards¹. These include:

- Employment history:*
- Board Member Reference A standardised board member reference process will be followed (as detailed in the NHSE Fit and proper Person Framework and using the Board member Reference Template
- qualification and professional registration checks (the original for inspection and verification)
- right to work check
- proof of identity
- an appropriate DBS check (on a case-by-case basis and if they have a role that falls within the DBS eligibility criteria). Including date DBS received.
- search of insolvency and bankruptcy register
- disqualified directors check
- Disqualification from being a charity trustee check.
- Social Media check
- Medical Clearance Dated (including confirmation of OHA)
- Employment tribunal judgement check
- Disciplinary findings – That is, any upheld finding pursuant to any trust policies or procedures concerning employee behaviour, such as misconduct or mismanagement

¹ NHS Employers Employment Check Standards, the Rehabilitation of Offenders Act (1974), guidance issued from the Disclosure and Barring Service (DBS), statutory guidance for Regulated Activity and Home Office

relevant to FPPT, this includes grievance (upheld) against the board member, whistleblowing claims against the board member (upheld) and employee behaviour upheld finding.

- Any ongoing and discontinued investigations relating to Disciplinary/ Grievance/Whistleblowing/Employee behaviour should also be recorded.
- Self-attestation form signed
- Sign-off by chair/CEO.
- NHS FPPT letter of confirmation submitted to the Regional Director NHS England (Appendix Five)

* Fields marked with an asterisk (*) – do not require validation as part of the annual FPPT unless a specific reason arises. However, these fields should still be updated in the event of a change to the information held.

Annual Review of Existing Directors

In line with the Fit and Proper Person Framework, the Trust is required to regularly review the fitness of directors to ensure that they remain fit for the roles they are in. The following processes take place annually:

- An audit of the retained evidence of documentation required as listed above
- Verification of the documentation completed for the director appraisals.
- A completed Declaration of Interest form (via Civica Declare²)
- Self-attestation form signed to be completed as part of annual appraisal
- Sign-off by chair/CEO.
- An Annual NHS FPPT report will be submitted to the Regional Director NHS England

Each director is responsible for identifying any issues which may affect their ability to meet the statutory requirements and bringing these issues on an ongoing basis and without delay to the attention of the Trust Chair or the Company Secretary.

The above checks are overseen by the Chief People Officer & Company Secretary, evidence of the checks is documented on each of the individual's personal files and saved on ESR.

Reporting

The Fit and Proper Person's Requirements (FPPR) place ultimate responsibility on the Chair to ensure that all relevant post holders meet the required fitness criteria and do not fall under any of the 'unfit' categories.

In line with this, the Trust was required to submit its annual NHS FPPR report to the Regional Director of NHS England by 30 June 2025. A draft version of the report was presented to the Audit Committee on **23 June 2025**, where it received approval for final submission.

² [Civica Declare](#) is the Trusts fully integrated end-to-end cloud governance software, enabling declarations of interest to be captured and published, Declarations are publicly available on the Trusts Website.

The final report was duly signed by both the Chair and the Senior Independent Director, confirming that all Board members meet the FPPR standards. It also affirms that supporting evidence has been retained on the Electronic Staff Record (ESR) system.

3. CONCLUSION

Pre-employment and annual checks have been completed for all Trust Board members and individuals within the scope of the Fit and Proper Persons Policy. These checks were overseen by the Chief People Officer and the Company Secretary.

Evidence of compliance has been documented in each individual's personal file and securely stored on the Electronic Staff Record (ESR) system.

The NHS Fit and Proper Person Test (FPPT) submission template was completed and submitted to the NHSE Regional Director on 24 June 2025, ensuring compliance with the 30 June 2025 deadline.

4. RECOMMENDATIONS

The Trust Board is asked to note the following:

- i. The Fit and Proper Persons Test has been conducted in accordance with the NHS England Fit and Proper Person Framework and the Leadership Competency Framework for Board Members.
- ii. The Trust can provide assurance that all current directors within scope meet the FPPT requirements.
- iii. The Annual NHS FPPT report was submitted to the Regional Director, NHS England, by the required deadline of 30 June 2025, following approval by the Audit Committee on the 23 June 2025.

REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/25/08/73			
SUBJECT:	Committee Chairs Annual Reports I) Quality Assurance Committee II) Strategic People Committee in Common III) Finance and Sustainability Committee			
DATE OF MEETING:	6 August 2025			
AUTHOR(S):	Cliff Richards, No-Executive Director and Chair of QAC Julie Jarman Non-Executive Director & Chair of SPC John Somers, Non-Executive Director & Chair of FSC			
EXECUTIVE DIRECTOR SPONSOR:	Steve McGuirk, Chair			
LINK TO STRATEGIC OBJECTIVE: <i>(Please select as appropriate)</i>	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: - Quality Assurance Committee - Strategic People Committee - Finance and Sustainability Committee			

	Have met their Terms of Reference and have gained assurance throughout the reporting period of the Trust's performance.		
PURPOSE: <i>(please select as appropriate)</i>	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	Quality Assurance Committee Strategic People Committee in Common Finance, Sustainability and Performance Committee	
	Agenda Ref.	QAC/25/07/90 SPCIC/25/06/059 FPSCiC/25/07/25	
	Date of meeting	8 July 2025 16 July 2025 28 July 2023	
	Summary of Outcome	Approved for reporting to Trust Board	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: <i>(if relevant)</i>	None		

QUALITY ASSURANCE COMMITTEE

1. BACKGROUND/CONTEXT

The Committee is required to report annually to the Board outlining the work it has undertaken during the year, and where necessary, highlighting any areas of concern. This paper presents the Quality Assurance Committee Annual Report which covers the reporting period 1 April 2024 - 31 March 2025.

The Quality Assurance Committee is accountable to the Board of Directors for providing oversight and assurance on all aspects of quality, including strategy, quality improvement, delivery, clinical risk management and clinical governance, clinical audit and the regulatory standards relevant to quality and safety. This includes assurance around relevant Health and Safety matters.

The Committee is accountable to the Board for ensuring that the Trust's Strategic Objective 1: **"We will ... Always put our patients first delivering safe and effective care and an excellent patient experience"** is delivered.

This report details the role of the Committee and the work that it has undertaken during the 2024/25 financial year.

2. KEY ELEMENTS

2.1 Terms of Reference

The committee Terms of Reference were reviewed during Quarter 4 of 2024/25, along with the Cycle of Business. This included a review of the membership, quoracy and duties and responsibilities of the committee.

2.2 Frequency of Meetings and Summary of Activity

Meetings continued to take place monthly throughout 2024/25, with the addition of one extraordinary meeting during July 2024 to help ensure all reports were appropriately scrutinised. Subsequently the Committee met 13 times during the year. Each of the meetings held during 2024/25 were quorate.

2.3 Summary of Committee Activity throughout 2024/25

2.3.1 Engagement Stories

Given the time restraints of committee meetings and the ever-increasing oversight required, agendas have become increasingly busy, as a result Engagement Stories have been presented less frequently than in previous years in the knowledge that the Trust Board also received engagement stories at each of its meetings. Examples of such stories from 2024-25 were:

- Dementia provision for patients with newly diagnosed Dementia at WHH Healthy and Home
- Organ Donation
- Please Just Listen To Me – White Coat Syndrome

The 2025/26 Cycle of Business has scheduled engagement stories on a bi-monthly basis.

2.3.1 Deep Dives & Hot Topics

At each meeting, the Committee received a 'Hot Topic' and 'Deep Dive' presentation. Hot Topics provided high level information that shared a story or a journey. Each relating to areas of national, local, partner or internal focus; new services, accreditation of services or items escalated from sub-committees or other meetings. Deep Dives provided an in-depth review of a topic that had been escalated from sub-committees or other meeting, areas noted from other reports and wider triangulation, areas flagged by the CQC or items requested by the Trust Board.

Deep Dives received during the year included:

- Sepsis Performance
- Theatre Safety Culture Survey & Culture Plan
- Surveillance Programmes Backlogs
- Medication Errors
- Procedural Safety Steering Group Never Events
- Culture Plan
- Infection Prevention Control
- Critical Medication

Hot topics received during the year included:

- MIAA Theatre Safety Audit
- Overview of Maternity Mortality Governance & Mortality Data – Last 5 years
- Out of Date Policies
- Fragile Services – Cardiology
- Quality Surveillance in Surgical Outcomes
- Impact on Quality Considerations
- Delays to Follow-up
- Stroke
- Birth Trauma – WHH Position
- ED Triage

2.4 Risk Management (Quality)

The committee oversees the Trust's Quality Strategic Risks on behalf of the Board and liaises with the Audit Committee to ensure the Strategic Risk Register and Board Assurance Framework drives the internal audit plan on quality and safety issues and to provide the Audit Committee assurance regarding systems of internal control.

The Board Assurance (BAF) and corporate risks related to quality are presented to the committee on a bi-monthly basis with actions, mitigations and scoring discussed and amended as appropriate. During the year the committee assigned individual risk appetites to each of its strategic risks in line with the overall Trust Risk Appetite Statement. All recommended changes are presented to and approved by the Trust Board.

Throughout the year 2024/25, the Quality Committee monitored four risks on the Board Assurance Framework. At year end (31st March 2025), the following ratings and appetites were held by each of the four strategic risks monitored by the committee:

Risk ID	Exec Lead	Risk Description	Q4 2024/25	Q3 2024/25	Q2 2024/25	Q1 2024/25	Target
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. Risk Appetite: Open	20 (L5xC4) ↔	20 (L5xC4) ↔	20 (L5xC4) ↔	20 (L5xC4)	8 (L2xC4)
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. Risk Appetite: Open	20 (L4xC5) ↔	20 (L5xC4) ↔	20 (L5xC4) ↔	20 (L5xC4)	6 (L3xC2)
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. Risk Appetite: Minimal	20 (L5xC4) ↔	20 (L5xC4) ↔	20 (L5xC4) ↔	20 (L5xC4)	6 (L3xC2)
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. Risk Appetite: Minimal	12 (L3xC4) ↓	16 (L4xC4) ↔	16 (L4xC4) ↔	16 (L4xC4)	8 (L2xC4)

2.4.1 Amendments to Risk Descriptions and De-escalation of Risks:

During Q3 of the 2024/25 financial year, the following amendments to the description of risk 224 were approved:

Quarter 3

From: *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.*

To: 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.

2.4.2 De-escalation of Risks

Whilst none of the strategic risks monitored by the QAC were de-escalated during 2024/25, during Q3, the Strategic People Committee and Board approved the de-escalation of risk 1757, given that the remaining risk related to the operational impact of the GP collective action, the only remaining assurance gap.

Risk 1757: *If GP collective action continues to take place, then operational delivery may be negatively impacted affecting delivery of services.*

The risk is now monitored through the QAC via the Corporate Risk Register and ownership has moved from the Executive Medical Director and Chief People Officer to the Executive Medical Director only, with operational ownership from the Trusts Emergency Preparedness, Resilience and Response Lead.

2.4.3 Committee Deep Dives of Risk Appetites and Target Risk Ratings

Each of the monitoring committees undertook a Deep Dive of their assigned strategic risks during Q2 2024/25. The aim of the Deep Dives was to review the risk details including agreeing individual risk appetites for each of the Trusts strategic risks and to align target risk ratings to the agreed risk appetites.

Key changes to risk appetites following committee Deep Dives:

Following the Deep Dive discussion at the Quality Assurance Committee on 9 July 2024, the risk appetite of two risks were updated.

Risk 224 – The risk appetite was amended from **Cautious** to **Open** as it more accurately reflected the actions taken and controls in place to improve the position, such as the introduction of the LLP and boarding.

Risk 1215 – The risk appetite was amended from **Minimal** to **Open**, due to the willingness to consider all potential delivery options while also providing an acceptable level of reward.

There were no amendments to targets risk ratings for the strategic risks monitored by the Quality Assurance Committee following the deep dive.

BAF reports to committees and Trust Board now include a unique risk appetite for each strategic risk, these are assigned based on the risk appetite matrix recommended by The Good Governance Institute.

2.5 Strategy Development

The committee received regular updates in relation to the Strategic Quality Priorities for the Trust. In addition, updates of enabling quality strategies were provided e.g. Mortality reports, Violence Reduction Strategy, Risk Management Strategy, Quality Strategy, Dementia Strategy, Nursing and Midwifery Strategy, Digital Strategy, Palliative Care End of Life Strategy, Patient Experience Strategy.

2.6 Quality Integrated Performance Report / Dashboard

The committee has overseen an ongoing review of quality Key Performance Indicators, which are monitored through the Integrated Performance Dashboard. A report of the Quality Dashboard was received bi-monthly to review performance and to determine assurance of mitigating actions as appropriate, in advance of presentation at Trust Board meetings.

The Trusts Integrated Performance Report (IPR) is reviewed at least annually in line with the Trust's Performance Assurance Framework (PAF) to ensure all indicators remain relevant and up to date.

During March 2025, the committee approved several amendments to Quality Indicators on the Trust's IPR. No new indicators were added.

2.7 Investigations and Learning from Experience

The Committee receives a regular update to assure itself that investigations from patient safety incidents are being undertaken as per statutory and regulatory requirements. This also includes monitoring Duty of Candour.

The Committee receives a quarterly Learning from Experience Report which contains both quantitative and qualitative data analysis using information obtained from the Datix Risk Management System and other governance functions to triangulate the data and learning from incidents, complaints, claims, health and safety, clinical audit, compliance, quality improvement and research and development. The report provides summary of themes, trends and key findings that have influenced learning and actions to support and sustain improvement.

2.8 Reports following Incidents/Concerns

The schedule of hot topics and deep dives described in section 2.3.1 highlights some specific incidents and concerns that have resulted in the committee taking a focussed view during the year. As a result of an audit conducted by the Trust's internal auditor, Mersey Internal Audit Agency (MIAA), in relation to theatre safety, the committee agreed to monitor the response to the audit on an ongoing basis.

2.9 Scheduled Quality Assurance Agenda Items

The committee receives several regular reports to provide assurance on quality and safety matters, reports are presented by members of the Trust Executive Team, supported by subject matter experts, include:

- Quality Priorities – quarterly, providing progress against each of the annual priorities selected as part of the Quality Account.
- Infection prevention and control – quarterly reports
- Quality Improvement – biannual progress report
- Learning from Deaths – quarterly report
- Safe Staffing – Quarterly Report

The Committee also received an exception report at each meeting from the Patient Safety & Clinical Effectiveness Sub-Committee. The report included updates on the services classed as 'fragile' to demonstrate clarity and focus. 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'.

2.10 Regulatory and Statutory monitoring

The committee continued to monitor the statutory and regulatory requirements relating to quality governance throughout the year. This included monitoring of the post Care Quality Commission Inspection Action plan (also via the Compliance Update agenda item) national audit activity, NICE guidance, national surveys, quality KPIs and complaints improvement.

The QAC, supported and approved a number of annual reports including, Patient Experience, Health & Safety, Medicines Management & Controlled Drugs, Safeguarding, Risk Management, Complaints, Infection Prevention & Control, Clinical Audit, Quality Strategy and Dementia Strategy.

2.11 Maternity Oversight

Following increased scrutiny and the requirement for oversight at Board level on key national maternity safety and quality issues and in line with the requirements of the Maternity Incentive Scheme - Safety Action 9*. The Director of Midwifery presents a number of reports concerning Quality & Safety within the Maternity and Neonatal services as scheduled in the Cycle of Business, these have included:

- Ockenden Report
- Maternity Incentive Scheme Year 6 Update/sign off
- Cheshire & Merseyside Perinatal Mortality Report (PMRT)
- Avoiding Term Admission into Neonatal Unit (ATAIN)
- Perinatal Mortality Report
- Maternity Incentive Scheme (MIS) to include Saving Babies Lives Care Bundle (SBLCB)
- Maternity Self-Assessment Tool
- Maternity & Neonatal Quality Review Report (inc Inpatient Maternity Survey)
- Review of Harm Events
- Transitional Care Audit (limited time)
- Post Partum Haemorrhage (Audit), now included in Maternity and Neonatal Quality Review

Where required these reports were also presented at Trust Board meetings.

**Maternity Incentive Scheme (MIS) - Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues*

2.12 Issues Carried Forward – john to review

There are a number of issues which the Committee will carry forward into 2023-24.

- MIAA Theatre Audit – Update on actions
- Fuller Mortuary Enquiry
- New Approach to Hospital 7 Day Service
- ED Improvement Programme
- Medication Errors
- Sepsis
- Implementation of the Quality Priorities for the year.
- Monitoring of the requirements of the Ockenden Review
- PPH Audit

2.13 Summary

As the Chair of the QAC I encourage honest and open discussion, so that areas of success can be celebrated, and areas of improvement escalated and actioned. To ensure that the patient voice is heard the meeting regularly commences with a patient/staff story.

I would like to thank all members of the Committee, along with Directors, staff, internal and external advisors for their responses, support and contributions during the year.

Dr Cliff Richards, Chair of Quality Assurance Committee

3. RECOMMENDATIONS

The committee is asked to note the report for onward reporting to the Trust Board.

STRATEGIC PEOPLE COMMITTEE

1. BACKGROUND/CONTEXT

The Committee is required to report annually to the Trust Board outlining the work it has undertaken during the year, and where necessary, highlight any areas of concern. This paper presents the Strategic People Committee Annual Report which covers the reporting period 1 April 2024 – 31 March 2025.

The Strategic People Committee was accountable to the Board of Directors for providing oversight and assurance on all aspects of the Trust's human resources and organisational development arrangements. The Committee maintained a strategic overview ensuring that these were designed to provide a positive working environment for colleagues, and that the Trust had in place at all levels the right people systems and processes to deliver, from a patient perspective, safe high-quality care. The Committee also maintained a strategic overview of the systems and processes in place to provide an inclusive working environment for our workforce through the delivery of the Workforce Equality, Diversity and Inclusion Strategy which provided assurance that the culture of the Trust is aligned to the NHS People Promise and has oversight of all regulatory submissions and reporting.

The Committee was accountable to the Board for ensuring that the Trust's 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*** was delivered and that arrangements were in place to enable staff to have a voice, through the development of a just and restorative culture which values diversity, inclusion, compassionate leadership and equity for all.

The Committee provided oversight and assurance on organisational strategic workforce risks and ensured that these are managed appropriately.

This report details the membership and role of the Committee and the work that was undertaken during the reporting period.

2. KEY ELEMENTS

2.1 Establishment of Committee in Common, Terms of Reference and Cycle of Business

In Quarter 4 and following the decision by the respective Boards of Warrington & Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare Foundation Trust (BCHT) for WHH to acquire BCHT, and as part of the process to support effective integration; the Committee supported the disestablishment of the Trust's Strategic People Committee and the establishment of the a Strategic People Committee in Common (SPCiC).

The Strategic People Committee in Common was established to oversee the Trusts' people and organisational development strategies, aligning them with WHH's Strategic Objective 2 and BCHT's Strategic Objectives 3, 5, and 6. These objectives emphasise creating an engaged, diverse workforce and fostering inclusive, compassionate cultures that enhance patient care and operational efficiency.

The SPCiC will provide assurance to both Boards that people strategies - including the joint People Strategy, Workforce Equality, Diversity and Inclusion Strategy, and Culture Plan - are robust, equitable, and effectively implemented.

The Terms of Reference are attached at Appendix 1 and the Cycle of Business 2025-26 at Appendix 2. The Committee continues to focus on assurance monitoring, with its reporting Sub-Committees meeting to deliver the agenda.

Chair's Logs from Sub-Committees are provided to the Committee for assurance purposes.

2.2 Frequency of Meetings

Meetings continued to take place monthly in 2024-25. During the reporting period, there were 12 meetings.

During the reporting period, the Committee has been composed of two Non-Executive Directors with a quorum of two (one of whom must be a Non-Executive Director). Any Non-Executive Director is able to attend the Committee to cover absence.

The Committee attendance record is attached at Appendix 3.

2.3 Committee Effectiveness Review for 2024-25

Due to the establishment of the SPCiC, the Committee effectiveness review was postponed until the end of Q1 2025-26, after three Committee meetings have occurred, allowing a proper evaluation of the new structure

2.4 Summary of Activity

2.4.1 Staff Stories

Staff Stories received by the Committee were:

- Hospital Volunteer work
- Culture Champions
- Internship

2.4.2 Deep Dives

Deep Dives received by the Committee were:

- Culture (received in April 2024 and January 2025)
- Bank Reduction
- Sexual Safety
- Reward and Recognition
- Fixed and Variable Pay
- Safer Nursing Care Tool
- E-Rostering, Flexible Working

2.4.3 Hot Topic

Hot Topics received by the Committee were:

- Vacancy Management
- Integration with WHH and BCH
- Physician Associates
- GP Collective Action

- Impact of CIP on Workforce Strategic Priorities
- PWC Report and Workforce (received in October and December 2024)
- Agenda for Change – Nursing and Midwifery
- PWC Final Report

2.4.4 Risk Management (Workforce)

The Committee oversees the Trust's Workforce Strategic Risks on behalf of the Board and liaises with the Audit Committee to ensure the Strategic Risk Register and Board Assurance Framework drives the internal audit plan on workforce issues and to provide the Audit Committee assurance regarding systems of internal control.

The Board Assurance (BAF) and Corporate Risks related to Workforce are presented to the Committee on a bi-monthly basis with actions, mitigations and scoring discussed and amended as appropriate. All changes are shared with the Trust Board.

Throughout the year 2024/25, the Committee monitored two risks on the Board Assurance Framework:

Risk #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

Risk #1757: If GP collective action continues to take place, then operational delivery may be negatively impacted affecting delivery of services

Amendments to Risk Descriptions and De-escalation of Risks:

During Q3 of the 2024/25 financial year, the following amendments to the description of risk 1757 were approved:

Quarter 2

From: *If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action then this could result in significant workforce gaps which would negatively impact service delivery and patient safety*

To: If industrial action continues to take place, then workforce availability and wellbeing may be negatively impacted affecting delivery of services.

Quarter 3

From: *If industrial action continues to take place, then workforce availability and wellbeing may be negatively impacted affecting delivery of services*

To: *If GP collective action continues to take place, then operational delivery may be negatively impacted affecting delivery of services.*

Amendments to risk ratings:

Risk #1757: As a result of the resolution of the pay disputes the Trust Board approved the proposed amendment to the risk rating from **20** (Likelihood 5 x Consequence 4) to **9** (Likelihood 3 x Consequence 3) to reflect the improved position. The Trust does not currently have any operational and live strike mandates for any staff groups within the Trust or across the NHS (except for the GP collective action).

Risk #1134 Following discussions as part of the strategic risk deep dive by the committee and Risk Review Group on 5th March 2024, it was agreed to decrease the rating of the risk from **20** (Likelihood 5 x Consequence 4) to **12** (Likelihood 3 x Consequence 4). The recommendation to reduce risk was a result of sustained reduction in the sickness absence rate, the significant improvement in long terms sickness absence rates, improvements in permanent staff turnover and a reduction in Bank and Agency reliance.

Risk ID	Exec Lead	Risk Description	Current Rating Q4 2024/25	Q3 2024/25	Q2 2024/25	Q1 2024/25
1757	CPO	If GP collective action continues to take place, then operational delivery may be negatively impacted affecting delivery of services Risk Appetite: Cautious		Risk De-escalated to CRR 9 (3Lx3C) ↓	(L5xC4) ↔	(L5xC4)
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 Risk Appetite: Open	2 (L3xC4) ↔	2 (L3xC4) ↔	(L3xC4) ↓	(L4xC5)

De-escalation of Risks

During Q3 of the 2024/25 financial year, the Board approved the de-escalation of risk 1757, given that the remaining risk related to the operational impact of the GP collective action, the only remaining assurance gap.

The risk is now monitored through QAC via the Corporate Risk Register and ownership has moved from the Executive Medical Director and Chief People Officer to the Executive Medical Director only, with operational ownership from the Trusts Emergency Preparedness, Resilience and Response Lead.

Committee Deep Dives of Risk Appetites and Target Risk Ratings

The Strategic People Committee was the first committee to undertake a deep dive of their assigned strategic risks, this took place in February 2024, for other committees this took place during Q1/2 2024/25. The aim of the deep dives was to review the risk details including agreeing individual risk appetites for each of the Trusts strategic risks and to align target risk ratings to the agreed risk appetites.

As above, following the deep dive the committee approved the decreased scoring of risk 1134. Target risk ratings remained unchanged. The risk appetite for risk 1134 was updated from Cautious to Open

BAF reports to committees and Trust Board now include a unique risk appetite for each strategic risk, these are assigned based on the risk appetite matrix recommended by The Good Governance Institute.

2.4.5 Strategy Updates

The Committee has been regularly updated on the Trust's strategic workforce priorities, receiving biannual reports on the WHH People Strategy and the WHH Workforce Equality, Diversity, and Inclusion Strategy. Additionally, to align with the collaborative strategic direction with BCHT, the Committee has received monthly integration updates since August 2024.

2.4.6 Workforce Integrated Performance Report

The Trusts Integrated Performance Report (IPR) is reviewed at least annually in line with the Trust's Performance Assurance Framework (PAF) to ensure all indicators remain relevant and up to date. The Workforce Indicators are reviewed by the Committee.

The Workforce Integrated Performance Indicators were reviewed in February 2024 and approved at Trust Board for inclusion in the Trust Integrated Performance Report (IPR) dashboard from April 2024 – March 2025.

The table below lists the IPR reporting to Trust Board and SPC for 2024-25.

IPR	Reporting Period	Board	SPC
Looking After Our WHH People – Supporting Attendance			
Sickness absence	Annualised	X	X
Welcome Back Conversations	Annualised		X
Long term sickness absence	Annualised		X
Short term sickness absence	Annualised		X
Looking After Our People – Occupational Health and MH Wellbeing			
Number of management referrals received	In month		X
Number of OH DNAs (includes Physio)	In month		X
Number of referrals into Physio service	In month		X
Number of referrals into MH Wellbeing Hub	In month		X
Innovating the Way We Work - Workforce Profile			
Vacancy rate	Annualised		X
% Funded FTE Utilised	In month		X
Turnover	Annualised	X	X
Retention	Annualised	X	X
Innovating the Way We Work - Resourcing			
Bank and agency reliance	Annualised	X	X
Bank reliance	Annualised		X
Agency reliance	Annualised		X
Time to hire	Annualised		X
Growing Our WHH Workforce for the Future - Training			
Core/Mandatory training compliance	In month	X	X
Role Specific training compliance	In month		X
PSIRF training compliance	In month		X
Growing Our WHH Workforce for the Future - Development			
PDR compliance	Annualised	X	X
Use of the Apprenticeship Levy	In month		X
Workforce carrying out an Apprenticeship qualification	In month		X
Belonging in WHH – ED&I			
Non-disabled staff compared to disabled staff being appointed from shortlisting	In month		X
White staff being appointed from shortlisting compared to BME staff	In month		X
Representation of BME staff in Bands 7+ (Agenda for Change only)	In month		X
Improvement of disability declaration rates	In month		X

The Committee review in March 2024 supported the reporting of Safeguarding training compliance as part of core and mandatory training compliance.

2.4.7 Regulatory and Statutory Reporting

The Committee continued to monitor the statutory and regulatory requirements relating to workforce, equality and diversity governance throughout the year which included:

- GMC National Trainee Survey
- GMC Revalidation Annual Report / NHSE Statement of Compliance and Annual Organisation Audit
- Guardian of Safe Working Hours
- Facilities Time Off
- Equality Duty Assurance Report
- Workforce Equality Assurance Report
- Equality Delivery System 2022
- Gender Pay Gap Report
- Workforce Race Equality Standard
- Workforce Disability Equality Standard

The Committee receives a bi-annual Freedom to Speak Up (FTSU) Report presented to by the Freedom to Speak Up Guardian, providing an overview of policy changes; the range of issues raised by our workforce; the number of FTSU Champions; promotional activities promoting access to the FTSU service and training compliance. The Chair of the Committee is the FTSU Non-Executive Lead.

The Committee receives bi-annual Health and Wellbeing (HWB) Guardian Reports. This report details benchmarking against national toolkits and HWB framework; the range of HWB activities and offers available to our staff – bespoke, individual and team based; details of access of these services and the benefits to our staff. The report is presented to the Committee by the HWB Guardian.

2.4.8 Workforce Policies and Procedures Overview Report

The Committee received quarterly updates regarding policy development, review, and ratification workstreams managed through the People Policy and Procedure Group, JNCC and JLNC, and ratified at OPC. The Committee through this report also received oversight of the Trust people policy and procedure framework, receiving assurance that the framework is being maintained, policies remain valid and in date.

2.4.9 Improving People Practices Report

The Committee received bi-annual assurance regarding employee relations case management activity across the Trust. Employee relations in this context refers to the Disciplinary, Supporting Performance Improvement, Resolving Workplace Disputes and Supporting Attendance Policies.

The Committee received an overview of the level of activity, areas of risks, and wider actions to improve employee relations case management performance.

2.4.10 Safe Staffing Reports

The Committee receive monthly updates regarding the staffing of wards to support the delivery of safe levels of care. The report provides assurance to the Committee that the Trust is safely staffed, staffing is closely monitored, and processes are in place to support appropriate escalation and to ensure risks are identified and mitigated accordingly.

Furthermore, the Committee receives a quarterly Midwifery Safe Staffing report to provide assurance of safe midwifery staffing at WHH against national recommendations for safe maternity staffing and triangulation against maternity red flag incidents.

2.5 Topics Carried Forward

There are a number of topics which the Committee will carry forward into 2025-26 to maintain oversight of including:

- Impact of flexible working
- Continued Implementation of the People Strategy and Workforce Equality, Diversity and Inclusion Strategy programmes of work for the year.
- Oversight of the industrial relations climate and maintaining good relationships with the workforce and Staff Side colleagues, including implementation of the HCSW Framework and national review of job profiles and terms and conditions.
- Monitoring of the requirements of all regulatory and statutory reporting
- To ensure that the staff voice is heard, on a bi-monthly basis, with the Committee commencing with a staff story.

2.6 Chair's Summary

I, as Chair of the Strategic People Committee, encourage honest and open discussion and challenge, so that areas of success can be celebrated, and areas of improvement identified, addressed and escalated as necessary.

I would like to thank all members of the Committee and the workforce for their responses, support and contributions during the year.

Julie Jarman

Chair of the Strategic People Committee

8 RECOMMENDATIONS

The Committee is asked to note the report for onward reporting to the Trust Board.

Appendix 1 - Terms of Reference

Appendix 2 - Cycle of Business 2025-26

Appendix 3 – Attendance Record 2024-25

Finance and Sustainability Committee

1. Background/context

The Committee is required to report annually to the Board outlining the work it has undertaken during the year, and where necessary, highlighting any areas of concern. This paper presents the Finance and Sustainability Committee Annual Report which covers the reporting period 1 April 2024 - 31 March 2025.

The Committee is accountable to the Board for ensuring that the Trust's Strategic Aim 3: **"We will...Work in partnership with others to achieve social and economic wellbeing in our communities"** is delivered. The Committee is responsible on behalf of the Board for reviewing financial and operational planning, digital, performance and strategic and business development.

This report details the role of the Committee and the work that it has undertaken during the 2024/25 financial year.

2. Key elements

2.1 Terms of Reference

The committee Terms of Reference were reviewed during Quarter 4 of 2024/25, along with the Cycle of Business. This included a review of the membership, reporting and administrative arrangements.

2.2 Frequency of Meetings and Summary of Activity

Meetings continued to take place monthly throughout 2024/25, with the addition of one extraordinary meeting during August 2024 to help ensure all reports were appropriately scrutinised. Subsequently the Committee met 13 times during the year. Each of the meetings held during 2024/25 were quorate.

During the reporting period, the Committee has primarily been composed of two Non-Executive Directors with a quorum of two (one of whom must be a Non-Executive Director). Any Non-Executive Director is able to attend the Committee to cover any absence.

2.3 Summary of Committee Activity throughout 2024/25

2.3.1 Deep Dives & Hot Topics

At each meeting, the Committee received either a 'Hot Topic' and/ or 'Deep Dive', dependent on issues raised. Hot Topics provided high level information about a current topic that needed focussed attention and discussion by the Committee and relating to areas of national, local, partner or internal focus; new services, accreditation of services or items escalated from a sub-committees or other meetings.

Hot topics received during 2024/25.

- Road to Recovery – 5 Year Plan
- Bank Reduction Plan
- CIP & Cost Pressures update following Executive Director Peer Review
- Recovery Update Q1
- C&M Mandated Support
- Theatre & Outpatient Productivity
- PWC
- PWC
- PwC Update and Report
- Non-recurrent elective restoration monies. Inc Elective Restoration Q3 Update
- Operational Plan, Capacity, Strategy, Drivers of the deficit
- Transformation Monitoring/ Governance and Transformation Capacity

Deep Dives provided an in-depth review of a topic that had been escalated from sub-committees or other meeting, areas noted from other reports and wider triangulation.

Deep Dives presented as part of the assurance process included during 2024/25 included:

- GIRFT Transformation
- Theatre Capacity Productivity
- Strategic Risk Deep Dive incl BAF and Risk Register Report
- Benefits Realisation A&E
- Benefits Realisation Urology
- Establishment
- Top 3 Cost Pressures
- EPCMS
- CIP Update, Governance & Review
- Drivers of the deficit
- Theatre Productivity
- CIP and Cost Pressures

2.4 Risk Management (Finance and Sustainability)

The Committee oversees the Trust's risks that relate to finance and sustainability on behalf of the Board and liaises with the Audit Committee to ensure the Strategic Risk Register and Board Assurance Framework drives the internal audit plan on workforce issues and to provide the Audit Committee assurance regarding systems of internal control.

The BAF and corporate risks relevant to the Committee's remit were presented on a bi-monthly basis with actions, mitigations and scoring discussed and amended as appropriate. During the year the committee assigned individual risk appetites to each

of its strategic risks in line with the overall Trust Risk Appetite Statement. All recommended changes are presented to and approved by the Trust Board.

Throughout the year 2023/24, the Finance and Sustainability Committee monitored four risks on the Board Assurance Framework. At year end (31st March 2025), the following ratings and appetites were held by each of the five strategic risks monitored by the committee:

Risk ID	Exec Lead	Risk Description	Current Rating Q4 2024/25	Q3 2024/25	Q2 2024/25	Q1 2024/25
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) ↔	20 (L5xC4) ↔	20 (L5xC4) ↔	20 (L5xC4))
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) ↔	16 (L4xC4) ↔	16 (L4xC4) ↔	16 (L4xC4))
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) ↔	16 (L4xC4) ↔	16 (L4xC4) ↔	16 (L4xC4))
2273 New	CSPO	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	9 (L3xC3) ↔			

2.4.1 Amendments to Risk Descriptions and De-escalation of Risks:

During March 2025 the Committee (FSC) approved the merger of strategic risks 1898, 145 and 125 to form a single strategic risk 2273, monitored by the FSC. Given this, risks 1898 and 145 were closed and risk 125 deescalated to the Corporate Risk Register.

Each of the monitoring committees undertook a Deep Dive of their assigned strategic risks during Q2 2024/25. The aim of the Deep Dives was to review the risk details including agreeing individual risk appetites for each of the Trusts strategic risks and to align target risk ratings to the agreed risk appetites.

Key changes to target risk ratings following committee Deep Dive.

Following the Deep Dive discussion and the Finance and Sustainability Committee on the 26 June 2024, the target risk ratings of three risks were updated.

- **Risk 134** - The target risk rating was increased from 10 (5Lx4C) to 12 (4Lx3C) to better align with the agreed risk appetite of **Open**
- **Risk 1114** - The target risk rating reduced from 6 (2Lx3C) to 5 (1Lx5C) to better align with the agreed risk appetite of **Minimal**.
- **Risk 1898 now closed** – The target risk rating increased from 4 (L1xC4) to 9 (3Lx3C) to better align with the agreed risk appetite of **Seek**.

There were no amendments to risk appetites for the strategic risks monitored by the committee.

BAF reports to committees and Trust Board now include a unique risk appetite for each strategic risk, these are assigned based on the risk appetite matrix recommended by The Good Governance Institute.

2.5 Finance and Key Issues

2.5.1 Key financial headlines at 31 March 2025

The Trust recorded an adjusted deficit of £16.8m which is £5.5m away from the £11.3m deficit plan (adjusted from £27.8m following receipt of £16.5m deficit support funding). This adjusted deficit is the value which NHSE monitors the Trust against and the movement from plan was approved by the ICS. The annual capital programme was £21.7m (including IFRS16 and donated assets) and the actual spend for the year was £21.9m.

The cash balance at the end of the year was £16.3m. The cash balance will be utilised to pay both capital (£8.4m) and revenue creditors.

There were no failures in financial governance during the year.

The Finance and Sustainability Committee reviewed and scrutinised the financial position and performance of the Trust closely throughout the year and escalated any relevant items to the Board in the Chair's exception report.

In addition, the Board has regularly reviewed the financial position, providing challenge to forecast outturns and the associated mitigations.

Capital expenditure has been closely monitored throughout the year by both the Capital Planning Group and the Finance and Sustainability Committee, with particular attention given to schemes exceeding £0.5m.

Over the past 12 months, the Trust has maintained regular engagement with the ICS and NHS England, during which the financial position, forecasts, and capital plans have been discussed, reviewed, and appropriately challenged.

2.5.2 PWC Report

PWC was commissioned to evaluate three strategic areas: Grip and Control, Theatre Productivity, and Integration. Their draft report identified potential full-year savings of up to £5.5m, with £1m achievable in-year. Final estimates were expected to settle around £4.5m and £0.6m respectively. These savings were aligned to support the Trust's £8.6m risk-adjusted deficit. PwC acknowledged that several grip and control initiatives were already underway and recognised significant progress in operational control and integration since month 4.

However, the absence of a decision on the options appraisal had constrained further in-year opportunities. Opportunities in Theatre productivity—particularly through increased day case activity and improved utilisation—were expected to contribute to the CIP. Concerns were raised by committee members regarding the feasibility of certain recommendations. The committee continues to receive updates on the PWC work during 2025/26.

2.5.3 Regular Scheduled Agenda Items

- Corporate Performance Report
- Monthly Productivity Improvement Update – added in year in response to performance
- Monthly CIP/GIRFT update
- Cost Pressures
- Monthly recovery update
- Pay Assurance Report
- Cash position/ Cash Support
- Capital Position inc. schemes over £500k
- Digital Strategy Group update

2.5.4 Revenue Requests/Approvals

Two revenue requests were sought during 2024/25 these were:

- I. Radiology in July 2024. The request was to seek non-recurrent funding of **£2,547,750** to:
 - Provide 2,309 Radiology Consultant WLI sessions and approx. 20,000 hours of Radiographer WLI's 2024/25
 - Outsource 200 cases per week for 12 weeks of Radiology reporting as a short-term solution to support delivery of Key Performance Indicators (KPIs) within Clinical Support Services and across the Trust

The request was supported by the committee and formally approved by the Trust Board in August.

- II. Waiting List Initiative- Planned Care in November 2024. The request was to seek non-recurrent funding of £987,060 for the provision of Planned Care

Waiting List Initiatives (WLI). To support the delivery of Cancer Fast Track (CFT) patients and high risk new and follow up patients across the following specialities: Gynaecology, Ophthalmology, Gastroenterology, Endoscopy, Trauma and Orthopaedics, Breast, Urology and Paediatrics.

Funding of £1,007,922 had been ring-fenced funding as part of the 2024/2025 budget setting process.

The Finance and Sustainability Committee, Approved the Revenue Request and agreed that updates in relation to the reduction of the backlog be included as part of the monthly recovery update report.

2.5.5 Theatre Productivity

Following concerns relating to theatre productivity, the committee received several deep dives and Hot Topic presentations and subsequently requested regular performance reporting. Focus areas included late starts—particularly at Warrington due to winter pressures—on-the-day cancellations, and the need for stronger oversight. Progress was made in transitioning the FDP to business-as-usual by April 2025, alongside ongoing workforce reviews and policy alignment. These actions supported broader aims to improve utilisation, reduce cancellations, and optimise capacity. Regular reporting will continue into 2025/26.

2.5.6 Issues Carried Forward/Escalated

- Capital position
- Deficit position 2025/26
- CIP/GIRFT performance
- PWC
- Theatre Productivity

3. Summary

The Committee continues to encourage open and constructive discussions among all regular attendees, and I would like to thank members of the Committee and colleagues for their continued support, engagement, and valuable contributions throughout the year.

As Chair of the Finance and Sustainability Committee, I must acknowledge the significant financial challenges the Trust is currently facing in delivering recovery plans and improving productivity. The Committee's role is to provide oversight and assurance on the Trust's financial grip and control, and I can confirm that strong governance arrangements remain in place. However, there are ongoing challenges in meeting the financial plan for 2025/26, particularly given the recent 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.

While the Committee is assured on the robustness of current controls, the financial position remains extremely constrained, requiring continued close scrutiny and a clear focus on delivering Cost Improvement Plans (CIPs) and productivity gains. It is hoped that the proposed acceleration of the Trust's acquisition of Bridgewater, subject to ICB approval, will allow some benefits to be realised within the 2025/26 financial year to help ease these pressures.

The Committee will continue to monitor these challenges closely over the coming year, maintaining oversight of financial performance, recovery progress, CIPS and the timely delivery of planned productivity improvements.

4. Recommendations

The committee is asked to note the report for onward reporting to the Trust Board.

John Somers, Non-Executive Director

Chair – Finance and Sustainability Committee, July 2025

REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/25/08/74			
SUBJECT:	Finance, Sustainability & Performance Committee in Common Terms of Reference and Cycle of Business			
DATE OF MEETING:	6 August 2025			
AUTHOR(S):	John Culshaw, Company Secretary			
EXECUTIVE DIRECTOR SPONSOR:	Nikhil Khashu, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: (Please select as appropriate)	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience			
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future			
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (Please DELETE as appropriate)	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			
	1114 If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.			
	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			
	2273 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			
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:				
	Yes	No	N/A	

	3. Foster good relations between people who share a protected characteristic and those who do not			✓
	Further Information:			
EXECUTIVE SUMMARY (KEY ISSUES):	In order to provide assurance to the Trust Board, all Committees of the Board are required to refresh their Terms of Reference (ToR) and Cycle of Business on an annual basis to assure itself that it will support the discharge of its duties before presenting to the Trust Board for formal ratification. This report seeks approval from the Board for the establishment of the Finance, Sustainability & Productivity Committee in Common (the "Committee"), as detailed in the attached Terms of Reference (Version 1, effective July 2025). The Committee will enhance collaboration, strategic alignment, and efficient decision-making, and support the Trusts' journey toward integration by April 2027, while ensuring compliance with NHS regulations and local priorities. The proposed Cycle of Business is also included.			
PURPOSE: (please select as appropriate)	Approval ✓	To note	Decision	
RECOMMENDATION:	The Trust Board is asked to: 1. Approve the Terms of Reference for the Finance, Sustainability & Productivity Committee in Common (Version 1), effective April 2025. 2. Note the Committee's review schedule, with the next review due by March 2026.			
PREVIOUSLY CONSIDERED BY:	Committee	Finance + Sustainability Committee		
	Agenda Ref.	FSPCIC/25/07/03		
	Date of meeting	28 July 2025		
	Summary of Outcome	Supported		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: (if relevant)	None			

REPORT TO TRUST BOARD

SUBJECT		AGENDA REF:	BM/25/08/74

1. BACKGROUND/CONTEXT

In order to provide assurance to the Trust Board, all Committees of the Board are required to refresh their Terms of Reference (ToR) and Cycle of Business on an annual basis to assure itself that it will support the discharge of its duties before presenting to the Trust Board for formal ratification.

This report seeks approval from the Board for the establishment of the Finance, Sustainability & Productivity Committee in Common (the "Committee"), as detailed in the attached Terms of Reference (Version 1, effective July 2025). The Committee will enhance collaboration, strategic alignment, and efficient decision-making, and support the Trusts' journey toward integration by April 2027, while ensuring compliance with NHS regulations and local priorities.

The proposed Cycle of Business is also included.

2. KEY ELEMENTS

What is a Committee in Common?

A Committee in Common (CiC) is a governance arrangement where two or more statutory NHS organisations establish aligned committees that meet together to coordinate decision-making and strategic oversight. Unlike a Joint Committee, which can make binding decisions on behalf of multiple organisations through delegated authority, a CiC retains the sovereignty of each participating body. Each Trust's committee operates under its own terms of reference, albeit shared/ aligned, making decisions that are synchronised but separately ratified by its respective Trust Board. This structure facilitates collaboration without compromising the legal independence of each organisation, making it an effective mechanism for partnerships progressing toward integration, as is the case with Warrington & Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCHT).

In practice, the CiC enables efficient discussion and alignment on shared objectives—such as workforce strategies—while allowing each Trust to address unilateral matters pertinent to its own operations. Decisions requiring joint action are agreed in principle during CiC meetings, with formal approval resting with each sovereign Trust Board.

Context and Rationale

The Finance, Sustainability & Productivity Committee in Common is established to oversee financial and operational planning, operational performance, strategic and business development, estates and digital matters, and sustainability across both Trusts, ensuring compliance with NHS regulations and local priorities.

The Committee will provide assurance to both sovereign Trust Boards that financial strategies align with quality aims as the Trusts progress toward integration by April 2027

The CiC replaces the existing WHH Finance & Sustainability Committee (v10) and BCHT Finance & Performance Committee (v2.4), consolidating efforts to streamline governance and

reduce duplication. Monthly meetings, alternating between Warrington Hospital and Spencer House, will ensure regular collaboration, with in-person attendance encouraged to maximise engagement.

Key Features of the Committee

Membership: Comprises senior representatives from both Trusts, including Non-Executive Directors (one serving as Chair per meeting location), Chief Finance Officer/Director of Finance, and joint roles such as the Chief Operating Officer, Executive Medical Director, and Chief Nurse ensuring cross-Trust representation.

Quorum: Requires four members (two per Trust, including one Non-Executive Director and the Chief Finance Officer/Director of Finance/equivalent or deputy), maintaining flexibility for unilateral decisions if needed.

Authority: Authorised to investigate matters within its remit, request information, and escalate issues to the Audit Committees, while adhering to each Trust's Schemes of Reservation & Delegations.

Duties: Provides strategic oversight and assurance on finance, performance, and operational planning, including scrutiny of financial performance, review of budgets and service lines, monitoring of efficiency savings and pay policies and advises on strategic risks and investments.

Reporting: Provides bi-monthly assurance reports to the Boards and an annual performance review, ensuring transparency and accountability.

Benefits and Alignment

The CiC will:

- Enhance collaboration on financial planning and performance ahead of integration.
- Provide a unified oversight mechanism for finance-related risks and performance indicators.
- Ensure statutory obligations are met efficiently across both Trusts.

This aligns with the broader NHS context of moving from localised to system-wide approaches, as seen in Integrated Care Systems and provider collaboratives, while preserving each Trust's autonomy

3. RECOMMENDATIONS

The Trust Board is asked to:

1. Approve the Terms of Reference for the Finance, Sustainability & Productivity Committee in Common (Version 1), effective April 2025.
2. Note the Committee's review schedule, with the next review due by March 2026.

TERMS OF REFERENCE FINANCE, SUSTAINABILITY & PERFORMANCE COMMITTEE IN COMMON

1. PURPOSE

The Finance, Sustainability & Performance Committee in Common (the "Committee") is established to enable collaboration, strategic alignment, and efficient decision-making between Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCHT).

It oversees financial and operational planning, operational performance, strategic and business development, estates and digital matters, and sustainability across both Trusts, ensuring compliance with NHS regulations and local priorities.

The Committee provides assurance to both sovereign Trust Boards that financial strategies align with quality aims as the Trusts progress toward integration by April 2027.

2. FREQUENCY OF MEETINGS

Meetings shall be held monthly at either the Warrington Hospital site or Spencer House.

3. MEMBERSHIP

3.1. Membership of the WHH Committee will comprise of:

- Two Non-Executive Directors (to include Committee Chair for meeting held at Warrington)
- Chief Finance Officer (WHH)
- Joint Chief Operating Officer and (Deputy Chief Executive WHH)
- Joint Executive Medical Director
- Joint Chief Nurse
- Joint Director of Delivery Unit (Deputy Chief Executive BCHT)
- Chief People Officer
- Chief Strategy & Partnerships Officer
- Director of Communications & Engagement
- Deputy Chief Finance Officer (WHH)
- Company Secretary
- Associate Director of Estates and Facilities Management
- Chief Information Officer

3.2. Membership of the BCHT Committee will comprise of:

- Two Non-Executive Directors (to include Committee Chair for meeting held at Bridgewater)
- Director of Finance (BCHT)
- Joint Chief Operating Officer and (Deputy Chief Executive WHH)
- Joint Executive Medical Director

- Joint Chief Nurse
- Joint Director of Delivery Unit (Deputy Chief Executive BCHT)
- Director of People and Organisational Development (BCHT)
- Deputy Director of Finance (BCHT)
- Financial Controller

The Joint Chief Executive and other staff members may also be invited/ expected to attend for appropriate agenda items; however, there is no requirement to attend the whole meeting.

3.3. Observers:

- Council of Governors' representative from WHH and BCHT
- Other staff members may also observe the meeting with prior permission of the Committee Chairs.

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. However, attendance in person at the meeting is strongly encouraged to facilitate more effective collaboration, engagement, and decision-making. Should the need arise, the Committee in Common may approve a matter in writing by receiving written approval from the quorate membership of the Committee, such written approval may be by email from the members NHS email account.

4. QUORUM

A quorum requires four members: two from each Trust, including one Non-Executive Director per Trust and the Chief Finance Officer/ Director of Finance (or nominated Deputy). If a Non-Executive Director is unavailable, a substitute Non-Executive Director from the respective Trust may attend and count toward the quorum.

The Committee shall be quorate provided each Trust's Committee is quorate; however, if a single Committee of one Trust is quorate, it can undertake business exclusive to that Trust. Each single Committee will reserve the right during a committee meeting to unilaterally decide matters pertaining only to their Trust, should agreement on the matter not be possible across both Committees.

For the avoidance of doubt, a person can count as a member of both committees provided they hold a related common role.

5. AUTHORITY

The Committee in Common is authorised by both sovereign Trust Boards to investigate matters within its remit, request information from employees (who must comply), and escalate issues requiring further assurance to either Trust's Audit Committee.

The Committee in Common may also receive a specific request to provide further assurance on a defined area of work from the Audit Committee at WHH or BCHT.

The Committee in Common must comply with the provisions of the respective Trust's Schemes of Reservation & Delegations and Standing Financial Instructions, including the declarations concerning conflicts of interest.

Date:

Approved: FSPCiC xx.xx.xx: Trust Boards WHH xx.xx.xx BCHT xx.xx.xx

Review Date: March 2026

The CiC does not inherently make joint decisions that legally bind the sovereign boards of both organisations. It is a governance arrangement where separate statutory bodies meet together to coordinate decision-making. Each committee remains accountable to its own sovereign board, and decisions made within a CiC are technically separate but synchronised to achieve a unified outcome.

6. REPORTING

The Committee will have the following reporting responsibilities:

- The minutes of the Committee meetings will be formally recorded.
- The Chair(s) of the Committee will provide a written Committee assurance report to the Board bi-monthly following each meeting to draw to the attention of the Board and Audit Committee (at BCHT or WHH) any issues that require disclosure to it, approval or require executive action.

The Committee will report to the Trust Boards at WHH and BCHT annually on its work and performance in the preceding year.

7. DUTIES & RESPONSIBILITIES

Finance and Performance

- Provide overview and scrutiny of financial performance referred by the Trust Board, especially regarding NHS Provider License breaches.
- Receive and consider financial and operational plans; make recommendations to the Board.
- Monitor effectiveness of financial performance reporting systems; ensure Board assurance via annual and exception reporting.
- Review Trusts' performance against annual financial plan and budgets.
- Review service line reports and seek assurance on service improvements.
- Review operational performance against annual plan; monitor corrective actions.
- Oversee development and monitoring of operational plan (activity, workforce, finance, budget, capital programme, cashflow).
- Ensure triangulation across portfolios in medium and long-term financial models.
- Monitor in-year delivery of annual efficiency savings programmes.
- Monitor compliance with NHSE pay policy requirements.
- Review and monitor Trusts' overall pay bill.
- Benchmark financial and operational performance within ICS, regionally and nationally.
- Approve capital expenditure up to £5m on behalf of the Trust Board. (WHH only)
- Oversee Emergency Preparedness and Response (EPRR) Framework.

Date:

Approved: FSPCiC xx.xx.xx: Trust Boards WHH xx.xx.xx BCHT xx.xx.xx

Review Date: March 2026

Risk Management and Internal Control

- Receive relevant elements of Board Assurance Framework and Corporate Risk Register; escalate concerns to Audit Committee or Board.
- Receive reports and assurance from Directors on:
 - Significant risks for inclusion in Board Assurance Framework.
 - Divisional action plans to mitigate risks and close assurance gaps.
 - Escalation of significant finance and performance risks.
- Work with Directors to assess and advise on financial/operational aspects of Risk Management Strategy.

Revenue Requests/ Business Cases

- In accordance with the Trusts' Standing Financial Instructions and Scheme of Reservation & Delegation, the Committee will consider revenue requests/ business cases in excess of £500,000, prior to presenting the request to the Trust Board for final approval.

Strategy, planning and development

- Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management.
- Advise the Board and maintain an oversight on all major investments and business developments.
- Advise the Board on all proposals for major capital expenditure over £5m or such capital expenditure of lower levels that have a material impact on the Trusts' operation.

Estates and Assets

- Consider proposals for Estates and Assets.
- Seek assurance on delivery of Estates Strategy.
- Review and recommend Health and Safety Strategy to the Board (BCHT only)
- Receive assurance on compliance with estate and health/safety guidance/legislation.

Quality

- Refer finance-related matters with significant quality implications to the Quality and Safety Committee.

Duties of members:

Ensuring, through agreed communication strategies, that key decisions and requirements are appropriately disseminated and that appropriate responses are implemented.

Date:

Approved: FSPCiC xx.xx.xx: Trust Boards WHH xx.xx.xx BCHT xx.xx.xx

Review Date: March 2026

The groups listed in the next paragraph are required to submit the following information to the Committee:

- the formally recorded minutes of their meeting; and/or
- separate reports to support the working of the Committee or addressing areas of concern these Reporting Groups may have; and/or
- an Annual Report setting out the progress they have made and future developments.

The following groups will report directly to the Committee:

WHH:

- Capital Planning Group
- Financial Resources Group
- Digital Strategy Group
- Medical Staffing Review Group
- Strategy & A Greener WHH Sub-Committee
- GIRFT/Clinical Productivity Group
- Improvement & Productivity Group

BCHT:

- Capital Council
- Boosting Efficiency Council
- DIGIT
- Estates Sub Committee
- Health & Safety Sub Committee
- Performance Council

8. ATTENDANCE

A record of attendance will be kept, attendance of 75% per year is expected. Members unable to attend must send a nominated deputy who is able to make decisions on their behalf.

9. ADMINISTRATIVE ARRANGEMENTS

- The Committee will be supported by a member of the Corporate Governance Team from either WHH or BCHT
- The Terms of Reference will be reviewed annually by Trust Boards
- A Cycle of Business will be established

Unless prior agreement is reached with the Chair of the Committee, Agenda and Papers will be sent 3 working days before the date of the meeting. No papers will be tabled at the meeting without prior approval of the Chair. The Committee will be supported by the Secretary to the Trust Board.

10. REVIEW / EFFECTIVENESS

The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements. By standard, these Terms of Reference will be reviewed annually by the Committee.

Date:

Approved: FSPCiC xx.xx.xx: Trust Boards WHH xx.xx.xx BCHT xx.xx.xx

Review Date: March 2026

**TERMS OF REFERENCE
REVISION TRACKER**

Name of Committee:	Finance, Sustainability & Performance Committee in Common
Version:	V1
Implementation Date:	July 2025
Review Date:	March 2026
Approved by:	TBC
Approval Date:	TBC

REVISIONS			
Date	Section	Reason on Change	Approved

TERMS OF REFERENCE OBSOLETE		
Date	Reason	Approved by:

Finance, Sustainability and Performance Committee in Common Cycle of Business 2025/26															
Calendar Year (April 2025 - March 2026)				2025									2026		
	Reporting Frequency	Process	Lead	April	May	June	July	August	September	October	November	December	January	February	March
Opening Business															
Apologies for Absence	Standing Item	Noting	Chair				√ WHH	√ BCH	√ WHH	√ BCH	√ WHH	√ BCH	√ WHH	√ BCH	√ WHH
Declarations of Interest	Standing Item	Noting	Chair				√	√	√	√	√	√	√	√	√
Business Cycle	Standing Item	Noting	Chair				√	√	√	√	√	√	√	√	√
Rolling Attendance Log	Standing Item	Noting	Chair				√	√	√	√	√	√	√	√	√
Minutes of the last meeting and Action Log	Standing Item	Approval	Chair				√	√	√	√	√	√	√	√	√
Matters Arising	Standing Item	Noting	Chair				√	√	√	√	√	√	√	√	√
Standing Items															
Deep Dive	Monthly	Assurance	Chair/CFO				√	√	√	√	√	√	√	√	√
Hot Topic	Monthly	Assurance	Chair/CFO				√	√	√	√	√	√	√	√	√
Integration Update	Monthly	Information	CS&PO				√	√	√	√	√	√	√	√	√
Financial Assurance															
Finance Report ▪ WHH - including Finance and Resources Group Minutes and Capital Planning Group Minutes ▪ BCH	Monthly	Assurance	CFO/Dir of Finance				√	√	√	√	√	√	√	√	√
CIP Report	Monthly	Assurance	CFO/Dir of Finance				√ Separate	√ ? Joint Report	√	√	√	√	√	√	√
Reports/minutes from the Delivery Unit - escalation committee, pay, non-pay and performance	Monthly	Assurance					√	√	√	√	√	√	√	√	√
Capital Expenditure (including schemes above £500K)	Monthly	Assurance	CFO/Dir of Finance				√ Joint	√	√	√	√	√	√	√	√
Cost Pressures (WHH)	Monthly	Assurance	CFO				√	√	√	√	√	√	√	√	√
Pay Assurance Report (WHH)	Bi-Monthly ?tbc	Assurance	CPO					√		√		√		√	
Cash Support Update (WHH)	Monthly	Assurance	CFO				√	√	√	√	√	√	√	√	√
Costing Update Joint report (including National Cost Collection and Service Line Reporting BCH)	Quarterly	Assurance	CFO/Dir of Finance				Q4					Q1 & Q2 Bi Annual			Q3
Benefits Realisation Quarterly Report (WHH only)	Quarterly	Assurance	CFO					Q1			Q2			Q3	
Procurement Report (BCH)	Bi-Annual	Assurance	Dir of Finance						√				√		
Annual Report and Accounts WHH and BCH ? Remove?	Annual	Approval	CFO/Dir of Finance												
Annual Budget Setting Reports ▪ WHH ▪ BCH	Bi- Annual	Approval	CFO/Dir of Finance						√						√
Annual Financial Plan (for recommendation to the Board) ▪ WHH ▪ BCH	Annual	Approval	CFO/Dir of Finance												√
Indicative Financial Cost of Harm Joint Report	Annual	Assurance	CFO/Dir of Finance												
Capital Planning Group Annual Report (WHH)	Annual	Assurance	CFO				√								
Performance Assurance Framework (PAF) Review and Refresh of Trust KPIs ▪ WHH ▪ BCH	Annual	Assurance	CFO/Dir of Finance												√
Performance															

REPORT TO TRUST BOARD

AGENDA REFERENCE:	BM/25/08/75			
SUBJECT:	Cheshire and Merseyside Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common			
DATE OF MEETING:	6 August 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 (CMASST) 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. 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: <i>(please select as appropriate)</i>	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: <i>(if relevant)</i>	None		

REPORT TO TRUST BOARD

SUBJECT	Cheshire and Merseyside Provider Collaborative (CMPC) Joint Working Agreement and Committee in Common	AGENDA REF:	BM/25/08/75

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: NWS 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

**CMAS~~T~~CMPC LEADERSHIP BOARD
TERMS OF REFERENCE FOR A
COMMITTEE OF THE BOARD TO MEET
IN COMMON WITH COMMITTEES OF
OTHER CMAS~~T~~CMPC TRUSTS**

TERMS OF REFERENCE

1 Introduction

1.1 In these terms of reference, the following words bear the following meanings:

Cheshire & Merseyside ~~Acute and Specialist~~ Trusts Provider Collaborative or ~~CMAS~~<u>CMPC</u>	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.
~~CMAS~~<u>CMPC</u> Agreement	the ~~J~~ joint ~~w~~ Working ~~a~~ Agreement signed by each of the Trusts in relation to their provider collaborative working and the operation of the [TRUST] CiC together with the other ~~CMAS~~ <u>CMPC</u> CiCs;
~~CMAS~~<u>CMPC</u> CiCs	the <u>Trust CiC and the other respective</u> committees established by each of the Trusts to work alongside ~~the committees established by the other Trusts~~ <u>each other</u> and " ~~CMAS~~<u>CMPC</u> CiC " shall be interpreted accordingly;
<u>CMPC Leadership Board</u>	<u>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</u> <u>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.</u>
~~CMAS~~<u>CMPC</u> Programme Steering Group	the Group, to provide programme support and oversight of the delivery of agreed collaborative activities;
~~CMAS~~<u>CMPC</u> Programme Lead	Named Lead Officer or any of subsequent person holding such title in relation to ~~CMAS~~ <u>CMPC</u> ;
~~CMAS~~<u>CMPC</u> Programme Support	Administrative infrastructure supporting ~~CMAS~~ <u>CMPC</u> ;
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 ~~CMAS~~ <u>CMPC</u> CiC meetings when they meet in common;
Member	a person nominated as a member of an ~~CMAS~~ <u>CMPC</u> 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.
<u>NHS Cheshire & Merseyside Integrated Care Board or “C&M ICB”</u>	<u>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.</u>
[TRUST] CiC	the committee established by [TRUST] NHS Foundation Trust, pursuant to these Terms of Reference, to work alongside the other ~~CMAS~~ CMPC CiCs in accordance with these Terms of Reference;
[TRUST] NHS Foundation Trust	[TRUST] NHS Foundation Trust of [Address] ;
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, <u>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</u> and “ Trust ” shall be interpreted accordingly;
Working Day	a day other than a Saturday, Sunday or public holiday in England;

- 1.2 The **[Trust]** **NHS Foundation** Trust is putting in place a governance structure, which will enable it to work together with the other Trusts in ~~CMAS~~**CMPC** to implement change.
- 1.3 Each Trust has agreed to establish a committee which shall work in common with the other ~~CMAS~~**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 CMAS~~T~~CMPC but is not forming its own CMAS~~T~~CMPC CiC and will be in attendance at meetings of the CMAS~~T~~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 CMAS~~T~~CMPC CiC will be different.
- 1.5 Each Trust has entered into the CMAS~~T~~CMPC Agreement on **[DATE]** and agrees to operate its CMAS~~T~~CMPC CiC in accordance with the CMAS~~T~~CMPC Agreement.

2 Aims and Objectives of the **[TRUST] CiC**

- 2.1 The aims and objectives of the **[Trust]** CiC are to work with the other CMAS~~T~~CMPC CiCs on system work or matters of significance as delegated to the **[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 [TRUST] 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 [TRUST] CMAP CiC. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the [TRUST] CiC.
- 3.2 The [TRUST] CiC shall work cooperatively with the other GMASTCMPC CiCs and in accordance with the terms of the GMASTCMPC Agreement.
- 3.3 The [TRUST] CiC is a committee of [TRUST] NHS Foundation Trust's board of directors and therefore can only make decisions binding [TRUST] NHS Foundation Trust. None of the Trusts other than [TRUST] NHS Foundation Trust can be bound by a decision taken by [TRUST] CiC.
- 3.4 The [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 [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 [TRUST] NHS Foundation Trust's Constitution.
- 4.2 [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 [TRUST] CiC in paragraph 4 of these Terms of Reference shall be retained by [TRUST] NHS Foundation Trust's Board or Governors, as applicable. For the avoidance of doubt, nothing in this paragraph 5 shall fetter the ability of [TRUST] 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 [TRUST] CiC Members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to [TRUST] NHS Foundation Trust's Board for inclusion on the private agenda of [TRUST] NHS Foundation Trust's next Board meeting in order that [TRUST] NHS Foundation Trust's Board may consider any additional delegations necessary in accordance with Appendix A.
- 6.2 The [TRUST] CiC shall send the minutes of [TRUST] CiC meetings to [TRUST] NHS Foundation Trust's Board, on a monthly basis, for inclusion on the agenda of [TRUST] NHS Foundation Trust's Board meeting.
- 6.3 [TRUST] CiC shall provide such reports and communications briefings as requested by [TRUST] NHS Foundation Trust's Board for inclusion on the agenda of [TRUST] NHS Foundation Trust's Board meeting.

7 Membership

- 7.1 The [TRUST] CiC shall be constituted of directors of [TRUST] NHS Foundation Trust. Namely the [TRUST] NHS Foundation Trust's Chief Executive who shall be referred to as a "Member".
- 7.2 Each [TRUST] CiC Member shall nominate a deputy to attend [TRUST] CiC meetings on their behalf when necessary ("Nominated Deputy").
- 7.3 The Nominated Deputy for [TRUST] NHS Foundation Trust's Chief Executive shall be an Executive Director of [TRUST] NHS Foundation Trust.
- 7.4 In the absence of the [TRUST] CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:
 - 7.4.1 attend [TRUST] CiC's meetings;
 - 7.4.2 be counted towards the quorum of a meeting of [TRUST] CiC's; and
 - 7.4.3 exercise Member voting rights,and when a Nominated Deputy is attending a [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 [TRUST] CiC shall be nominated by the [TRUST] CiC.

- 7.6 When the CMAS~~T~~CMPC CiCs meet in common, one person nominated from the Members of the CMAS~~T~~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 CMAS~~T~~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 **[TRUST]** CiC. **The **[TRUST]** 's Chair shall be invited to meetings of the CMAS~~T~~CMPC CiCs on at least a quarterly basis (or where the CiC feels it is appropriate – see CMAS~~T~~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 **[TRUST]** CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the CMAS~~T~~CMPC CiCs.
- 8.3 The CMAS~~T~~CMPC Programme Lead shall have the right to attend the meetings of **[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 CMAS~~T~~CMPC CiCs' meetings, but for the avoidance of doubt, any such persons in attendance at any meeting of the CMAS~~T~~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 **[TRUST]** CiC.

9 Meetings

- 9.1 Subject to paragraph 9.39.39.2 below, **[TRUST]** CiC meetings shall take place monthly.
- 9.2 The **[TRUST]** CiC shall meet with the other CMAS~~T~~CMPC CiCs as the CMAS~~T~~CMPC Leadership Board in accordance with the CMAS~~T~~CMPC Agreement (as set out in clause 4 of the CMAS~~T~~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 CMAS~~T~~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 CMAS~~T~~CMPC Programme Lead shall give five (5) Working Days' notice to the Trusts.

9.4 Meetings of the [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 ~~CMAS~~~~CMPC~~ Agreement.

9.5 Matters not discussed in public in accordance with paragraph 9.4 above and dealt with at the meetings of the [TRUST] CiC shall be confidential to the [TRUST] CiC Members and their Nominated Deputies, others in attendance at the meeting and the members of [TRUST] Board.

10 Quorum and Voting

10.1 Members of the [TRUST] CiC have a responsibility for the operation of the [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 [TRUST] CiC shall have one vote. The [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 [TRUST] CiC shall comply with the provisions on conflicts of interest contained in [TRUST] NHS Foundation Trust Constitution/Standing Orders, the ~~CMAS~~~~CMPC~~ Agreement and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in [TRUST] NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the [TRUST] CiC.

11.2 All Members of the [TRUST] CiC shall declare any new interest at the beginning of any [TRUST] CiC meeting and at any point during a [TRUST] CiC meeting if relevant.

12 Attendance at meetings

12.1 [TRUST] shall ensure that, except for urgent or unavoidable reasons, [TRUST] CiC Members (or their Nominated Deputy) shall attend [TRUST] CiC meetings (in person) and fully participate in all [TRUST] CiC meetings.

12.2 Subject to paragraph 12.1 above, meetings of the [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 **[TRUST]** CiC will be provided by CMAS~~T~~CMPC Programme Support (or such other route as the Trusts may agree in writing). The CMAS~~T~~CMPC Programme Support will:
 - 13.1.1 draw up an annual schedule of CMAS~~T~~CMPC CiC meeting dates and circulate it to the CMAS~~T~~CMPC CiCs;
 - 13.1.2 circulate the agenda and papers three (3) Working Days prior to CMAS~~T~~CMPC CiC meetings; and
 - 13.1.3 take minutes of each **[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 **[TRUST]** CiC meeting.
- 13.2 The agenda for the **[TRUST]** CiC meetings shall be determined by the CMAS~~T~~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 CMAS~~T~~CMPC Programme Support to agree such within five (5) Working Days of receipt.

APPENDIX A – DECISIONS OF THE [TRUST] CiC

The Board of each Trust within CMAS~~T~~CMPC remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to [TRUST] NHS Foundation Trust's Scheme of Delegation, the matters or type of matters that are fully delegated to the [TRUST] CiC to decide are set out in the table below.

If it is intended that the CMAS~~T~~CMPC CiCs are to discuss a proposal or matter which is outside the decisions delegated to the [TRUST] CiC, where at all practical, each proposal will be discussed by the Board of each Trust prior to the [TRUST] CiC meeting with a view to [TRUST] CiC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by [TRUST] NHS Foundation Trust's Board). Any proposals discussed at the [TRUST] CiC meeting outside of these parameters would come back before [TRUST] NHS Foundation Trust's Board.

References in the table below to the "Services" refer to the services that form part of the CMAS~~T~~CMPC Agreement for joint working between the Trusts (as set out in Clause 2.6 of the CMAS~~T~~CMPC Agreement and which may be supplemented or further defined by an annual CMAS~~T~~CMPC Work Programme) and may include both back office and clinical services.

	Decisions delegated to [TRUST] CiC
1.	Providing overall strategic oversight and direction to the development of the <u>CMAS~~T~~CMPC</u> 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 [TRUST] CiC referred to it by the <u>CMAS~~T~~CMPC</u> 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 impact to <u>CMAS~~T~~CMPC</u> Programmes and recommending remedial and mitigating actions across the system;
5.	Formulating, agreeing and implementing strategies for delivery of <u>CMAS~~T~~CMPC</u> Programmes;

	Decisions delegated to [TRUST] CiC
6.	In relation to services preparing business cases to support or describe delivery of agreed <u>CMAS^TCMPC</u> priorities or programmes (including as required by any agreed <u>CMAS^TCMPC</u> 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; 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;

	Decisions delegated to [TRUST] CiC
	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 ~~CMAST~~ <u>CMPC</u> ~~Joint Working~~ Agreement on an annual basis.

APPROVED BY BOARD OF DIRECTORS: [DATE]

Draft No: 24
Date of Draft: June 2025 September 2024

Dated 20254
**CHESHIRE & MERSEYSIDE ACUTE AND
SPECIALIST TRUSTS PROVIDER
COLLABORATIVE (CMPCAST)
JOINT WORKING AGREEMENT**

Between

- (1) BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST
(2) CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST
(4)(3) COUNTRESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST
(2)(4) LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
(3)(5) WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST
(4)(6) WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST
(5)(7) THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST
(6)(8) LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST
(7)(9) THE WALTON CENTRE NHS FOUNDATION TRUST
(8)(10) LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
(9)(11) ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST
(12) MERSEY CARE NHS FOUNDATION TRUST
(10)(13) EAST CHESHIRE NHS TRUST
(14)(14) MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST
WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST
(15) MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST
(16) WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST
- and
- (12)(17) NORTH WEST AMBULANCE SERVICE NHS TRUST

Commented [A1]: UPDATE FOR MERSEY CARE / C&W BW and WC

Draft No:
Date of Draft:
2024

24
June 2025 September

DRAFT

CLAUSE	CONTENTS	PAGE
1	INTRODUCTION.....	1
2	BACKGROUND.....	2
3	RULES OF WORKING.....	4442
4	PROCESS OF WORKING TOGETHER.....	5553
5	FUTURE INVOLVEMENT AND ADDITION OF PARTIES	6664
6	EXIT PLAN	6664
7	TERMINATION.....	7764
8	INFORMATION SHARING AND COMPETITION LAW	7775
9	CONFLICTS OF INTEREST	9995
10	DISPUTE RESOLUTION	9995
11	VARIATION.....	1010106
12	COUNTERPARTS.....	1111106
13	GOVERNING LAW AND JURISDICTION.....	1111116
APPENDIX 1 – 147 TERMS OF REFERENCE		
APPENDIX 158 - EXIT PLAN.....		32323224
APPENDIX 169 - INFORMATION SHARING PROTOCOL		33333325

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 CMASTCMPC CiCs;
CMASTCMPC CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and " CMASTCMPC CiC" shall be interpreted accordingly.
CMASTCMPC Leadership Board	the CMASTCMPC 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 CMASTCMPC CiC Member nominated (from time to time) in accordance with paragraph 7.6 of the Terms of Reference, to preside over and run the CMASTCMPC CiC meetings when they meet in common;
Member	a person nominated as a member of a CMASTCMPC 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 [CMASTCMPC](#) as a provider collaborative.
- 1.3 Each Trust has agreed to establish a committee which shall work in common with the other [CMASTCMPC](#) 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 [CMASTCMPC](#) but is not forming a [CMASTCMPC](#) CiC and will be in attendance at meetings of the [CMASTCMPC](#) 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 [CMASTCMPC](#) CiC will be different.
- 1.5 The [CMASTCMPC](#) 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 [CMASTCMPC](#) 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 [CMASTCMPC](#) are to:
 - 2.2.1 Deliver the [CMASTCMPC](#) 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 [CMASTCMPC](#)'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 [CMASTCMPC](#) CiCs acting through the [CMASTCMPC](#) Leadership Board.

2.5 More specifically the [CMASTCMPC](#) CiCs and the [CMASTCMPC](#) Leadership Board will facilitate the Trusts' work in the following key work programmes at this initial stage of [CMASTCMPC](#) 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;](#)

[2.5.22.5.4](#) Cancer Alliance delivery and enablement – subject to requests of the Alliance;

[2.5.32.5.5](#) 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;

[2.5.42.5.6](#) Initiation of proposals and case for change for clinical pathway redesign - subject to discrete decision making as may be appropriate;

[2.5.52.5.7](#) Coordinating and enabling [CMASTCMPC](#) members contribution and response to collective system wide workforce needs, pressures and the People agenda;

[2.5.62.5.8](#) Coordinating and enabling [CMASTCMPC](#) members contribution and response to system wide financial decision making, pressures and financial governance;

2.5.72.5.9 Responding to and coordinating [CMASTCMPC](#) action in response to any national, regional or ICB initiated priorities for example TIF, system or elective capital prioritisation, reduction in long waiters; and

2.5.82.5.10 The [CMASTCMPC](#) 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 [CMASTCMPC](#) will provide both intelligence to the ICB and respond to ICB calls for action. Where necessary and appropriate [CMASTCMPC](#) 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 [CMASTCMPC](#) Trusts in accordance with the principle outlined in clause 4.6.

The areas within scope of this Agreement may be amended through variation, by Trust Board resolutions or agreement of the annual [CMASTCMPC](#) workplan.

- 2.6 The Trusts will remain as separate legal entities with their own accountabilities and responsibilities. The priorities for [CMASTCMPC](#) 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 [CMASTCMPC](#) CiCs as the [CMASTCMPC 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 [CMASTCMPC](#) 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;](#)

3.1.73.1.8 Empower and expect our professional (executive) groups to think from a system perspective and to develop proposals with this in mind;

3.1.83.1.9 Recognising and respecting the collective view and keeping to any agreements made between the [CMASTCMPC](#) CiC's;

3.1.93.1.10 Maintain [CMASTCMPC](#) collective agreed position on shared decisions in all relevant communications;

3.1.103.1.11 Be accountable. Take on, manage and account to each other for performance of our respective roles and responsibilities; and

3.1.113.1.12 Appropriately engage with the ICB and with other partners on any material service change.

4 Process of working together

4.1 The [CMAS~~T~~CMPC](#) CiCs shall meet together as the [CMAS~~T~~CMPC](#) Leadership Board in accordance with and discuss the matters delegated to them in accordance with their Terms of References (attached here as Appendices 1-148).

4.1.1 Meetings of the [CMAS~~T~~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. [CMAS~~T~~CMPC](#) Leadership Board – Operational business - Informal CEO discussions and representing the standard regular meeting structure;¹
- B. [CMAS~~T~~CMPC](#) Leadership Board – Decisions to be made under the [CMAS~~T~~CMPC](#) CiC delegations - CiC CEOs;
- C. [CMAS~~T~~CMPC](#) Leadership Board – CiC CEOs and Chairs discussion (or NED designate)

4.2 The [CMAS~~T~~CMPC](#) CiCs shall work collaboratively with each other as the [CMAS~~T~~CMPC](#) Leadership Board in relation to the committees in common model.

4.3 Each [CMAS~~T~~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 [CMAS~~T~~CMPC](#) CiC or its duty to act in the best interests of its Trust, each [CMAS~~T~~CMPC](#) CiC shall seek to reach agreement with the other [CMAS~~T~~CMPC](#) CiCs in the [CMAS~~T~~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 [CMAS~~T~~CMPC](#) CiCs meet in common, as the [CMAS~~T~~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 20256.

4.5 The Trusts agree that they will adopt a tiered approach to bringing decisions which come within the Terms of Reference to the [CMAS~~T~~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 CMAS~~T~~CMPC Trusts (e.g. local issue related to place)	Matter for the Trust involved and notified to the CMAS~~T~~CMPC Leadership Board if appropriate.
Matter only involves or impacts a smaller group of CMAS~~T~~CMPC Trusts and not all (e.g. specialised commissioning issue for specialist trusts)	The CMAS~~T~~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.

¹ Chairs will be invited to [CMAS~~T~~CMPC](#) Leadership Board meetings, at least quarterly.

	Notify the CMAS^TCMPC Leadership Board.
Matter involves or impacts all CMAS^TCMPC Trusts and comes within the delegation under the CMAS^TCMPC CiCs (e.g. collaborative approach to non-clinical services or workforce)	Matter to be dealt with through the CMAS^TCMPC CiCs at the CMAS^TCMPC Leadership Board in accordance with this Agreement and the Terms of Reference.

- 4.6 Each [CMAS^TCMPC](#) Trust will report back to its own Board and the [CMAS^TCMPC](#) Leadership Board will be responsible for transparent information sharing in the form of common briefings and updates to each of the [CMAS^TCMPC](#) Trust Board meetings. The [CMAS^TCMPC](#) Trust chairs ~~will~~ may (as well as their quarterly [CMAS^TCMPC](#) meetings - clause 4.1.1 above) meet regularly as a group to share information and for general discussions on [CMAS^TCMPC](#) on an informal basis. In addition, the [CMAS^TCMPC](#) Leadership Board will seek to ensure that each [CMAS^TCMPC](#) 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 [CMAS^TCMPC](#) 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 [CMAS^TCMPC](#) (or if relevant, section of the meeting), ~~will~~ may be held in public except where a resolution is agreed by the [CMAS^TCMPC](#) 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 [CMAS^TCMPC](#) 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. Within three (3) months of the date of this Agreement the Trusts shall develop and, it is a necessity that an~~ agreed ~~an~~ exit plan ~~which shall~~ 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 [CMAS^TCMPC](#) CiC Chairs varying the Agreement under clause 10.6.2.
- ~~6.1.36.1.4~~ cost apportionment, where appropriate, will be applied on a proportionate fair shares basis
- 6.2 ~~Once agreed by all of the Trusts, the~~ An exit plan ~~approach is drafted~~ shall be inserted into this Agreement at Appendix ~~1589~~ 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 [CMASTCMPC](#) 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 [CMASTCMPC](#) 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 [159](#)) 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 [CMASTCMPC](#) 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 [CMASTCMPC](#) 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 [CMASTCMPC](#) 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 [c](#)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 from 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.

[CMASTCMPC](#) is committed to clear, consistent and transparent communication across the [CMASTCMPC](#) Trusts and with system partners' where appropriate. It is specifically recognised that [CMASTCMPC](#) 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 [CMASTCMPC](#) and the [CMASTCMPC](#) Trusts may be asked to represent both their own organisations and [CMASTCMPC](#) 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 entirety 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 [CMASTCMPC](#) 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 [CMASTCMPC](#) 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 further operation or development of [CMASTCMPC](#) 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 196 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement².

9 Conflicts of Interest

- 9.1 Members of each of the [CMASTCMPC](#) CiCs shall make arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the [CMASTCMPC](#) 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 [CMASTCMPC](#)'s decision-making processes.
- 9.2 The [CMASTCMPC](#) Leadership Board will, where relevant, agree policies and procedures for the identification and management of conflicts of interest which will be published on the [CMASTCMPC](#) website. It is proposed that such policies will either be [CMASTCMPC](#) developed or [CMASTCMPC](#) will support the adoption and application of the policy of the [CMASTCMPC](#) Chair and/or Meeting Lead.
- 9.3 All [CMASTCMPC](#) Leadership Board, committee and sub-committee members, and employees acting on behalf of [CMASTCMPC](#), will comply with the [CMASTCMPC](#) 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 [CMASTCMPC](#). 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 [CMASTCMPC](#) Leadership Board.
- 9.5 Where an individual, including any individual directly involved with the business or decision-making of the [CMASTCMPC](#) 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 [CMASTCMPC](#) 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 [CMASTCMPC](#) 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 [CMASTCMPC](#) CiCs at the [CMASTCMPC](#) Leadership Board the appropriate course of action to take.
- 10.4 If the Meeting Lead and the [CMASTCMPC](#) Leadership Board reach a decision that resolves, or otherwise concludes a Dispute, the Meeting Lead will advise the Trusts of the decision by

² To date (2022 – 2024) it has been considered unnecessary and unwarranted by virtue of ICS facilitated and governed ways of working

written notice. Any decision of the Meeting Lead and the [CMASTCMPC](#) Leadership Board will be final and binding on the Trusts once it has been ratified by the Trusts' Boards (if applicable).

10.5 If the matter referred to in clause 10.3 above cannot be resolved by the Meeting Lead and the [CMASTCMPC](#) Leadership Board, within fifteen (15) Working Days, the Trusts agree that the Meeting Lead and the [CMASTCMPC](#) Leadership Board, may determine whatever action they believe necessary to resolve the Dispute which may include:

- 10.5.1 appointment of a panel of [CMASTCMPC](#) 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 [CMASTCMPC](#) 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 [CMASTCMPC](#) 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 [CMASTCMPC](#) 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

~~10.6~~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 [CMASTCMPC](#) Leadership Board may decide to recommend their Trust's Board of Directors to:

~~10.6-1~~10.7.1 terminate the Agreement;

~~10.6-2~~10.7.2 vary the Agreement (which may include re-drawing the member Trusts); or

~~10.6-3~~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 4~~ **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 2~~ **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 3~~ **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 4**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 5~~ **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 6~~**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 7**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 8~~ **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 9~~ **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 10~~**APPENDIX 13 – TERMS OF REFERENCE FOR THE EAST CHESHIRE NHS TRUST
CIC**

[Insert Terms of Reference for the East Cheshire NHS Trust CiC]

Appendix 11 **APPENDIX 14 – TERMS OF REFERENCE FOR THE MERSEY AND WEST
LANCASHIRE ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS FOUNDATION**
TRUST CIC

**[Insert Terms of Reference for the Mersey and West Lancashire Teaching
Hospitals NHS Foundation Trust CiC]**

~~Appendix 12~~**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 13~~APPENDIX 17 – TERMS OF REFERENCE FOR THE NORTH WEST AMBULANCE
SERVICE NHS TRUST CIC

[Not applicable]

~~Appendix 14~~**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 ~~thirteenth~~ seventeenth of any professional advisers' fees incurred by and on behalf of ~~CMAS~~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 ~~CMAS~~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 ~~CMAS~~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 ~~CMAS~~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 incurred by and on behalf of ~~CMAS~~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 ~~CMAS~~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 15~~APPENDIX 19 - INFORMATION SHARING PROTOCOL

[to be inserted once deemed necessary and agreed]

SUGGESTION from one Trust that - Competition-sensitive information needs inclusions: How will the CMPC ensure compliance with competition law, especially in the absence of a finalised Information Sharing Protocol (Appendix 19)?

Is there a boiler plate ISA that could be provided? The CEOs (while there has been some change within the group) were mainly of the view that this was not a necessity nor deal breaker however the comment suggests to me we may be entering territory where ISA could be used as a reason not to as vs to do something

FURTHER safeguards are in place to ensure that shared data (especially financial or workforce-related) is handled in compliance with GDPR and FOIA obligations? Should a breach of data submitted by a Trust to CMPC occur who is liable. I think my response to this is the hosts of CMPC functions have to declare the breach but costs associated with CMPC activities are not borne by the host alone but by all members as this is a shared / membership endeavour? Fyi – we have 3 host employers atm