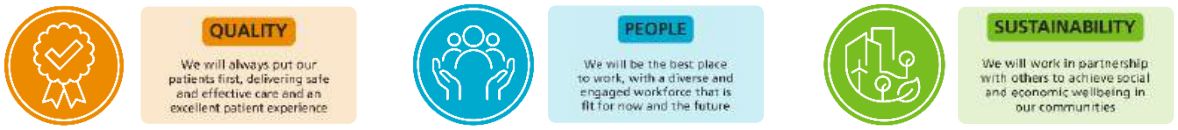
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 4 February 2026, 10am – 12:45pm
Trust Conference Room, Warrington Hospital

Agenda Item	Time	Agenda Item	Objective/ Desired Outcome	Process	Presenter
BM/26/02/146	**10:00**	Engagement Story - Urgent Emergency Care Experience	***To note***	**Presentation**	Olivia Leech, Patient and Ashley Halliday UEC Matron
BM/26/02/147	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***	***Verbal***	Chair
BM/26/02/148	**10:17**	Minutes and Action Log of the previous meeting held on • 3 December 2025	***For approval***	***Minutes***	Chair
BM/26/02/149	**10:20**	Matters Arising	***To note for assurance***	***Verbal***	Chair
BM/26/02/150	**10:25**	Chief Executive's Report	***For assurance***	***Report & Verbal***	Deputy Chief Executive
BM/26/02/151	**10:35**	Chair's Report	***For info/update***	***Verbal***	Chair
BM/26/02/152	**10:40**	Board Assurance Framework	***For approval***	***Report***	Company Secretary
Strategic aims:					
BM/26/02/153 (a)	**10:50**	Integrated Performance Reports (IPR) and Assurance Committee Reports IPR Dashboard	***For assurance***	***Report***	All Executive Directors
		Quality Dashboard **Including** Assurance Reports Quality Assurance Committee 09.12.25, 13.01.26	***For assurance***	***Report***	Chief Nurse Cliff Richards, Committee Chair
(b)		**People Dashboard** **Including** Assurance Reports Strategic People Committee in Common 17.12.25, 21.01.26	***For assurance***	***Report***	Chief People Officer Julie Jarman, Committee Chair
(c)		**Sustainability Dashboard - *including Cash Support*** **Including** Assurance Reports Finance, Sustainability and Productivity	***For assurance***	***Report & Presentation***	Chief Finance Officer John Somers, Committee Chair

		Committee in Common 22.12.25, 26.01.26			
Strategic aim:	**Quality**				
BM/26/02/154	**11:15**	Fragile Clinical Services Update	***To note for assurance***	**Report**	Chief Nurse /Executive Medical Director, Chief Operating Officer & Deputy Chief Executive
BM/26/02/155	**11:25**	**Maternity Update – Overview Paper** I. Maternity Incentive Scheme year 7 Submission (MIS) to include Saving Babies Lives Care Bundle (SBLC) II. Maternity & Neonatal Quality Review Report	***To note for assurance***	**Report**	Interim Director of Midwifery
BM/26/02/156	**11:45**	Mortuary Licensed Activity Report - Including Fuller update	***To note for assurance***	**Report**	Chief Nurse
Strategic aim	**People**				
BM/26/02/157	**11:50**	Bimonthly Communications and Engagement Report	***To note for assurance***	**Report**	Director of Communications and Engagement
BM/26/02/158	**12:00**	Charity update - Charity Commission Fundraising Checklist for Trustees 2024/25 Charity Impact Report	***To note for assurance***	**Report**	Director of Communications and Engagement
Strategic Aim	**Sustainability**				
BM/26/02/159	**12:10**	Integration Update - Branding	***For info/update***	***Report***	Chief Strategy & Partnerships Officer and Director of Communications & Engagement
BM/26/02/160	**12:25**	Bimonthly Strategy Highlight Report	***To note for assurance***	**Report**	Chief Strategy & Partnerships Officer
BM/26/02/161	**12:35**	Biannual Strategy Delivery Report	***To note for assurance***	**Report**	Chief Strategy & Partnerships Officer

Governance					
BM/26/02/162	**12:40**	Quality, Safety & Assurance Committee in Common Terms of Reference and Cycle of Business	***To approve***	**Report**	Company Secretary

SUPPLEMENTARY PAPERS for noting (see Supplementary Pack)

To Note For Assurance					
BM/26/02/163	Safe Staffing Report; 6 Monthly Establishment Review 2024/2025. (February – July 2025)	Quality Assurance Committee Date: 09.12.2026 Ref: QAC/25/12/208 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/26/02/164	Learning from Deaths Q2	Quality Assurance Committee Date: Ref: QAC/25/12/209 Outcome: Noted	***To note for assurance***	**Report**	Executive Medical Director
BM/26/02/165	Infection Prevention and Control Board Assurance Framework Compliance	Quality Assurance Committee Date: 13.01.2026 Ref: QAC/26/01/239 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/26/02/166	Violence Reduction Strategy	Quality Assurance Committee Date: 13.01.2026 Ref: QAC/26/01/231 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse/ Chief Operating Officer
BM/26/02/167	Health and Wellbeing Report	Strategic People Committee in Common Date: 17.12.2025 Ref: SPCIC/25/12/177ii Outcome: Noted	*To note for assurance*	Report	Chief People Officer
BM/26/02/168	Equality Delivery System (EDS) 2026	Strategic People Committee in Common Date: 21.01.2026 Ref: SPCiC/26/01/198 Outcome: Noted	*To note for assurance*	Report	Chief People Officer
BM/26/02/169	Trust Senior Management Organograms	N/A	*To note for assurance*	Report	Company Secretary
Closing					
BM/26/02/170	**12:45**	Review of the Meeting	To discuss	**Verbal**	Chair
BM/26/02/171		Any Other Business	To discuss	**Verbal**	Chair
Date and time of next meeting 1 April 2026, Trust Conference Room, Warrington Hospital					

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Urgent Emergency Care Experience

Board Patient Story February 2026

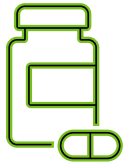
Patient and Presenter: Olivia Leech

Background

Warrington and Halton Teaching Hospitals NHS Foundation Trust

August 2025

Olivia, first time mum



Experienced stomach pains

Attended Maternity Triage and discharged

Safe arrival of son

Ongoing pain

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Emergency Department experience

25 August 2025

- Pain returned 1½ weeks after birth
- Attend WHH A&E
- Triaged
- Doctor
- Discharged

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Same Day Emergency Care experience

26 August 2025

- Returned to WHH
- Diagnosis and concerns
- Discharged

27 August 2025

- Pain
- Triage
- Treatment not explained
- Diagnosis

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Ward and Surgical experience

28 August 2025

- Ward move
- Communication

29 August 2025

- Surgery
- Recovery

30 August 2025

- Review and discharged

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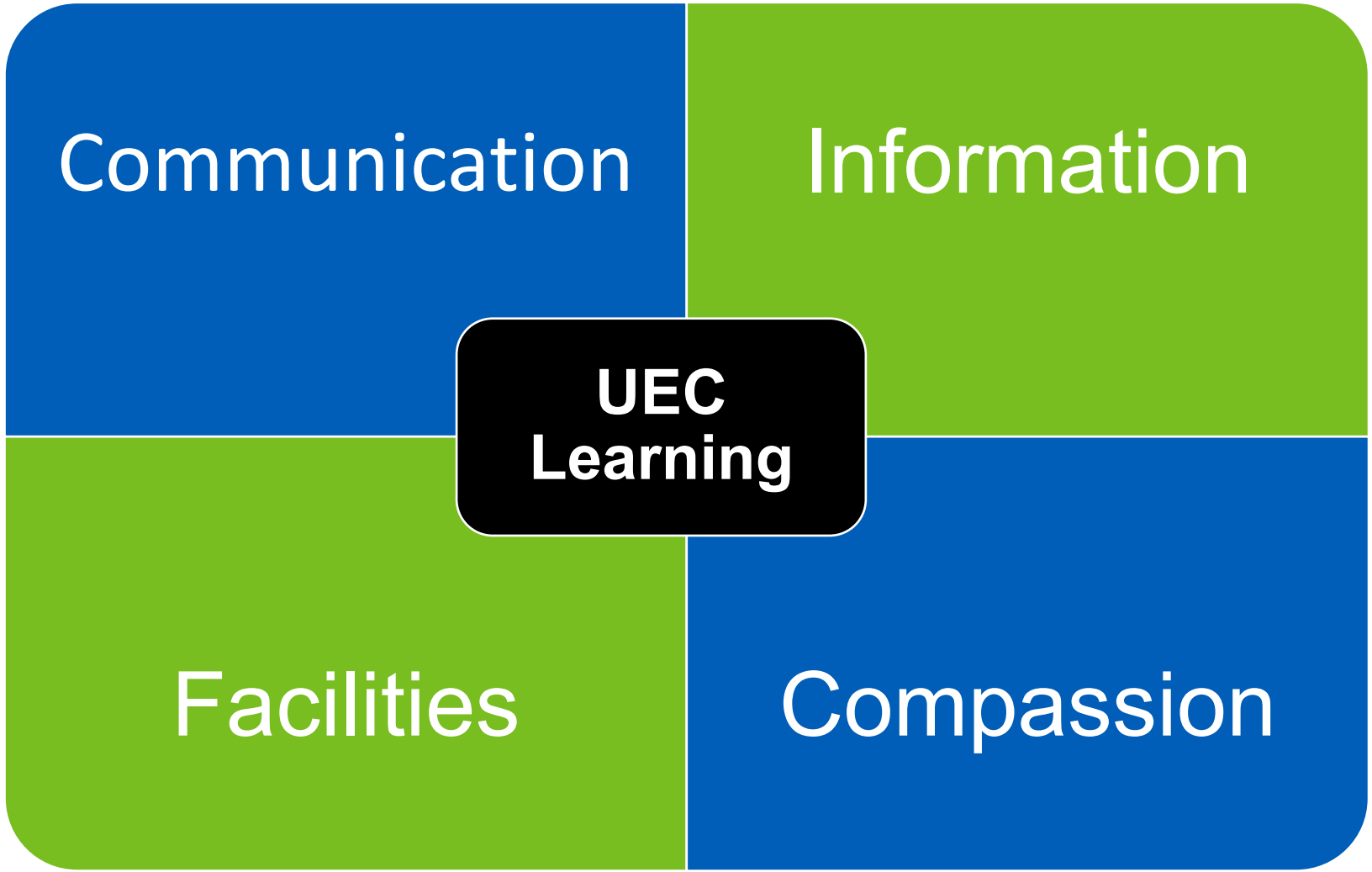
NHS Foundation Trust

My experience what could be improved

- Early identification
- Discharge
- Medication
- Wait list
- Communication

Warrington and Halton Teaching Hospitals
NHS Foundation Trust



NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

Conflicts of Interest

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

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

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

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

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

Interests fall into the following categories:

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 3 December 2025 Trust Conference Room, Warrington Hospital/Via MS Teams	
Present	
Steve McGuirk (SMcG)	Chair
Nikhil Khashu (NK)	Chief Executive
Michael O'Connor (MOC)	Non-Executive Director & Senior Independent Director
Jayne Downey (JD)	Non-Executive Director
Julie Jarman (JJ)	Non-Executive Director
John Somers (JS)	Non-Executive Director
Dan Moore (DM)	Chief Operating Officer and Deputy Chief Executive
Paul Fitzsimmons (PF)	Executive Medical Director
Jane Hurst (JH)	Chief Finance Officer
Ali Kennah (AK)	Chief Nurse
Apologies	
Lynne Carter (LC)	Director of Delivery Unit
Cliff Richards (CR)	Non-Executive Director & Deputy Chair
In Attendance	
Lucy Gardner (LG)	Chief Strategy and Partnerships Officer
Kate Henry (KH)	Director of Communications & Engagement
Michelle Cloney (MC)	Chief People Officer
Tina Moors (TM)	Deputy Director of Midwifery
Hannah Parker (HP)	Bereavement Midwife (**BM/25/12/121**)
Sarah Nuttie,(SN)	Consultant Midwife (**BM/25/12/121**)
John Culshaw (JC)	Company Secretary
Emily Kelso	Corporate Governance and Membership Manager **(minutes)**
Observing	
Sue Fitzpatrick	Lead Governor – Public Governor, Warrington and Halton
Andy Carter	Incoming Chair

Agenda Ref	Agenda Item
BM/25/12/121	**Engagement Story – Engagement Story - Angela's story - Amara and her journey** SD introduced the engagement story, HP and SN, narrated Angela's experience across two pregnancies: the butterfly team's compassionate care for baby Amar who was born with anencephaly sadly passing away at 10 days old and the continuity of bereavement-informed support into Angela's subsequent pregnancy on the Trust's newly established rainbow pathway, culminating in the safe birth of Theo. SN explained that Angela consented to sharing her story but could not attend; the team emphasised how continuity of carer, blended clinical vigilance such as early reassurance by prioritising auscultation of fetal heart at each appointment with emotionally attuned midwifery.

	JD reflected that Hannah's approach reaffirmed why she became a nurse, describing how the baby's death was dignified and family-centred, and how WHH knowing Angela and her history made for a well-planned and supported approach heading into the next pregnancy. The team described the "Rainbow Day" and Lantern Walk, establishing peer support so families who felt isolated after achieving a rainbow pregnancy could meet, connect, and celebrate hope after storm. SN set out the Willow Tree Hub campaign to create a designated, private space outside the maternity unit for consultations, scans and counselling—addressing the distress of receiving devastating news in antenatal environments. Fundraising had reached "just short of £128k toward a £200k goal, with activities ranging from skydives and runs to church donations and family-led sponsored events; the appeal needs continued Trust-wide support and public sponsorship to reach target. SMcG conveyed condolences and appreciation, and recognised the appeal's strong progress, noting how local communities, were likely to rally further around a tangible, local cause. NK asked about midwife training and ongoing support for such sensitive work; HP outlined her path from general midwifery caring for bereaved families into a dedicated bereavement role, citing external training (Sands, Child Bereavement UK), close collaboration with Tommy's Rainbow Clinic in Manchester, and monthly regional supervision among bereavement midwives that provides peer support for emotionally demanding caseloads. SMcG queried that faith and cultural needs were highlighted - not so much by this specific case but by the 'what-if' questions it raised confirmed knowledge of religious practices and time-sensitive burial requirements, the availability of faith-specific packs on the butterfly suite, and facilitation of rapid burials when needed. JD observed that the current butterfly suite's proximity to busy areas can challenge the ideal environment, urging Board awareness of location constraints. AK highlighted how the story underscored the importance and value of specialist roles, whose superb everyday work profoundly affects families. KH agreed to amplify campaign messaging and calls to sponsor/join events to close the £200k Willow Tree Hub target. **The Trust Board noted the content of the very moving patient story and asked for a formal thanks and best wishes to be communicated to Angela via the maternity team.**
BM/25/12/122	**Welcome, Apologies and Declarations of Interest** SMcG welcomed the Trust Board, attendees and observers to the meeting, and noted apologies as detailed above. It was confirmed that there were no declarations of interest. SMcG informed all present that the meeting would be recorded for the purposes of producing the minutes using AI, in line with the Digital Acceptable Use Policy, and no objections were raised.

	The Trust Board noted the apologies and declarations of interest.
BM/25/12/123	**Minutes and Action Log of the previous meeting held on 1 October 2025** The minutes were taken as read and approved for accuracy. JJ requested a correction to clarify that the reference was to the values survey consultation (for renaming) rather than the staff survey; JC noted the amendment for publication in the final record. The action log was reviewed; JC confirmed items were up to date and the summary quality risk summit was planned. **The Trust Board approved the minutes of the meeting held on 1 October 2025 and noted the Action Log**
BM/25/12/124	**Matters Arising** NK noted the appointment of Andy Carter as the new Chair starting formally in post - 1 April 2026, which would be discussed further under Chair/CEO updates. No other matters were raised. **The Trust Board noted that there were no matters arising.**
BM/25/12/125	**Chief Executive's Report** NK began by welcoming Andy Carter (AC) as the incoming Chair and expressed gratitude to SMcG for his outstanding leadership and commitment to the Trust as Chair. The following key highlights were taken from the presentation of the report and Board discussion • The importance of winter planning, noting the dual challenge of maintaining patient safety and operational performance during a period expected to be particularly difficult due to seasonal pressures and ongoing financial constraints. NK explained that finance remained a central focus, with ongoing discussions with PwC and a key meeting scheduled for 10 December. It was noted that the Board should anticipate an extraordinary meeting to consider and make decisions on the Trust's financial position and next steps. • the formal launch of the Mutually Agreed Resignation Scheme (MARS) across both Bridgewater and WHH, which had generated significant interest among staff. • Congratulations were reiterated to the WHH Strategy & Partnerships team for being highly commended at the HSJ Awards and the HR team for similar recognition at the HPMA 2025 awards, noting these achievements as evidence of the Trust's commitment to excellence and innovation. • The escalation of the flu vaccination campaign in response to rising flu cases in the North-East and North West, following a national call with Jim Mackey. He emphasised the need for a renewed push on vaccination uptake, • The "Voice Matters" staff survey, closed on Friday, with results to be analysed and shared in due course. • Nominations had opened for the joint Thank You Awards with Bridgewater, scheduled for May, NK further highlighted the positive impact of recent joint events, such as the Long Service Awards. • The recent period of industrial action had taken place 14 – 19 November 2025, NK warned of further potential strikes between 17 and 22 December, stressing the need for ongoing vigilance and contingency planning. He provided updates on system leadership, including the appointment of Sir

	David Henshaw as interim Chair of the ICB and Liz Bishop as interim Chief Executive, noting their experience and the continuity they would bring to the region. SMcG encouraged a renewed push on flu vaccination, observing a surprisingly strong anti-vaccine sentiment among staff. NK elaborated on the challenges, citing campaign fatigue and misconceptions about the vaccine, and confirmed that while uptake was declining nationally, there was no mandatory requirement for staff to be vaccinated. MOC inquired about the existence of a financial incentive (CQUIN/sequin) for vaccination rates, to which MC confirmed there was none at present. On the staff survey, MC reported a 38.8% completion rate, placing the Trust just above its post-COVID response rate and within the national range (29%–66%). JJ commented that indicators of morale discussed at the SPCiC reflected broader national trends and fatigue, rather than issues unique to the Trust or its integration programme. NK noted that his own observation visits sometimes revealed a more positive atmosphere than survey data might suggest. JS raised a question about strategic system financial planning in light of the current year's financial position; NK proposed to address this in Part 2 of the meeting, referencing correspondence with Stephen Hay. The Board noted that planning for next year would be crucial, particularly in light of the lessons learnt from this year's challenges and achievements. It was acknowledged that this would be the third set of system leaders the Trust had worked with in the past 12 months, which presented additional challenges for continuity and strategic delivery. NK emphasised the importance of embedding learning to ensure robust forward planning. **The Trust Board noted the Chief Executive's Report**
BM/25/12/126	**Chair's Report** SMcG reported attendance at NHS England Chairs webinars led by Penny Dash, noting emphases on recovering constitutional performance linked to money, and on the suggested need for bold/braver leadership given limited prospects of increased funding. He highlighted that there had been vague proposals for new roles of NHS England regional Chairs and that there would be a need for clear governance as there was a risk of a confusing overlap with the roles of ICB Chairs and yet more confusion around which system respective leaders were responsible for leading. SMcG provided an update on the governor election results, noting the Trust's significant progress in building a strong and engaged Council of Governors. This year's elections saw a high level of interest, with 24 nominations received. Several existing governors were re-elected, ensuring continuity, and two new staff governors joined, bringing fresh perspectives. Bridgewater Governors had engaged positively in elections, with one was successfully elected, supporting ongoing integration between the organisations. SMcG attributed this strong turnout to recent improvements in membership communications, database cleansing and constituency changes, which have made the process more accessible and appealing. He reflected that, in previous years, the Trust often struggled to fill governor positions, but now most seats

	were contested, a marked turnaround and testament to the Corporate Governance and Membership team's efforts. He noted that such engagement is unusual across the sector, as many Foundation Trusts still face vacancies and low interest. SMcG encouraged Board members to read the latest Members Newsletter, which highlighted the governors' dedication and activities. **The Trust Board noted the Chair's updates and the Governor Elections results.**
BM/25/12/127	**Board Assurance Framework (BAF)** JC introduced the report which provided the Board with an update on each of the Trust's strategic risks. He explained the proposed updated description of risk 2253 (integration) reflecting due diligence insights, and noted actions/controls and improvement plans were embedded. It was noted that the Audit Committee had sense-checked alignment between BAF risks and the Trust Board and Committee agendas (e.g., fragile services, integration). JD drew attention to some inconsistencies in risk descriptions; JC agreed to correct and ensure consistent placement of the accurate narrative across the paper. **The Trust Board approved the changes and updates to the Strategic Risk Register and Board Assurance Framework and commented that the agenda for the Board very much reflected the risks in the BAF.**
BM/25/12/128	**Integration Update** LG presented an overview with supplementary slides, reminding the Board that NHSE had given Amber strategic case rating (14 November), enabling the Full Business Case (FBC) stage. Recommendations from NHSE's strategic review had been addressed either within the FBC or through further integration planning; over 100 supplementary documents had been previously submitted, with further ongoing active supporting documents for the next submission (CQC reports, governance plans, comms & engagement logs, etc.). LG explained that of the documents being presented as part of the today's integration update most had already been reviewed and approved by the Executive or Trust board elsewhere, with the five Secretary of State (SoS) documents presented today (one remaining "summary of everything else" to be approved virtually by Executives on Friday). The timetable slide tracked amended constitution, final application letter, final NHSE transaction rating, and Council of Governors approvals—including extraordinary public Board and CoG meetings in March that JC will organise to continue targeting 1 April single-organisation day. NK stressed a key action: landing how the combined organisation will report RTT and waiting list metrics from 1 April, seeking agreed dispensation while numbers are reconciled.

SMcG noted the rapid pace of this transaction. “by NHS standards,” acknowledging the bureaucratic burden of the paperwork and raising questions of proportionality. He also drew a link back to the consistent urging of NHS leadership for trusts to be bolder and braver, indicating that when such attempts are made, there are difficulties in the system being able to respond. It has required an extraordinary effort and a high level of tenacity and resilience on the part of WHH's executives to maintain momentum with this transaction. This is not to suggest that NHSE has been unsupportive, on the contrary. But it is to identify the implications of the growth of procedure and bureaucracy over the last twenty or so years as identified in the Lord Darzi report. And the real-world implications that will continue to make it very difficult for systems to change at the pace necessary to cope with the real-world issues of 2026 and beyond.

JD asked that quality measurement be explicit across clinical, financial and estates strategies, and raised the unresolved £900k written to the ICB; NK confirmed persistence (WHH would not paying for this; if we do, we will go off plan”). LG clarified the total identified integration effort cost was £1.1m with detailed time accounting across teams.

LG also described a supplementary paper on quality governance and performance impact (waits), mapping current WHH and Bridgewater governance to the proposed structure, and analysing key IPR metrics likely to change with integration. A benefits tracker with clinical benefits would report monthly via Better Care Together.

SMcG then took approvals in turn:

- **Full Business Case:** with formatting checks by the Communications Team complete, the Trust Board approved the final FBC for submission on Friday.
- **Board Certification:** The Trust Board approved the certification documentation.
- **Post Transaction Integration Plan (PTIP):** recognised as a live document; in discussion of TUPE and harmonisation/consolidation complexities, MC explained initial measures notified to staff side, legal advice on collective agreements, pay-affecting contractual policies (e.g., two years’ pay protection transferring, with intent to move to one year in scope under ETO reasons), alignment to Agenda for Change where differences were dynamic, and regular union engagement. SMcG asked for clarity on which decisions require full Board vs. executive decision to assure governance if later scrutinised (tribunal risk); MC noted the low number of policies with material variance which would be reviewed within the framework. The Trust Board approved the PTIP, with a note that policy changes with significant industrial relations impact would be brought for Board oversight.
- **Secretary of State documents:** The Trust Board approved four SoS documents; Executives would finalise the remaining “summary” for Friday submission. SMcG congratulated LG and the team, noting NHSE review meetings beginning the first week after Christmas (prep would be provided to Board members).

It was noted that JC would work with colleagues to schedule extraordinary public Board and CoG for March and coordinate Governor engagement in February/March aligned to NHSE rating.

	The Trust Board Approved the Full Business Case (FBC), Board Certification, Post-Transaction Integration Plan (PTIP), and Secretary of State (SoS) documents for approval ahead of planned submission to NHSE on 5th December 2025.
BM/25/12/129	**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. **Performance:** DM reported 65-week waits in terms of elective recovery: 17 October breaches; November closed at 11 (forecast 10), considered an acceptable level; December target of zero carried risk in T&O (likely to come in at between 8 -12 above forecast of zero) due to third unplanned consultant absence and delays in reliance on external providers/insourcing with changed dates. All patients were booked in with no current breaches, but some pathways may not clock-stop within month. DM highlighted that it was likely to attract scrutiny if the Trust didn't comply with a zero position by the end of December. Furthermore, industrial action remained a risk. **Quality:** PF reported the stabilisation of HSMR/SHMI to steady state after earlier artefactual changes; WHH remains a low-risk organisation. NICE has withdrawn CG51 and issued new sepsis guidance and metrics; PF would bring a proposal to the next QAC meeting to adopt and monitor the new metrics, believing they're more reflective of patient need. AK highlighted no CDT in October, along with no further MRSA, with the Trust remaining a CDT positive outlier regionally though near threshold. The staffing fill rates for RGN nights had dipped, with increased HCAs, suggesting rate dynamics alone aren't explanator, work was ongoing to analyse last-minute cancellations and whether the October dip was an anomaly. MUST compliance was creeping up which was good to see and maternity work on PPH was progressing. JD explained that the committee had raised concerns regarding fractured neck of femur (FNOF) time-to-theatre risks, which had also been discussed at the Audit Committee meeting in November following issues highlighted by QAC. AK reassured the Trust Board that teams were being closely managed due to these risks, with a strong focus on improving performance. PF, DM, and AK had taken responsibility for daily briefs to maintain oversight and provide additional resources and assurance. A review visit was scheduled for the following week. NK confirmed that the team was scheduled to meet with himself and PF to further strengthen governance oversight. NK further noted that recent lower limb consultant interviews had included questions on how candidates would address these issues if appointed. JD further highlighted the progress made particularly around governance in theatres following the MIAA Audit, which the QAC continued to receive assurance on. It was noted that there was still more work to do around Culture in theatre however programmes were in place led by the quality improvement team working closely with consultants.

JD explained that Rheumatology had been escalated to Fragile Serviced, the committee had received an update on this and the plans in place to improve.

People & Culture:
MC reported organisational sickness at 6.44%, not good within the NW context. The Trust was rolling out the “Be present, be here” campaign with in-reach of MSK and other services into clinical areas, and manager training for proactive support. As Cheshire & Merseyside CPO lead, MC was proposing a consistent attendance policy across C&M organisations, reducing triggers (e.g., episodes from 4→3; days thresholds tightened) to align KPIs comparably; Bridgewater previously piloted trigger removal, but NHS England was bringing triggers back, consistent with Jim Mackey’s approach. MC confirmed WHH would proceed via extraordinary JNCC/consultation, noting contract law expects presence at work.

JJ reflected on the SPCiC assurance reports, noting an increase in red and amber ratings for quality and people, with fewer concerns in finance, which was symptomatic of current risk. She highlighted Model Hospital data showing Bridgewater’s corporate services benchmarking as extremely high regionally, recommending referral to FSCiC and referencing outputs from the due diligence report. JJ also raised risks around staff reduction, explaining that relying solely on natural turnover would take approximately seven years to reach the target levels; the committee agreed that more proactive action was required. SMcG corroborated ICB feedback that Bridgewater’s corporate costings were among the highest in the region and stressed that this situation could not be allowed to persist for years.

Finance, Sustainability and Performance:

SMcG explained the outcomes of recent monitoring meetings by PWC and the ICB, and the importance of a continued focus on the enormous financial challenges facing the trust. He also stressed, however, that running alongside the trust's financial challenges are the operational challenges, as indicated elsewhere in discussions about performance league tables. It was absolutely vital, therefore, that the board maintained a laser-like focus on the concurrence of these two key issues for board decision-making and assurance.

JH summarised the performance against KPIs, the key points below were highlighted:

- **Capital** – was behind programme due to EPR funding and carry-forward scheme mobilisation, but M7 was near in-month plan and catch-up was underway. Contingencies were being monitored closely through CPG chaired by the COO, the board was assured of the strong governance around capital contingencies.
- **CIP** recurrence improved from 36%→50% through push and check-and-challenge, with further sessions planned with care groups to shift non-recurrent to recurrent (target ~70–75%);
- **bank reduction** Bank reduction target was at 10% versus last year's plan; performance was slightly up but not quite at target."
- **cash support** - Board approval was being sought

The Board supported submission of the cash support request to NHSE and approved the request.

JS highlighted five key areas for Board attention regarding finance, performance and sustainability:

1. **Emergency Department Performance:**
   The Trust's position in national league tables for emergency care, noting that the 4-hour wait rate was ranked 101/118th, the 12-hour wait rate was 115/118, and 52-week waits were 106/118 trusts. He acknowledged that improvement plans were in place but expressed disappointment that LC was not present to allow for deeper interrogation of these issues. this will be addressed in the next meeting. He also made it clear that there remained a continued challenge with the ability to discharge patients, given the troubled financial circumstances - although not unique, extraordinary circumstances - of one of our two local authorities; given that government envoys have been deployed to that local authority.
2. **Cost Improvement Programme (CIP) Risk:**
   A total CIP risk of £16.3 million, with £5.1 million against business-as-usual schemes and an £11.2 million in stretch target. JS noted that while the Board could reasonably assume delivery of the £5.1 million, the £11.2 million remained unmitigated. He also highlighted the ongoing challenge of converting non-recurrent savings to recurrent ones, however there had been some positive progress.
3. **Forecast Outturn for 2025/26:**
   The forecast outturn for 2025/26 showed a £12.9 million shortfall, with some risks still present in the plan. He pointed out that income delivery was underperforming by £3.4 million and that the underlying deficit stands at £43.8 million, which he described as somewhat optimistic. In the main, however, the shortfall (and the off-plan issue) largely represented the stretch target that was a system target established at the start of the financial planning process. For the avoidance of doubt, WHH had always accepted that the means to deliver such a stretch target only realistically sat within Trusts themselves, as Trusts are ultimately the financial shock absorbers for the system. However, WHH from the outset, had raised a flag of concern and written to the ICB expressing formal concern that there were no formed plans of the practical means to deliver this stretch target.

   Equally, whilst WHH must and wanted to play its part, there was a need for a more integrated approach, as there were contingencies on practical matters between Trusts, as well as between this Trust and the ICB, that were necessary preconditions for delivery; given that the nature of the CIP delivery of 24/25 (supported by PWC's earlier analysis of WHH's scope for savings) and the delivery CIP 25/26 had left very few residual possibilities that would not directly affect frontline services. To be clear, 10% of the budget would have been removed over the course of two years.
4. **Cash Support:**
   The Trust was seeking £11.2 million in cash support for Q3 and anticipated needing up to £13 million in Q4, largely due to not receiving deficit support. He also noted that the Trust was incurring £6.4 million in interest costs.
5. **Productivity:**
   the Trust was not seeing major improvements in performance and JS cautioned against letting this situation slip. He mentioned that a session was scheduled for later that afternoon to address these concerns

DM was invited to provide an update on Emergency Department (ED) performance and related assurance. It was noted that the discussion had previously taken place at FSCiC in December, with a deep dive planned to

stress-test all schemes within the current plan. DM highlighted the importance of presenting the board with a clear picture of performance, referencing league tables published nationally.
The current position:

- For **4-hour performance**, including Type 3 activity, the Trust ranked approximately 80th out of 120 nationally.
- For **12-hour time in department**, the Trust had consistently remained in the bottom three nationally for the past six months, which was identified as the biggest patient safety challenge and a key reason for inclusion in the national tiering programme.

Key themes were outlined, including high occupancy rates and long waits to be seen, with too many patients being managed within the core ED department rather than alternative areas. Evidence-based schemes to address the issues were presented, with detailed work ongoing to implement improvements, noting several schemes were deployed in November and more were due; pre-hospital, in-hospital, and discharge "no right to reside" workstreams were running in parallel across system.

PF explained the Physician Associates withdrawal nationally and WHH's initial effectiveness of PAs compared with variable locum doctor productivity; ED workforce was being redeployed and internal professional standards for "patients seen per ED doctor" were being set to improve "wait to be seen" constraints that drive 12-hour breaches. DM/NK expressed conditional confidence in the dynamic schemes, citing strike-day tests where corridor occupancy dropped and waits improved under strong leadership conditions; the new ED management team started in November and GIRFT colleagues would assist with a longer-term cultural programme (ward-by-ward systems/process specialist onboarded).

AK detailed safety oversight for boarding/escalation on wards, rewriting the temporary escalation space procedure with executive sign-off, ordering buzzers for corridor patients and maintaining 1:5 staff-to-patient ratios; she distinguished safety assurance (processes in place) from poor patient experience due to estate constraints, and described nursing support for triage decision-making and culture work across teams. PF confirmed ED corridor care governance was reporting to QAC monthly.

JS suggested modelling the **UTC** impact and even **transporting patients** to Halton's UTC; LC provided figures of **~130/day** potential UTC patients (~60–70 Warrington ED attenders; with the remainder Warrington residents using out-of-borough UTCs) which would significantly help 4-hour performance.

SMcG acknowledged the significant effort being made and reiterated the importance of continued focus on performance improvement, he asked that ED improvement **Appendix 2** be placed **upfront** of IPR for better visibility; he reiterated that the board were assured on safety aspects.

Audit Committee: MO'C reported escalations on typing backlog and FNOF, indicating strong committee-to-audit triangulation; assurance rating for FNOF should be read pending undertakings.

The Trust Board noted the contents of the report and the Committee Assurance reports and approved the cash support request.

QUALITY

BM/25/12/130	**Fragile Clinical Services Update** PF introduced the report and provided a status update on the Trust's oversight of services currently designated as fragile: Chronic Pain, Urology, Cancer Services, Orthopaedics (FNOF), and Rheumatology (newly designated). The following key points were highlighted from the report: • Cardiology and cardiorespiratory were moving out of oversight • Rheumatology was expected to improve quickly through process efficiency. • urology and cancer were showing improvement. • chronic pain had a new clinical lead who was adjusting to administrative elements as the service transforms toward a community-based virtual model. The board discussed oversight approach's effectiveness in sustaining improvements without services moving in/out of oversight, noting the integration of interventions and sustained monitoring. **The Board noted the fragile services list, clinical risks and progress updates**
BM/25/12/131	**Maternity Update – Overview Paper** AK and TM presented a comprehensive update on maternity services, covering assurance across several key areas: • Perinatal Mortality Review Tool (PMRT), • Maternity Incentive Scheme (MIS) Year 7, • Maternity & Neonatal Quality Review, and • Maternity Self-Assessment Tool. AK explained that, following an unsuccessful recruitment process for the Director of Midwifery (DoM) post, the Trust proactively engaged the Local Maternity and Neonatal System (LMNS) to provide diagnostic support and external oversight. This approach was intended to ensure continued safety and quality in maternity services, and the LMNS subsequently confirmed that services at WHH remained safe. As a further measure, the LMNS invited WHH to participate in Joint Oversight Support (JOS)—a programme typically reserved for units identified as vulnerable or struggling. AK clarified that, in this case, WHH sought support proactively, rather than being placed in JOS due to concerns. A key point of discussion was the MIS requirement for a PMRT-related MVP (Band 8a) role, which remained unfunded across the system. The LMNS confirmed that WHH would be considered compliant with this action, provided the issue was formally escalated to the Board and the Integrated Care Board (ICB). AK confirmed that this escalation had taken place, ensuring transparency and ongoing compliance with national standards. JD highlighted the importance of leadership continuity within the maternity team, noting that TM had taken on the role through an internal secondment, which would help maintain stability and support ongoing improvement. The Board reviewed the report and was assured by the proactive steps being taken to maintain safety, compliance, and external oversight in maternity services, despite recruitment challenges.

	The Trust Board noted the content of the report.
BM/25/12/132	**Compliance Update Q2** AK provided a detailed update on preparations for anticipated CQC inspection focusing on Well-Led and potentially other services via regular Quality Compliance Summits and comprehensive care group data packs. SMcG noted that CQC's reprioritisation placed the Trust in a lower risk bracket due to good governance and assurance, with strong engagement. Nevertheless, complacency was to be avoided, and the Trust would continue to aim for a 'Good' rating." AK/SMcG highlighted Environmental Health five-star ratings now on both sites, reinforced by governor kitchen visits, and positive feedback from IRMER inspections. **The Trust Board noted the contents of the report.**
PEOPLE	
BM/25/12/133	**Bimonthly Communications and Engagement Report** KH highlighted three priorities from the report: • reducing expired patient information via streamlined processes and future updates. • progressing integration public-facing website with Healthwatch-chaired patient & public reference group (first session delivered this week); • internal training on public consultation requirements for service changes SMcG praised the Remembrance Day event leadership from Jo Pickstock and staff network engagement, noting Bridgewater colleagues attended. JJ queried governance siting of reducing health inequalities, observing that while reported under communications historically, it now cut across core business; LG confirmed that it sat in multiple areas and will be clarified as part of the integrated strategy refresh **The Trust Board noted the report**
BM/25/12/134	**Freedom To Speak Up Guardian Report** AJ reported that there had been 63 disclosures to date in 2024/25, with 87 recorded for the full year 2024/25, 31 in 2023/24, and 42 in 2022/23, based on rolling years and review blocks. Persistent themes included culture, alleged bullying, and relationship issues. AJ noted that collaboration with HR/OD, the People Promise Manager, and inclusion teams had strengthened staff confidence in speaking up. A Freedom to Speak Up (FTSU) survey conducted in June, which received 97 responses without a "hard sell," identified fear of breach of confidentiality and concern about being drawn into HR processes as key barriers to speaking up. AJ confirmed that changes to the disciplinary policy, such as the introduction of a 72-hour review, and further streamlining measures aim to address these concerns. Positively, staff reported equal confidence in speaking up to managers and guardians, and protected characteristics did not appear to present barriers.

	AJ summarised the following actions: establishment of a staff retention task-and-finish group; cultural reviews with rigorous anonymity and safe return-to-work planning where investigations displace individuals; implementation of the "See it, Report it, Stop it" campaign and active bystander training stands (with Non-Executive Director interest, including Bridgewater) targeted at reducing sexual safety incidents and bullying/harassment; reinforcement of incident reporting via Datix, including anonymous reporting; and promotion of safe staffing escalation awareness through SafeCare and daily huddles. SMcG welcomed the increase in disclosures as evidence of a strong speaking-up culture, and MOC commended the close relationship between FTSU and HR and the effectiveness of promotion efforts. **The Trust Board noted the contents of the report**
SUSTAINABILITY	
BM/25/12/135	**Bimonthly Strategy Highlight Report** LG noted two key developments: firstly, an invitation had been received to join the newly established Widnes Strategic Board, which, although not health-specific, was considered critical for ensuring appropriate healthcare provision within wider place-based development; and secondly, the appointment of Sarah Smith as Chief Executive of Warrington Borough Council, who had previously served as Executive Director for Health and Social Care at Knowsley. **The Trust Board noted the report.**
BM/25/12/136	**Emergency preparedness, resilience and response (EPRR) annual Core Assurance outcomes** DM reported that WHH had achieved 85% compliance with the 62 Core Standards, an improvement from 68% in the previous year, placing WHH in the 'partially compliant' category (the threshold for full compliance being 87%). Dip-sample testing had validated the self-assessment and acknowledged significant improvement. The remaining gaps were being tracked on the workplan, with completion forecasted within the year to enable a fully compliant submission in the next cycle. The Board noted the outcomes. It was agreed that the embedded EPRR team would continue to work towards the workplan to reach at least 87% compliance by the next submission cycle and provide an interim milestone update to the Trust Board in six months' time. **The Trust Board noted the report.**
GOVERNANCE	
BM/25/12/137	**Annual Review Scheme of Reservation & Delegation (SORD) & Standing Financial Instructions (SFIs)** JH confirmed the Audit Committee had reviewed annual changes and recommended extending the current version for two years, with inflationary threshold adjustments embedded. **The Board approved the SORD/SFIs for extension**
BM/25/12/138	**Proposal to extend the Membership Strategy to 2026** JC introduced the report which proposed extension aligned with other strategies, monitored by GEG and CoG;

	SMcG suggested refreshing the front-cover imagery to feel timely (rather than COVID-era visuals) while content remains valid. **The Board approved the extension to 2026 and agreed a cosmetic refresh.**
BM/25/12/139	**Updates to the Constitution – Partner Governor Composition** JC outlined the contents of the report which had been supported at the November Council of Governors meeting, replacing the vacancy created by Rachel Bagshaw's resignation (Walking Mums Cheshire) and proposing representation from the voluntary sector to align integration, while avoiding privileging any single network. LG confirmed supportive informal discussions in Warrington and Halton about using the CVS to choose a representative through a proper process; KH suggested referencing VCFSE (voluntary, community, faith, social enterprise) to include faith representation consistent with existing roles. JC proposed waiting until post-transaction constitutional updates were complete and then appointing via a transparent process. The Board agreed the approach. **The board approved the updates to the constitution**
Supplementary Papers – To note for Assurance	
BM/25/12/140	Patient Experience 6 Monthly Report – Patient Experience Sub-committee (PESC) - **Includes In-Patient Survey**
BM/25/12/141	Learning From Experience Summary Report Q2
BM/25/12/142	DIPC Q2 Report
BM/25/12/143	Guardian of Safe Working Report Q2
Closing	
BM/25/12/144	**Review of the Meeting** The Board reflected on the robust, detailed discussion of the IPR appropriate emphasis given public reporting of ED metrics and acknowledged efficient handling of other items through assurance routes.
BM/25/12/145	**Any Other Business** No further business was raised. **Meeting ended at 12:53pm**
Date and time of next meeting – 10am, Wednesday 4 February 2026 – Trust Conference Room, Warrington Hospital	

Signed:
Position: Chair
Date:

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/26/02/150**			
SUBJECT:	**Chief Executive's Report**			
DATE OF MEETING:	4 February 2026			
AUTHOR(S):	Nikhil Khashu, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will be the best place to work with a diverse and engaged workforce that is fit for now and the future.	✓		
	SO3 We will work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**All**			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.			
PURPOSE: *(please select as appropriate)*	**Approval**	**To note** ✓	**Decision**	
RECOMMENDATION:	The Trust Board is asked to note the content of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Chief Executive's Report	AGENDA REF:	BM/26/02/150

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

2. KEY ELEMENTS

2.1 Trust News

Inquest Conclusion – Baby Pippa Gillibrand

I want to bring to the Board's attention the conclusion of the inquest into the tragic death of baby Pippa Gillibrand, heard at Cheshire Coroner's Court on 26 and 27 January 2026.

Pippa was born on 25 August 2024 at Warrington Hospital after her mother was brought in by emergency ambulance following a planned home birth. Pippa sadly died less than two weeks later, on 5 September 2024, at Liverpool Women's Hospital.

The Coroner concluded that Pippa died as a result of a brain injury sustained due to an avoidable delay in her delivery. As a Trust, we have offered a full and unreserved apology to Mr and Mrs Gillibrand for their devastating loss, and we fully accept the coroner's findings.

When we fall short, it is essential that we acknowledge this openly, transparently, and with an absolute commitment to learning. Following the incident, a full and independent Maternity and Newborn Safety Investigation (MNSI) was undertaken. All recommendations from that investigation have been implemented through a clear and monitored action plan. We have also strengthened our home birth service through the introduction of a new model of care to ensure improved safety, support, and clinical decision-making.

While our maternity services have made significant progress in recent years, this case is a stark reminder that our improvement journey must continue with pace, purpose and humility. We remain wholly committed to ensuring safe, high-quality maternity care, and to making further changes where needed to reduce risk and improve outcomes for women, babies and families.

I recognise that this will have caused understandable concern among women and families currently in our care. I want to thank colleagues for the compassionate and proactive support they continue to provide to those who may be feeling anxious.

I also want to acknowledge the profound impact this has had on the teams involved. This has been an extremely difficult time for them, and I encourage any colleague who needs support to reach out, whether to their line manager, our wellbeing services, or a trusted colleague.

Our deepest sympathies remain with Mr and Mrs Gillibrand at this incredibly difficult time.

Recognising the Contribution of Our Chair, Steve McGuirk

This month marks a significant moment in the life of our organisation as we recognise that today will be Steve McGuirk's final public Board meeting as Chair of Warrington and Halton Teaching Hospitals before he concludes his term of office on 31 March 2026. Steve joined the Trust in April 2015, and over the past eleven years he has provided leadership that has been both steadying and transformative during one of the most challenging periods in the history of the NHS.

During Steve's tenure, the Trust has navigated unprecedented operational and strategic pressures, including wide ranging system reform, increasing demand, and the profound impact of the COVID 19 pandemic. Throughout, he has offered continuity, clarity and a strong commitment to public service. His leadership has helped maintain organisational stability through turnover across the Non-Executive cohort, and he has been a key figure in strengthening governance arrangements, embedding independence, and ensuring the Board could operate with the discipline and assurance required of a modern NHS provider. This period has also seen the Trust improve its Care Quality Commission rating from "Requires Improvement" to "Good", a significant achievement that reflects the sustained focus on quality, safety and robust governance that Steve has championed. Alongside his duties as Chair of the Board, Steve has also served as Chair of the Council of Governors, ensuring our governors have been well briefed, well engaged and able to carry out their statutory responsibilities with confidence.

Across his time as Chair, Steve has championed our strategic objectives, supported the development of a more mature and resilient Board, encouraged a culture of openness and accountability, and maintained a strong connection with our staff, partners and communities. His commitment to doing what is right for patients and for the Trust has been evident in every phase of his leadership. As we look ahead to the next stage of our journey, the foundations he has helped build will continue to shape our progress and our ambitions.

On behalf of the Board, our staff, and the communities we serve, we extend our sincere appreciation to Steve for his outstanding service, wise counsel and enduring dedication to Warrington and Halton Teaching Hospitals. We wish him every success and fulfilment in the future.

Operational Performance and Patient Flow

Multi-Agency Discharge Events (MaDE)

The Trust continued to build on learning from recent Multi-Agency Discharge Events, which have improved patient flow and reduced delays in transfers of care. These events have demonstrated that collaborative, system-wide working, particularly with NWAS and local authorities, significantly strengthens discharge processes during periods of operational pressure.

A Christmas MaDE was held from 17 December 2025 to 2 January 2026, with acute and community teams working together to support safe and timely discharge for medically optimised patients. This focus contributed to enhanced system resilience during the busy festive period.

GIRFT-Supported Ward Improvement Programme

Four pilot wards, A2, A3 (ACCU), B18 and K25 (OPSSU), have embarked on an intensive improvement programme supported by the GIRFT team. The objective is to increase safe and timely discharges by improving Board Rounds, establishing clearer Criteria for

Discharge, and reducing delays in patient pathways. Early feedback is positive, and improvement huddles are being held daily at 15:30 to support implementation. Plans are in place to expand this approach Trust-wide following evaluation of the pilot phase.

Workforce and Organisational Change

TUPE Integration Programme

Significant engagement has taken place with staff regarding ongoing TUPE processes. WHH and BCH are progressing through structured consultation phases, led in collaboration with staff-side partners. Key points include:

- Bridgewater Phase 2 consultation is underway, with Phase 3 one-to-one discussions being scheduled.
- WHH colleagues directly affected have begun formal meetings.
- Clinical teams will see minimal change, with a small number of exceptions in clinical support services.

Managers have been asked to proactively engage their teams, including colleagues absent from work, to ensure full understanding of the changes. Updated communication materials have been shared to support consistency and transparency.

Mutually Agreed Resignation Scheme (MARS)

As previously reported, the Trust has launched a Mutually Agreed Resignation Scheme (MARS) as part of our wider approach to financial recovery and workforce reshaping. The scheme provides an opportunity for colleagues who wish to leave the organisation on mutually agreed terms to do so, while enabling the Trust to release posts that can either be permanently removed or redesigned to better meet future service needs.

The scheme has generated a strong level of interest from staff across a range of departments. All applications are being assessed against clear criteria, including the potential to release recurrent savings, the impact on service delivery, and the feasibility of reorganising work without detriment to patient care or staff wellbeing. Approvals will only be granted where a robust and sustainable case is demonstrated.

The launch of MARS has been accompanied by targeted communication and direct engagement with teams to ensure colleagues understand the purpose of the scheme and its role within our financial improvement programme. HR teams are providing dedicated support to managers to ensure consistent, fair and timely decision-making.

Financial Position and Sustainability

End-of-Year Financial Focus

The Trust continues to operate in financial deficit, and we have implemented a number of principles designed to strengthen financial control while maintaining safe care. These include:

- Freezing non-clinical vacancies, with clinical or safety-critical exceptions.
- Restricting non-clinical overtime and bank usage without executive approval.
- Reviewing fixed-term contracts, supporting only those with a clear patient care impact.

- Ensuring senior roles above Band 8c are considered for shared arrangements with partner organisations.
- Stopping discretionary spend unless essential for safe care.
- Pausing WLIs and insourcing except where required for cancer or mandated performance outcomes.

Work continues to identify opportunities to convert non-recurrent savings into recurrent ones for 2026/27. The Trust is also examining clinical productivity and benchmarking opportunities to support activity improvement in line with national expectations.

Flu Vaccination Programme

The Trust's 2025/26 flu vaccination campaign has continued at pace throughout the winter period. As of 15 January 2026, 48.5% of our patient-facing workforce at WHH had received their vaccination, compared with 44% at the same point last year, demonstrating steady improvement despite ongoing operational pressures.

To maximise opportunities for staff to be vaccinated, Occupational Health has delivered extended clinic hours, early and late walkabouts, and on-site wellbeing days, which were well attended. Senior leaders have visibly supported the campaign by joining vaccination teams during ward walkabouts, reinforcing the importance of vaccination in protecting colleagues, patients and service resilience.

Despite these efforts, uptake remains below the national target of 50%, and common themes influencing hesitancy remain consistent with previous years, including high workload, perceived vaccine fatigue, and questions around effectiveness. To address this, further myth-busting communications, local champions, and targeted engagement in areas of lower uptake will continue through the remainder of the winter period.

I would like to record my thanks to all staff who have made time to be vaccinated and to our Occupational Health and clinical teams whose sustained efforts have enabled continued improvement in uptake during a challenging season.

Thank You Awards 2025–26

Preparations for this year's Thank You Awards are progressing well, with strong engagement from colleagues across WHH and BCH. A total of 500 nominations have been received from staff and the public, with 72% submitted from WHH and 28% from BCH, broadly reflecting the size and spread of the combined workforce. In addition, 32 public nominations were received for the People's Choice Award.

The digital judging process has now been completed, and nominations achieving the highest scores are being reviewed by the Judging Oversight Panel. Final judging is scheduled for 17 February, with finalists to be announced on 20 February.

2.2 National News

Industrial Action

Industrial action by resident doctors commenced on 17 December 2025, reflecting ongoing national disputes relating to training opportunities, progression within training programmes, and the restoration of pay to 2008 levels. The coincided with sustained operational pressure across the Trust, including heightened winter demand and increased flu-related activity, placing additional strain on services.

In preparation, the Trust implemented comprehensive mitigation plans to maintain patient safety and service continuity. These measures included strengthened rota coordination, increased senior clinical oversight, targeted redeployment to priority areas, and enhanced communication with affected teams. I would like to acknowledge the resilience and professionalism of colleagues who have continued to deliver high-quality care during this period.

Alongside operational responses, the Trust has progressed work to improve the working environment for resident doctors. The recent opening of the new doctors' mess at the Warrington site has been positively received, addressing several concerns raised through previous engagement. Further actions within the Improving Working Lives programme are being delivered to support medical staff wellbeing and engagement.

We continue to monitor the industrial action closely and engage with regional partners, ensuring that risks are effectively managed and that the impact on patients and staff is minimised.

NHSE National CEO Meeting

The national NHSE Chief Executives' meeting on 27 January set a clear tone for the year ahead, highlighting continued concerns around corridor care, leadership vacancies and declining staff and patient experience, alongside a call for organisations to make the "big leaps" needed in productivity, workforce efficiency and three-year planning. NHSE reported progress nationally on financial recovery, driven by significant reductions in agency and bank spend, and emphasised that future pathways and improvement tools will be digital by default. Providers were reminded of the importance of credible integrated plans across quality, workforce, finance and performance as NHSE strengthens oversight of delivery.

2.3 Regional Update

The ICB has recently strengthened its transformation and strategic capacity. In December 2025, Jude Adams joined as Interim Executive Director of Strategy and Transformation. Jude brings extensive board level experience and a strong operational and clinical background, having held senior roles across acute, children's and group model environments.

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

Friday 5th December

The Leadership Board reviewed a comprehensive digital transformation agenda intended to reposition digital as a system-wide driver of clinical and operational improvement. The Board

endorsed the direction of travel, including establishment of a Digital Centre of Excellence, development of shared architecture, and accelerated progress on key priorities. The Board agreed in principle to incorporate ICB digital functions into a shared collaborative model and requested a concise plan-on-a-page summarising vision, milestones, and governance.

A strategic discussion on collaborative procurement highlighted £1.2bn annual addressable non-pay spend and substantial efficiency opportunities. The Board endorsed progressing toward a single system-wide procurement service, supported by phased implementation, and an accelerated business case.

Operational updates noted that Cheshire & Merseyside remains an outlier on 65-week elective waits. Workforce matters included agreement on a target of 95% attendance threshold. Decisions on visas and recruitment freezes were deferred pending further guidance from a scheduled NHSE webinar.

Friday 19th December

The CMPC Leadership Board convened to review system-wide progress, organisational pressures, and future strategic direction. The meeting opened with an update from Liz Bishop, ICB CEO, highlighting rapid development of a commissioning strategy due in January, with a renewed focus on prioritised pathways, prevention, and a more standardised approach across Cheshire and Merseyside. ICB governance structures are under review, with executive appointments expected by the end of January.

A substantial portion of the meeting focused on in-year delivery and planning, including discussion of the recent NHS England Undertakings issued to several providers. The Board agreed on the need to focus on a three-year planning horizon supported by a small number of credible transformation schemes including workforce reduction strategies, corporate services consolidation, productivity improvements, and potential estate rationalisation.

The Board discussed workforce productivity tools, including acuity-based rostering tools and redesign of outpatient provision.

Friday 9th January 2026

The Leadership Board met on 9th January 2025 to review key programmes and system priorities. The Board approved continuation of the *Dermatology AI – Skin Analytics* programme, noting its strong clinical performance, and contribution to increased efficiency by reducing consultant appointments and biopsy rates.

The Board endorsed the proposed methodology for identifying fragile services across Cheshire & Merseyside, which applies a structured scoring matrix across quality, workforce, standards, and financial measures. This process will support the development of a prioritised shortlist by March.

A detailed update was provided on the LAASP business case. The work demonstrates a rigorous approach to assessing integration options across Liverpool providers. Key objectives include economies of scale, clinical pathway integration, improved workforce models and strengthened system working.

Updates on diagnostics and community capital planning highlighted tight national deadlines, with £41m available for diagnostics in 2026/27 and £14m across three years for community investment. Work is progressing to align a shared prioritisation matrix and to shift towards a more strategic system-wide approach to capital planning.

The ICB's financial planning for 2026–28 indicates an early ICB draft position of £9.4m surplus and a £74.8m CIP requirement., noting this position will change as plans iterate. Concerns were raised regarding the sustainability of incremental growth models and the need for a strategic resource-allocation framework aligned with the Blueprint.

The system remains broadly on track for delivery of the 65-week wait target, though immediate action is required to address residual cases. Trusts are encouraged to engage with Q4 outpatient sprint opportunity and RTT improvement funding to maximise activity delivery before year-end.

Finally, the Board discussed the need for strengthened oversight of service changes to avoid unintended system impacts, agreeing to refine processes for reviewing ICB Service Change Panel outputs, and welcomed the decision of the ICB to reconsider the previously proposed decommissioning of virtual ward beds.

2.5 Overview of Trust Performance

Appendix 1 is a snapshot dashboard overviewing Trust performance across the domains of Quality, People and Sustainability for the last full month of complete reported datasets. In this case, this is month 9 – December 2026. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside the relevant Committee Assurance Reports.

2.6 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:

December 2025

- Uk Disability History Month
- White Ribbon Day
- World Aids Day
- International Day of Persons with Disabilities
- Hanukkah

January 2026

- Dry January
- National Obesity Awareness Week
- Cervical Cancer Prevention Week
- Holocaust Memorial Day

2.7 Signed under Seal

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

2 MEETINGS ATTENDED

The following is a summary of some of key external stakeholder meetings I have attended in December 2025 and January 2026 since the last Trust Board meeting:

- Amanda Ridge, Interim Warrington Place Director
- Janelle Holmes, Chief Executive, Wirral university Teaching Hospitals NHS FT
- Sir Jim Mackey, NHS England Chief Executive, briefing on Flu
- NHS England to discuss the Integration Final Business Case
- Sir David Henshaw, Interim Chair, Cheshire & Merseyside ICB & Dr Liz Bishop, Interim Chief Executive, Cheshire & Merseyside ICB
- NW System Leaders
- Cheshire & Merseyside Provider Collaborative (CMPC) Leadership meeting
- Cheshire & Merseyside Provider Collaborative (CMPC Delivery Board
- PricewaterhouseCoopers (PwC)
- Linda Buckley, Managing Director CMPC
- Derek Twigg MP
- Cheshire & Mersey Planning Meetings
- Tiering Meetings with NHSE
- CMPC Blueprint meeting
- Cheshire & Merseyside Finance Investment & Revenues Committee

4 RECOMMENDATIONS

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

5 APPENDICES

Appendix 1: CEO Dashboard – Month 9 (December 2026)

Appendix 1 - CEO Dashboard Month 9 – December 2025

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality

Operational Performance

Indicator	Target/Limit	Actual	SPC
Diagnostic waiting times - 6 Weeks	above 95%	96.55%	?
RTT 18 Weeks	above 92%	61.10%	F
RTT - patients waiting 52+ Weeks	0	929	F
RTT - patients waiting 65+ Weeks	0	17	F
Elective Outpatient activity	104%	86%	?
A&E % patients seen within 4 hours	Below 78.00%	62.62%	F
A&E % waiting longer than 12 hours	Below 2.00%	22.37%	F
Cancer 28 Day Faster Diagnostic Standard	above 75%	76.70%	F
Cancer 62 Day Wait	above 85%	84.00%	F
Ambulance Vehicle Handovers within 45 mins	100%	79.88%	F
Cancelled Operations – not rearranged within 28 days	0	6	F
Capped Theatre Utilisation	above 85%	76.64%	F

Quality of Care

Indicator	Target/Limit	Actual	SPC
Incidents open over 40 days	0	84	F
Sepsis Screening Emergency	above 90%	70.00%	F
Sepsis Screening Inpatients	above 90%	68.00%	F
Sepsis Antibiotics Emergency	above 90%	52.00%	F
Sepsis Antibiotics Inpatient	above 90%	72.00%	F
Inpatient Falls	30 (10% reduction from 2024/25)	45	?
VTE	above 95%	91.84%	F
Pressure Ulcers (Category 2 and above)	11 (20% reduction from 2024/25)	15	?
Medication Reconciliation (within 24 hrs)	above 80%	33.22%	F
Complaints over 6 months	0	1	F
Healthcare Infections - MRSA	0	0 YTD	?
Healthcare Infections - MSSA	below 8 YTD	27 YTD	No SPC
Healthcare Infections – CDI (cumulative)	below 15 YTD	57 YTD	?
Healthcare Infections - E. coli (cumulative)	below 20 YTD	58 YTD	?
Healthcare Infections – Klebsiella (cumulative)	below 7 YTD	20 YTD	?
Healthcare Infections - P. aeruginosa (cumulative)	below 2 YTD	9 YTD	?
Maternity Postpartum Haemorrhage >1500ml	below 3.7%	4.73%	?
MUST nutritional assessment completion	above 85%	73.01%	F

Sustainability

Finance

Indicator	Target/Limit	Actual	SPC
Income & Expenditure (£m)	-£3.01	-£2.61	No SPC
Capital Spend (£m)	£18.91	£5.10	F
Cash Balance (£m)	£2.86	£13.00	No SPC
Better Practice Payment Code (£m)	above 95%	62%	F
Agency Reduction (£m)	£2.18 (30% reduction from 2024/25 plan)	£2.20	?
Bank Reduction (£m)	£20.52 (10% reduction from 2024/25 plan)	£24.03	F
CIP In Year Delivered in relation to plan	90% of plan	100%	P
CIP In Year Delivered in relation to plan (Recurrent)	90% of plan	48%	F

People

Workforce

Indicator	Target/Limit	Actual	SPC
Supporting Attendance	Below 5%	6.41%	F
Turnover	Below 13%	11.58%	P
Core/Mandatory Training	above 85%	91.20%	P
PDR Compliance	above 85%	80.69%	F

Strategy

- **WHH and BCH continue to work towards becoming a single organisation**. NHSE have completed their review of our strategic case and agreed for us to continue to develop the full business case (FBC) as the next step. The final draft of the FBC is now complete and has been approved by both WHH and BCH Trust Boards before being formally submitted to NHSE in early December. Focus of the programme now shifts to the critical actions required to complete the legal transaction and deliver a 'safe day one' as an integrated organisation.

- **The Runcorn Health and Education Hub** is due to complete construction in January 2026, start to open services from June 2026.

- **The Living Well Warrington programme was highly commended at the prestigious 2025 national HSJ awards in November**. The programme consists of three projects; Living Well Hub, Living Well in Warrington digital platform and Talking Points. Collectively, the three projects have reached over 200,000 people over the last 18 months, supporting them to live independently at home and access support in their local communities.

- **The Trust have commenced development of our five-year plan, in line with latest NHS England Planning Guidance**. This involves formulation and submission of:
  - 3- year plans for revenue, workforce, operational performance and activity
  - 4-year plan for capital
  - 5-year narrative plan

  Final submission due in February 2026, with approval of the plans at February's Trust Board.

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

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

? Inconsistently passing/failing target

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/26/02/152**
SUBJECT:	**Board Assurance Framework**
DATE OF MEETING:	**4 February 2026**
AUTHOR(S):	Emily Kelso, Corporate Governance & Membership Manager
EXECUTIVE DIRECTOR SPONSOR:	All Executives
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. ✓ SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future ✓ SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities. ✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***

1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	Yes	No	N/A
	✓		
Further Information:			

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

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

EXECUTIVE SUMMARY *(KEY ISSUES):*	**Board Assurance Framework** This report provides an update on the Trust's 11 strategic risks as per the Board Assurance Framework, following review by the assigned monitoring Committee. Each strategic risk is linked to one or more of the Trust's strategic objectives. A Risk Review Group has been established for oversight and scrutiny of strategic risks and for a rolling programme of review of CBU risks, to ensure risks are being managed and escalated appropriately. **Since the last Trust Board meeting:** • There have been no new strategic risks added to the BAF. • There have been no amendments to risk descriptions • There are two proposed updates to risk ratings, these are:

<table>
<tr><td></td><td colspan="3">

Risk 2253: Likelihood reduced 3 → 2, lowering overall score 9 → 6 due to sustained programme progress.
Risk 115: Likelihood increased 3 → 4, raising overall score 12 → 16 driven by sickness levels, vacancies, agency use, and ongoing escalation pressures.

No target risk ratings or risk appetites to current risks 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.
</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">The Trust Board is asked to:

Discuss and note the updates to the Strategic Risk Register and Board Assurance Framework
Approve the proposed updated risk ratings of:

Risk 115 from 12 to 16
Risk 2253 from 9 to 6

</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Quality Assurance Committee, Finance & Sustainability Committee, Strategic People Committee, Audit Committee</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="2">Multiple</td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="2">Multiple</td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="2">Approved</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="3">None</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	Board Assurance Framework	AGENDA REF:	BM/26/02/152

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 services remain fragile or the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.	20 (L5xC4) ⟷	Minimal	QAC
1114	EMD	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	16 (L4xC4) ⟷	Minimal	FSC
1372	EMD	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems	16 (L4xC4) ⟷	Cautious	FSC

		triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety			
2273	CSPO	If the Trust cannot deliver its strategic vision, secure funding for new hospital facilities, and the suport and resource required from the Cheshire & Merseyside ICS and beyond, it may fail to meet estates standards, provide quality services, and ensure a suitable environment, potentially leading to rising backlog maintenance costs, short-term fixes, non-compliance, and adverse effects on patient safety, outcomes, reputation, and finances	16 (L4xC4) ↔	Seek	FSC
115	CN	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	16 (L4xC4) ↑	Minimal	QAC
1134	CPO	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	12 (L3xC5) ↔	Open	SPC
1757	EMD	If industrial action takes place, then there is a risk of significant workforce gaps across critical services, which may disrupt operational service delivery and compromise the Trust's ability to maintain safe, effective, and timely patient care.	12 (L3xC4) ↔	Cautious	QAC
2253	CSPO	I 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. In addition, following the completion of due diligence work, there is an increased risk that previously unidentified financial, operational, or regulatory issues may remain unaddressed, then it could compromise the enlarged organisation's ability to deliver safe, effective, and sustainable services if integration does not proceed.	6 (L2xC3) ↓	Open	EMT

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

2. UPDATES SINCE THE LAST MEETING

2 Since the last meeting

2.1 New risks

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

2.6 Amendment to risk ratings

It is proposed to **reduce the likelihood score** of **Risk 2253** from 3 to 2, resulting in a reduction of the overall risk score from 9 to 6. This reflects that the integration programme is now well

established, with predominantly shared executive leadership in place and fully functioning joint governance structures. Key milestones including approval of the full business case by both Boards, completion of Board Certification, the Post-Transaction Integration Plan (PTIP), and Secretary of State documentation demonstrate sustained progress and reduced uncertainty.

Furthermore, following discussion at the Quality Assurace Committee meeting in January, it is proposed that the likelihood score for **Risk 115** (staffing levels in clinical areas) is **increased from 3 to 4**. This adjustment would raise the overall risk rating from 12 to 16. The recommended increase reflects ongoing operational pressures, including higher levels of sickness absence across several clinical areas, a modest rise in vacancy levels, and increased reliance on agency staffing. These challenges are being compounded by the sustained use of escalation capacity, which places additional strain on workforce availability and amplifies the likelihood of staffing shortfalls.

2.4 Amendments to descriptions

There have been no amendments to risk descriptions since the last meeting.

However, it is anticipated that the description of **Risk 1372** (Electronic Patient Record risk) will be updated following the Preliminary Market Engagement (PME), scheduled to commence during the week beginning 19 January 2026.

2.7 De-escalation of risks

No risks have been closed or deescalated.

2.8 Risk appetite

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

2.9 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
134	If the Trust is not financially viable then there may be an impact on patient safety, operational performance, staff morale and potential enforcement/regulatory action taken	**Controls** • Cash Support received for 2024/25 was £12.145m and £19.2mYTD 2025/26 **Assurances** • 2024/25 CIP £18.5m achieved of which £12.5m was the recurrent higher CIP achieved. At month 9 2025/26 CIP is on plan achieving £15.1m YTD.	**20 (L5xC4)**	No impact on risk rating
2001	If services remain fragile or the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.	**Assurance Gaps** • Further assurance that WHH Fragile Service sustainability will be strengthened by C&M Fragile Services programme	**20 (L4xC5)**	**none** ↔

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
2273	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	**Controls** • Runcorn Health & Education Hub funded by the Runcorn Town Deal led by WHH due to open in Quarter 1 2026/27. • Strategy refresh for 2026/27 approved by the Trust Board. • Bids recently submitted to UEC fund and CIR fund. • Work on phased estates plan and clinical strategy commenced. **Assurances** • The Trust has been selected as a site for one of two endoscopy hubs in Cheshire & Merseyside, hub opened.	**16 (L4xC4)**	None ⟷
115	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	**Assurances** • Increase in registered nursing establishment in the Emergency Department, November 2024. Ongoing recruitment, with regular shortlisting and interviews which has reduced band 5 vacancy rate to 32.74 WTE. • Nursing: Overall Registered Nurse vacancy for November 2025 is 8.35% which is below the Trust benchmark of 9% • Overall Healthcare Support Worker vacancy for November is 14,20% which is above the Trust benchmark of 9% • CSWD 5 cohorts of 15 CSWDs will be deployed throughout 2025 with 15 commencing their 6 month training programme within the Trust in January 2026 • In September 2025,15 wards achieved the 90% fill rate on day shifts and 23 ward achieved 90 % fill rates on nights **Assurance Gaps** • Increased operational capacity and demand results in the need to open additional areas to provide patient care, increasing the staffing need e.g. Treatment/MDT rooms on B14, B18 & A4; accelerated transfers and boarding out of hours – there were 297 escalated beds during October 2025 this increased to 312 in November 2025 • Necessity to consistently use Temporary Escalation Spaces with up to 2 extra patients and to ensure safety is maintained • The winter ward A10 closed in June 2025 and was utilised for one week in August 2025 for escalation. Ward A10 re-opened 2 November 2025 for escalation as part of the winter plan and closed on 22 December 2025. Discharge Lounge is bedded overnight when required with	**16 (L4xC4)**	**Increased likelihood from 3 to 4** ↑

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		patients being discharged the following day to support flow. • There were 610 Red Flags reported in October 2025, and this decreased to 569 reported in November 2025- Red Flags were linked to escalation areas and enhanced care • In Quarter 3 over 1200 patients were admitted to WHH with a mental health condition Increase in paediatric ED staffing gaps in Q3 2025 due to vacancies and sickness, requirement to use paediatric ward staffing to maintain safety		
1134	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	**Sickness Absence** The rolling 12-month sickness absence rate is 6.16% as at December 2025 and is showing a slight decrease from October 2025 (6.19%). Trust target from April 2025 is 5% as approved by the Strategic People Committee following a benchmaking exercise across the C&M region and consideration of health inequalities in the community we recruit staff from. **Assurance** • The Trust has seen a significant improvement in long term sickness absence rates since the full implementation and transition on to the new Supporting Attendance policy reducing from 4.39% in April 2022 to 3.16 % in December 2025. An MDT review in collaboration with HR and OH to review all long term sickness • Welcome Back Conversations annual compliance was 89.41% in December 2025. **Turnover and Attraction** • Turnover in December 2025 remains below the limit of 13% at 11.58%, a 1% decrease from the figure reported in February 2025. Turnover of permanent staff in December 2025 was 10.87%. • Retirements, relocation work/life balance remain the main reason for leaving. • The Trust's December 2025 vacancy rate is 6.05%, the Trust limit is 9%. **Assurances** • The responses to Exit Interviews are positive, only 11.98% as at December 2025 of questions answered are negative, with looking forward to going to work receiving the highest proportion of negative responses.	**12 (L3xC4)**	none ⟷
1757	If industrial action takes place, then there is a risk of significant workforce gaps across critical services, which may disrupt	**Assurance** • Further round of Resident Doctor industrial action 17th December – 22nd December 2025 without safety incidents and with >95% activity delivered	**12**	**none**

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	operational service delivery and compromise the Trust's ability to maintain safe, effective, and timely patient care.	**Assurance Gaps** • Ballot for further IA for Resident Doctors open till 2nd February (current strike mandate expires January 2026) • Currently there is no scheduled date for the next instance of industrial action and the current mandate for Resident Doctor IA expires in January 2026 – the next phase could possibly occur during a more significant period of winter pressure. Planning will be initiated once the notice has been received.		
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. In addition, following the completion of due diligence work, there is an increased risk that previously unidentified financial, operational, or regulatory issues may remain unaddressed, then it could compromise the enlarged organisation's ability to deliver safe, effective, and sustainable services if integration does not proceed.	**Assurance** Full Business Case approved by both Boards	**6 (L2xC3)**	Likelihood reduced from 3 to 2 ⬇

3. RECOMMENDATIONS

The Trust Board is asked to:

- Discuss and note the updates to the Strategic Risk Register and Board Assurance Framework
- Approve the proposed updated risk ratings of:
  - **Risk 115** from 12 to 16
  - **Risk 2253** from 9 to 6

Appendix 1

Board Assurance Framework – Trust Board February 2026

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

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

Board Assurance Framework – December 2025

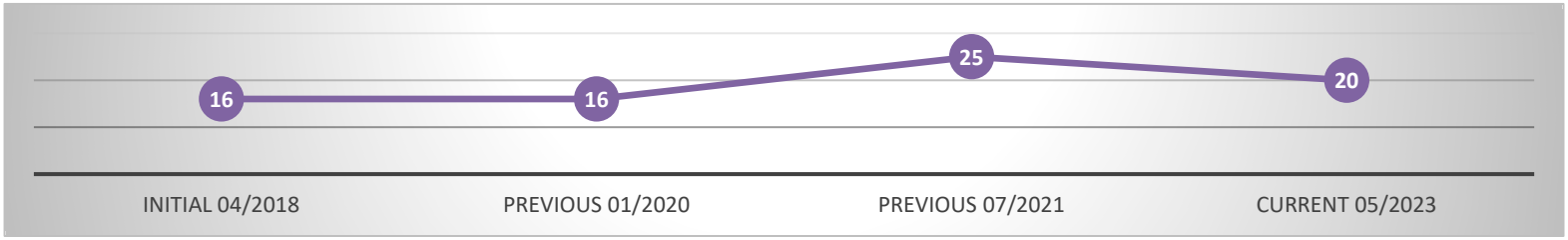
		environment, potentially leading to rising backlog maintenance costs, short-term fixes, non-compliance, and adverse effects on patient safety, outcomes, reputation, and finances						
115	CN	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	1	16 (L6xC4) ↑	8 (L2xC4)	Safe Caring	Minimal	Quality Assurance Committee
1134	CPO	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	2	12 (L3xC4)	8 (L2xC4)	Safe Caring	Open	Strategic People Committee
1757	EMD	If industrial action takes place, then there is a risk of significant workforce gaps across critical services, which may disrupt operational service delivery and compromise the Trust's ability to maintain safe, effective, and timely patient care.	1	12 (L4xC3)	8 (L4 xC2)	Safe Responsive	Cautious	Quality Assurance Committee
2253	CSPO	If the Trust is unable to integrate with Bridgewater Community Healthcare Foundation Trust via a formal transaction, then it will hinder the Trust's ability to deliver key benefits, such as a community-focused healthcare model, address health inequalities and ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, including the limited capacity of shared Board members to effectively manage competing demands, potentially impacting both Trusts' decision-making and service management. In addition, following the completion of due diligence work, there is an increased risk that previously unidentified financial, operational, or regulatory issues may remain unaddressed, then it could compromise the enlarged organisation's ability to deliver safe, effective, and sustainable services if integration does not proceed	1,2,3	6 (L2xC3) ↓	2 (1LxC2)	Well-Led	Open	Executive Management Team

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

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

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID	224	**Executive Lead**	Chief Operating Officer	**Rating**	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival resulting in an overcrowded Emergency Department.			**Initial**	16(L4xC4)
				Current	20(L5xC4)
				Target	8 (L2 xC4)
CQC Domain	**Effective and Responsive**				
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					

Assurance Details

Controls

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

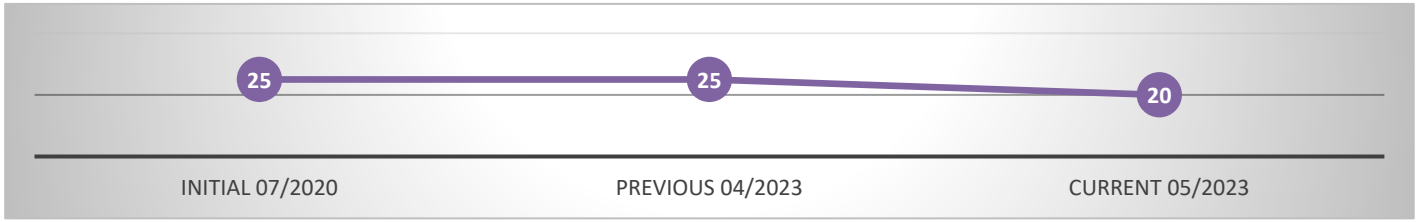
	• Additional Nurse Staffing paper to support increases in the substantive workforce and manage escalation areas supported by the Trust Board • On a daily basis the Trust utilises the SHREWD Resilience system to inform tactical and strategic site decision making in relation to flow and occupancy. • Progress chaser in ED to support flow and timely • Introduction of the new Manchester Triage Process from 14th April 2024 to support reduced overcrowding in ED and improve clinical quality and patient experience • Winter escalation capacity (ward A10 & bay of 6 on Ward B4) planned to be open in Winter 2025/26 to support flow and urgent care • The Performance Improvement & Oversight Group has been established in place of the ED Improvement Gorup and is the oversight group for the performance of the Urgent & Emergency Care System Improvement Group • The Performance Improvement & Oversight Group reports to the Finance & Sustainability Committee • QI led project completed to support improving Ambulance handover times • UEC improvement group established, supported by Executives with a focus on sustained recovery • Workforce review completed to increase evening cover where demand is highest **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. • Change to Triage model with the introduction of streaming to support deflection away from ED and faster triage times • Transition to type 5 SDEC from 1st November 2025. • 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. • Actions being followed up following external review by NEWTON to support decrease in LOS and support flow • Urgent & Emergency Care System Improvement Group established in May 2024. The aim of the Group is to deliver the opportunities identified by the Newton work. It covers 5 workstreams with system partners to improve urgent care performance and eradicate corridor care. This programme of work feeds into the ICB Urgent Care programme of work. • Review of the ED footprint being undertaken to identify opportunities to increase capacity and improve efficiency. • Updated nursing documentation to include risk assessment for when patient is cared for in an escalation space/corridor
Assurance Gaps	**Gaps in Controls** • Ongoing industrial action across a number of staffing groups including junior medical staff. **Gaps in Assurances** • Increase growth of higher acuity in types 1 & 3 as a result of population need and lack of access to Primary Care

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continued Escalation of Breaches and Patients Requiring Admission	Escalation of 4 hours quality standard and 12-hour decision to admit emergency access standard.	Escalation per ed safety escalation via Bed Meeting, Tactical Command and SMOC (out of hours) and Executive on Call.	Robinson, Jade	ongoing	

Ongoing Monitoring of the Emergency Access Standard	ED Insight report daily SITREP report National report and benchmarking outcome UEC north dashboard Robust ongoing monitoring	Ongoing monitoring of risk via daily report SITREP, Daily Capacity and Demand report from 4* daily bed meetings. Weekly PRG and monthly Unplanned Care Performance Meetings.	Robinson, Jade	ongoing	
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

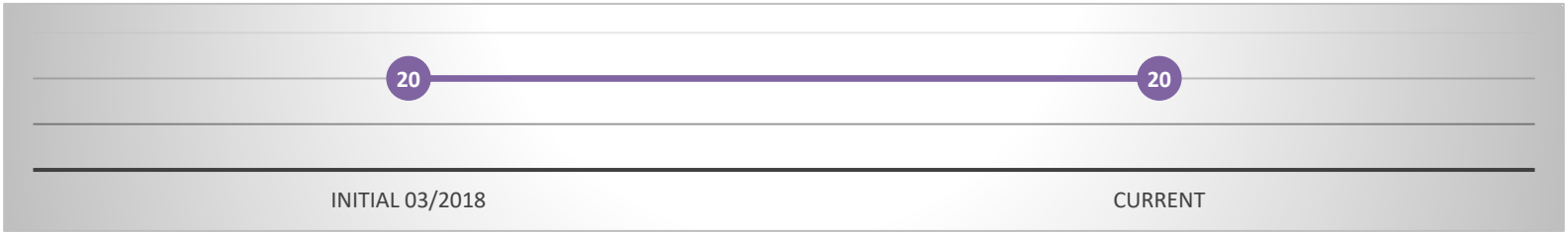
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID	1215	**Executive Lead**	Chief Operating Officer	**Rating**	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.			**Initial**	25 (L5xC5)
				Current	20 (L4xC5)
				Target	6 (L3xC2)
CQC Domain(s)	**Safe and Responsive**				
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Assurance Details	**Controls**. • 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. • Weekly theatre scheduling to ensure listing of patients in line with national guidance, with the support and guidance of Cheshire and Merseyside Productive Partners • Bioquell Pods deployed in ICU in March 2021 to support flow and IPC compliance. This will help reduce instances of having to escalate capacity to the Main Theatre at the Warrington site. • Continue to specifically focus on and monitor patients waiting greater than 52 weeks & 65weeks • Continue to ensure urgent cancers are prioritised in line with national guidance. • Continued use of Insourcing and outsourcing providers (NHS approved contractors) in 2025/2026 to support recovery will be reviewed to ensure value for money • Ongoing validation of the trust waiting lists to improve data quality • All performance activity monitored through weekly performance review group (PRG) • FOP Platform launched to support effective theatre scheduling • Overnight capacity on ward B4 at Halton planned to open October 25 will take pressure from the Warrington site and support elective recovery **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 GPs to inform them with recovery progress within the organisation and to highlight/address any identified problems. • Participation in the national 'My Planned Care' scheme to support and inform patient waiting time status and support safe management of waiting lists • Productivity Improvement Oversight Group (from May 2024) in place to deliver the GIRFT/Efficiency programme to increase theatre and outpatient productivity and utilisation • Endoscopy Hub is operational to provide additional capacity to WHH and C&M patients • CDC phase 1 gone live in July 2023. CDC phase 2 including CT & MRI opened in June 2025 CDC phase is underway • Trust Board support for additional use of independent sector to reduce waiting times. Monthly reporting to the Finance and Sustainability Committee.
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 • There are a number of Fragile services that require further support

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

Board Assurance Framework

Risk ID	134	**Executive Lead:**	Chief Finance Officer	**Rating**	
Strategic Objective	**Strategic Objective 3:** We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton			**Initial:**	20 (L5xC4)
				Current:	20 (L5xC4)
				Target:	12 (L4xC3)
CQC Domain(s)	**Well-Led**				
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Assurance Details	**Controls** •Core financial policies controls in place across the Trust •Finance and Sustainability Committee (FSC), Financial Resources Group (FRG) and Capital Planning Group (CPG) oversee financial planning • Procurement/tender waiver training in place • Latest guidance from MIAA Counter Fraud Team circulated • Counter Fraud campaign took place for national anti-fraud week 18/11/25 • Revised approach to GIRFT/ improvement/ CIP. Leadership from Executive Medical Director and joint reporting to FSC embedded. • Appointed GIRFT Finance Lead Head of Improvement • Financial strategy developed to support improvement in financial sustainability. 2022-2027 Financial Strategy approved by the Trust Board in May 2022 • High Level 5-year plan presented to the Finance & Sustainability Committee in April 2024, High level 4-year plan shared with PWC, Chair and CEO. The 4-year plan was reviewed. Further developed at the Exec Away Day September 2025 • Capital Plan for 2025/26 approved at 2 April 2025 Trust Board meeting. • Operational Plan approved by Trust Board 28.04.2025 • Introduced system of escalation where there are risks to CIP delivery • Process embedded that any new revenue spend must be submitted to the Executive Team and/or Trust Board for approval as appropriate. Approval will only be provided if it is self-funding or relating to patient/staff safety and consideration whether CIP has been fully identified. • In addition, new revenue spends to support activity targets is approved by Executives/ Trust Board only when the cost does not exceed tariff, all internal options have been considered (WLI, productivity) and no mutual aid is available • Introduced process for oversight of unfunded and partially funded cost pressures via routine reporting to the Executive Team and the FSC with Deep Dive at FSC on highest cost • Tightening controls of non-pay expenditure with executive review of non-catalogue spend and implemented cease option to purchase some items • Cash Support received for 2024/25 was £12.145m and £19.2m YTD 2025/26 • Enhanced ECF meetings in place with Chief Executive sign off, with ICS invited. Bridgewater Community Healthcare NHS FT in attendance. • Urgent & Emergency Care System Improvement (UECSIP) Lead with Place support • Introduced system of escalation where capital paperwork has not been produced by Q1 • Monthly review of non-recurrent CIP and move to recurrent if possible				

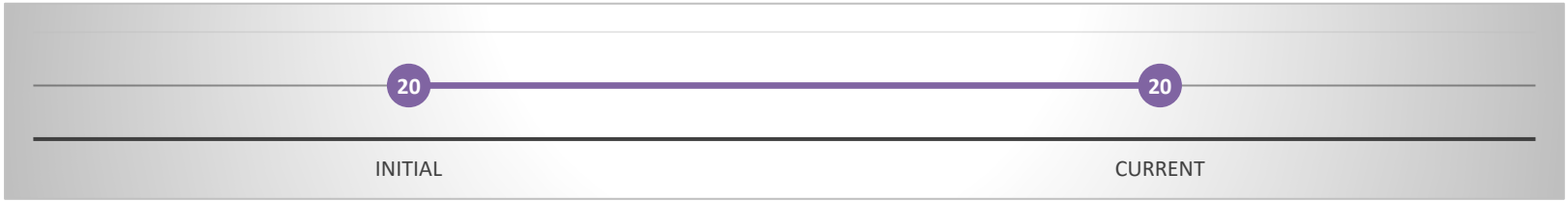
	• Fortnightly Executive led meeting to monitor spend on WLI/ Insourcing/ LLP to support 65- & 52-Week recovery. • 2024/25 Phase 2 PWC final report signed off, recommendations actioned and monitored each has an Exec lead and PID. • 2024/25 received high assurance for general ledger, accounts receivable, accounts payable, treasury management, with no recommendations to implement • Implemented reduction in bank rates 13/01/25, reducing exp circa £700k p.m and to bottom of scale 01.05.25 • Daily cash flow + 12 month forecast in place to manage cash • Delivery Unit Set Up - Delivery Unit Oversight Groups established, comprising the Delivery Unit Workforce (DUW), Delivery Unit Non-Pay (DUNP) and Delivery Unit Productivity (DUP), to provide robust oversight, challenge, and accountability for key financial and operational workstreams with focus on workforce pay, non-pay expenditure, and productivity improvements. **Assurances** • The 2024/25 position was £16.8m deficit which was in line with the forecast and £5.5m off plan. The Trust has highlighted the level of risk throughout the year. • Delivered 2023/24 and 2024/25 Capital Plans • Unqualified audit opinion (2024/25) submitted on time • Completed MIAA Governance Checklist received by Audit Committee • Monthly Report to Executive Team Meeting and FRG highlights the number of retrospective waivers compared to the previous year, the number of staff trained and the number of staff who have received training but not followed the correct process. • Refresher training offered to those who undertook training over 12 months ago but then submitted a retrospective waiver • Capital is reported monthly to FSC detailing all schemes above £500k monitoring underspends against plan and expected end date. This is in line with MIAA recommendations. • Changes to WTE have been reviewed by the Finance & Sustainability Committee during the year and the Trust has seen a significant reduction in agency and bank staff. The 2025/26 challenge is to reduce agency by 30% and bank by 10%. Agency is achieving this target. Bank is slightly over due to IA costs and specialing. • C&M ICS have indicated that there should be a 4% reduction in staffing in the 2025/26 plan in line with the 5% CIP target • HFMA self-assessment completed and audited. • Richard Barker/Graham Urwin Letter re: financial controls received. All actions received by the Finance & Sustainability Committee and the Trust Board. Response has been provided. • Continue to work with the system through the Warrington System Sustainability Group and One Halton to support system priorities and long-term sustainability. • Key financial controls review 2024/25 received high assurance for accounts receivable, general ledgers and treasury management with no recommendations. • System-wide diagnostic undertaken to quantify the operational opportunities to improve UEC effectiveness and efficiency across Warrington & Halton to provide clarity of operational and financial opportunities and outcomes by organisation. • 2024/25 CIP £18.5m achieved of which £12.5m was the recurrent higher CIP achieved. At month 9 2025/26 CIP is on plan achieving £15.1m YTD • Operational Plan submitted in line with timetable. • Monthly reports to be submitted to the Finance & Sustainability Committee to review the cash position, plus request for cash support approved at Trust Board as required. • Replied to the National Team to confirm enhanced control for pay and non-pay are in place and adhered to in line with cash support requirements
Control & Assurance Gaps:	• Non-recurrent and unidentified CIP, and high-risk schemes, presents a risk to in-year and future year financial position. • No external funding support for Halton Healthy New Town or Warrington Hospital new build. • Risk of unforeseen costs and under delivery of activity and income due to further Industrial action / Acuity of patients / NCTR / growth in ED attendance • Availability of social care to support the current super stranded position (currently c22% of bed base). Estimated annual cost of circa £11m • Additional capacity opened across the Trust supported in part by non-recurrent funds. This presents a risk to sustainability as capacity is funded part year only • Additional capacity remained open in quarter 1 and closed in June 2025, capacity which should have closed mid-January remained open in March 2025 • Required to deliver additional activity within existing resources whereby funding will be lost if activity not delivered within PbR • Risk to financial freedoms as the Trust has a deficit plan & requires cash support • Achieving 104% of 19/20 in core capacity is key to delivery of GIRFT/ CIP • There is a risk that NHSE will not approve the cash request. Mitigations to this could include, using capital cash in the short term and delay of payments to creditors •Risk of over performance of activity which may not be paid due to cap on income and affordability • Risk finding for Industrial Action will not be given • Risk funding for integration will not be given • Risk delivery of the system wide (Level 3) CIP £13M • Risk of not receiving deficit support funding. The Trust received Q1 but Q2 and Q3 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

Improve Trusts position on No Criteria to reside	Trust to work with ICB regarding No Criteria to Reside	Discussions and planning with ICB to improve the position	DM	31/3/26	
Ensure activity /targets met	Produce and monitor dynamic activity / income plan to ensure activity /targets met	Produce and monitor dynamic activity / income plan	DM	31/3/26	
Cash monitoring and management in line with national and regional guidance	Cash monitoring and management continues in line with national and regional guidance	continue in line with national and regional guidance	JH	31/3/26	
Monitor all GIRFT CIP schemes	Delivery unit continues to monitor all GIRFT CIP schemes	Delivery unit continues to monitor all GIRFT CIP schemes	LC	31/3/26	
Further CIP schemes to mitigation Level 3 / Stretch gap, plus high risk BAU CIP	Work with PwC and ICB to develop further CIP schemes to mitigation Level 3 / Stretch gap plus high risk BAU CIP	Work with PwC and ICB to develop further CIP schemes to mitigation Level 3 / Stretch gap Work with Board to develop and assess further CIP schemes	JH	31/3/26	

Board Assurance Framework

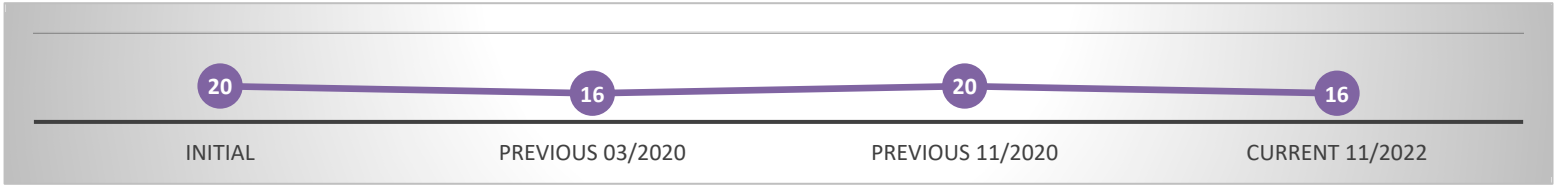
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID	2001	**Executive Lead**	Executive Medical Director	**Rating**	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description	If services remain fragile or the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.			**Initial**	20 (L5 xC4)
				Current	20 (L5xC4)
				Target	6 (L2 xC3)
Risk Appetite	**Minimal –** Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
CQC Domain(s)	**Safe, Responsive**				
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 • Cancer Services • Chronic Pain • Rheumatology **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 • Further assurance that WHH Fragile Service sustainabilty will be strengthened by C&M Fragile Services programme				

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

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID	1114	**Executive Lead**	Executive Medical Director	**Rating**	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.			**Initial**	20 (L5xC4)
				Current	16 (L4xC4)
				Target	8 (L2xC4)
CQC Domain(s)	**Well-Led**				
Risk Appetite	**Minimal –** Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Risk Movement					
Assurance Details	**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 ITHealth Assurance Dashboard is live, monthly external network penetration testing is now in place using NHS England's VMS service and BitSight security score is live. • Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. • Digital Services have implemented all national guidance regarding Log4J vulnerabilities highlighted by NHS Digital • WHHT return for assurance re cyber security to NHS England • Active core member C&M ICB Cyber Core Group, C&M ICB Cyber Security Group and the Cyber Associates Network (CAN) • Outcome of the third Phishing exercise by NHS England, communications have been sent out to staff members who entered details for awareness. • Digital Services uses several cyber threat intelligence services (C&M Cyber Group, NCSC, NHSE CSOC) • Audit on 3rd party vendor management by MIAA (waiting on audit report) • All servers and desktops are currently under Microsoft support, including extended support for Windows 10. **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 • Comply with NHS England high cyber alerts • Version 7 of Clinisys Ice has been upgraded to version 7.1.9 which is cyber secure
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	Migrate all 2003 and 2008 servers to 2016.	NICE guidance fully migrated by IT Services and the Communications Team.	Deacon, Stephen	30/06/25	31/07/25

longer provide security updates or technical support for these operating systems. Consequently, any server or system reliant on Windows Server 2003 and Windows Server 2008 (from Jan 2020) presents a cyber-security risk to the Trust. We either need to migrate or decommission the unsupported Windows Server 2003 and Windows Server 2008 to Windows 2016 (Latest server operating system).		Both servers now shutdown.			
Multifactor authorisation (MFA/PAM) review of Trust critical systems	NHS England reports that using Multi-Factor Authentication (MFA) can prevent or stop 80% of cyber attacks within 20 minutes. Reviewing critical Trust systems and implementing a PAM solution for WHH administrators and third-party vendors is recommended by NHS England's Data Security and Protection Toolkit (DSPT)	Objective: By 31 December 2025, integrate designated WHH system/network administrators and approved 3rd party vendors into the Privileged Access Management (PAM) system, ensuring all access to critical systems is protected with Multi-Factor Authentication (MFA). Specific Tasks & Owners: 1. Bid for ICB Funding – Digital Compliance, IT Services & Bridgewater Secure required capital for PAM procurement. Status: COMPLETE 2. Evaluate PAM Solutions – Digital Compliance, IT Services & Bridgewater Assess and select a suitable PAM product. Status: COMPLETE 3. Purchase PAM System – Procurement, Digital Compliance, IT Services & Bridgewater Acquire licenses and support. Status: COMPLETE 4. Install PAM System – IT Services Deploy system infrastructure and baseline configuration. Status: COMPLETE	Deacon, Stephen	31/03/2026	

		5. Configure Vendor Access (Phase 1) – Digital Compliance, IT Services Set up PAM access with MFA for 3rd party vendors. Status: IN PROGRESS 6. Configure WHH Admin Access (Phase 2) – Digital Compliance, IT Services Enforce PAM and MFA for all internal privileged users. Status: NOT STARTED Measurable Outcome: 100% of targeted WHH admins and approved vendors securely access critical systems via PAM with MFA by the target date Progress Tracking: 3rd Party Vendors added: - Autsco – CDC Nurse Call - DB Dental Equipment – Dental scanners - OBSBMS – Estates BMS systems - Solventum - Medicode WHH system and network administrators added: - To be completed after the vendors access			
Migrate Windows 10 to Windows 11	Upgrade Windows 10 to Windows 11 before October 2025, as security update support will end.	Objective: Complete the organisation-wide upgrade from Windows 10 to Windows 11 by 30 October 2025, ensuring compatibility with all critical systems and devices. Specific Tasks & Owners: 1. Internal Testing in IT Services – IT Services Validate Windows 11 functionality in a controlled environment. Status: COMPLETE	Waterfield, Tracie	14/10/2026	

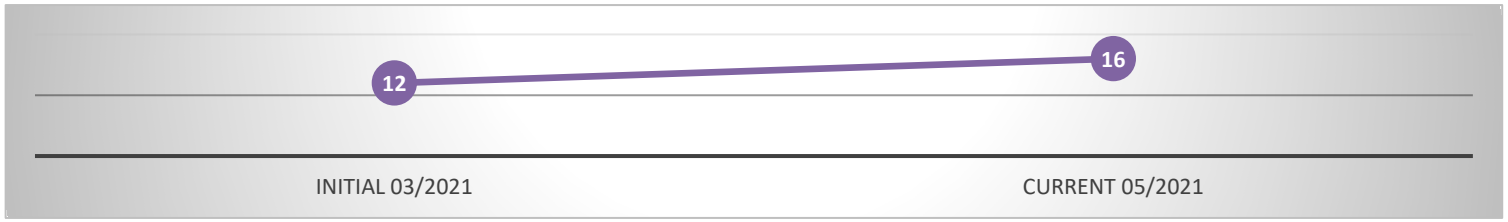
		2. Testing with Critical Systems – IT Services & Clinical/Business Application Owners Ensure compatibility with key operational systems. Status: COMPLETE 3. Rollout on New Devices – IT Services Deploy Windows 11 on newly procured hardware. Status: IN PROGRESS 4. Rollout on Rebuilt Devices – IT Services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

		Upgrade servers via an in-place upgrade or deploy new servers, then decommission the old servers. Status: IN PROGRESS 3. Plan and schedule complex server migrations – Server Team Upgrade servers via an in-place upgrade or deploy new servers, then decommission the old ones using vendor support when required. Status: IN PROGRESS Measurable Outcome: Upgrade completion rate reaches 100% by the 30 October 2026. Progress Tracking: Current progress is 65% complete.			
Removal of generic Window accounts	While generic accounts can simplify workflows for clinical staff, they pose security risks. Eliminating these accounts is essential, as their lack of individual ownership makes tracking activity difficult and increases the risk of data breaches or unauthorised access.	Objective: While generic accounts can simplify workflows for clinical staff, they pose security risks. Eliminating these accounts is essential, as their lack of individual ownership makes tracking activity difficult and increases the risk of data breaches or unauthorised access. Specific Tasks & Owners: 1. Clinical Safety Risk Assessment – CNIO, Digital Compliance, IT Services & Head of Information Review the existing and planned processes to assess potential risks, estimate user logon time with the new process, and determine the scope of the task. Status: COMPLETED 2. Plan for removal of generic accounts – IT Services Develop a plan for the removal of generic accounts. Status: STARTED	Waterfield, Tracie	31/03/26	

		3. Approval of plan via Change Advisory Group (CAG) – IT Services & Change Control Approval required for the plan to removal of generic accounts by CAG. Status: NOT STARTED 4. Implement the plan - IT Services Implement the plan for the removal of generic accounts. Status: NOT STARTED Measurable Outcome: All safe-to-remove generic accounts have been removed and users using their own accounts. Progress Tracking: The meeting proceeded with the proposal to trial the reduction of generic accounts on a single ward. The suggested ward, deemed least impacted, is Forget Me Not. All potential technical barriers to limiting generic accounts were reviewed during the discussion at the Digital Managers Huddle. To minimise disruption during out-of-hours operations, it was agreed that one generic account per ward will remain in place, with passwords changed regularly. The Head of Digital Compliance will engage with the CNIO regarding this recommendation. A slide was issued to team brief to communicate the intention to remove generic accounts.			
Mitigate the unsupported software used in BadgerNet	BadgerNet products have been discovered to have 2 3rd party components used within BadgerNet that no longer under support from their vendors. They have made NHS England and the National Chief Midwifery Information Officer	The BadgerNet v70 upgrade is scheduled for release on 15th July 2025. The Maternity department will submit a change control request to	Deacon, Stephen	24/07/25	24/06/25

	(CMdIO) team aware and provided a mitigation plan.	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.	No longer required as we have purchased the extended cover from a different fund.	Whitfield, Simon	31/10/25	31/10/25

Board Assurance Framework

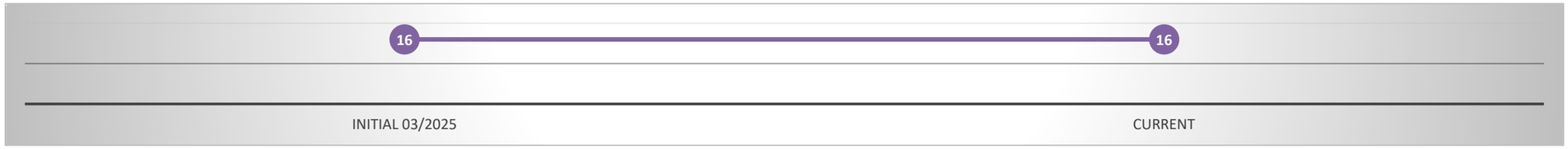
Risk ID	1372	**Executive Lead**	Executive Medical Director	**Rating**	
Strategic Objective	**Strategic Objective 3:** We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description	If the Trust is unable to procure a new Electronic Patient Record then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and a risk to patient safety			**Initial**	12 (L3 xC4)
				Current	16 (L4xC4)
				Target	8 (L2 xC4)
CQC Domain(s)	**Safe and Effective**				
Risk Appetite	**Cautious –** Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Risk Movement					
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 single instance relaunch with partner Trust. • Legal advice confirms that a single host contract is necessary to support and govern the single-instance model. • Program Governance and PMO function refreshed and improved following lessons learnt exercise • EPR project group and joint Programme Executive Board (PEB) have oversight on state of readiness for deployment and associated risks • Plan in place to mitigate for potential coterminous implementation of LIMS – January 2025 • PME to be launched January 2026 **Controls:** • Working with incumbant EPR vendor to extend contract for 2.5 years in support of time required to complete the procurement and deployment of a new EPR • Trust financial modelling includes 2.5 -year extension Lorenzo costs • ICB Executive Leads and FD program supportive of single instance in partnership with Merseyside and West Lancs NHS Trust – with output based specification (OBS) and pre procurement evaluation criteria complying with single instance guidance. • Program Director appointed • Financial modelling of realistic options to provide genuine 5, 10 and 15 year options to control whole life costs • Partnership procurement will lead to identification of further realistic cash releasing / cost reduction benefits • The collaboration agreement has been developed and endorsed by EMT and Board • Approach to standard clinical pathways and single instance architecture agreed wih FD team				
Assurance Gaps	**Gaps In Assurance** • FD convergence guidance remains a potential risk – though agreement of a single instance architecture with multiple tenants with FD has largely mitigated this • Complexity of coterminus LIMS implentation presents an emerging risk which requires a mitigating plan • FD now require a single OBC and FBC for EPRIB and Cabinet Office approval • Frontline Digitisation will conclude on 31 March 2026. Following this, the Trust will be able to apply to the Frontline Productivity Fund to secure the remaining funds required for the project. • Requirement for single contract pushing PME to January 2026				

Board Assurance Framework

	Gaps In Controls • Lorenzo is at end of life and is unlikely to see significant future development or enhancements • Delay to procurement has push implementation date past Lorenzo contract and Lorenzo sunsetting date requiring 2.5 year extension increasing the costs these costs will be formulised Q4 2025/26 • Phasing of frontline Digitisation Funding and funding availability the Trust will have to rebid for remaining funding from new funding programme Frontline Productivity to complete the project • 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 Planning to launch the PME in January 2026, with OBC development running in parallel. The Investment Agreement (IA) has been submitted to NHSE and we are currently awaiting feedback. Current Frontline Digitisation funding is due to expire in March 2026 . A new funding scheme Frontline Productivity will be available for the Trust to further bid for EPR and other digital initiative aligning with the 10 Yr plan	Poulter, Tom	30/11/25 March 2026	

Board Assurance Framework

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

Control & Assurance Details

Controls

- Annual capital funding is allocated for mandated and statutory estates projects.
- Estates team manages Planned Maintenance (PPM) and reactive maintenance through CAFMS.
- Six Facet survey annually assesses estate conditions, informing backlog maintenance priorities.
- The 10-year planned maintenance capital program is updated yearly based on the Six Facet survey and completed works.
- Effective clinical networking and partnerships are in place.
- Full delivery of the TIF (elective) programme due to complete in 2024/25, which includes £9m investment to provide 2 new operating theatres, an Endoscopy Room and Elective ward capacity.
- Full Business Case (FBC) for Pathology Hub to be created with MWL to be presented to the Trust Board in Quarter 1 2025/26
- CSPO participates in Runcorn and Warrington Town Deal Boards, overseeing £50m in regeneration funds.
- Living Well Hub funded via Warrington Town Deal fund led by WHH opened in March 2024
- Runcorn Health & Education Hub funded by the Runcorn Town Deal led by WHH due to open in Quarter 1 2026/27.
- Strategy refresh for 2026/27 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.
- Bids recently submitted to UEC fund and CIR fund.
- Work on phased estates plan and clinical strategy commenced.

Assurances

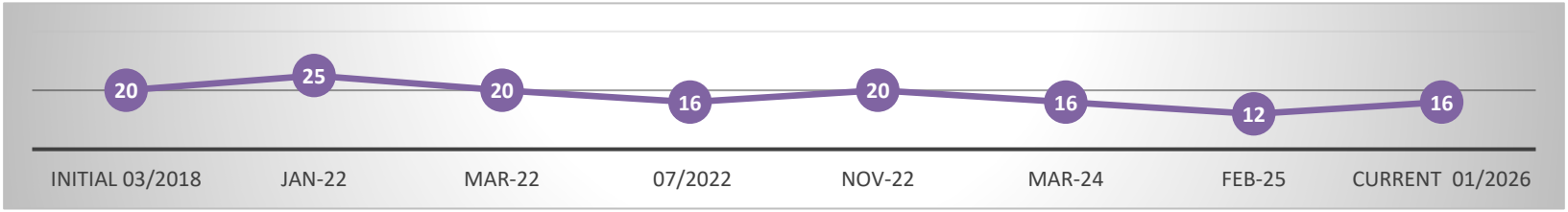
- 3 Phase CDC funded nationally due to complete in June 2025. CDC Phase 2 opened in December 2023, including ultrasound, spirometry, sleep studies, audiology, and phlebotomy services at Halton Health Hub. CDC Phase 3 (including CT and MRI) opened in June 2025.
- Regular meetings through Capital Planning 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, hub opened.

Board Assurance Framework

	• Strategic and Collaborative Efforts - Regular strategy updates are provided to the Council of Governors and Trust Board.
Assurance Gaps	**Funding and Financial Challenges** • **Unsuccessful NHP Phase 3 Funding:** The Trust was unsuccessful in securing funding via the NHS Phase 3, which is a major setback for completing the development of the phased new hospital plan, with funding for a new hospital unlikely before 2040. • **Limited Capital Funding:** There is a lack of sufficient capital funding nationally to address the full backlog, which delays and limits key infrastructure and maintenance projects. • **Unfunded Maintenance Costs:** Unforeseen and emergency maintenance costs continue to be a significant burden on the income and expenditure (I&E) budget, making it harder to stay on top of all required maintenance and upgrades. • **Cost Pressures on Capital Schemes:** The process to obtain full design costs for capital schemes is lengthy, and with the uncertain market conditions, this adds additional pressure on project timelines and costs. • Trust allocates depreciation generated capital funds to mandated and statutory estates projects and is therefore reliant on external funding via bids for strategic development. **Staffing and Resource Constraints -** Staffing shortages further exacerbated by the requirement to meet non-clinical Cost Improvement Program (CIP) targets, adding strain to already stretched resources. **Operational and Infrastructure Issues -** Some equipment is difficult or impossible to access for maintenance due to age and design, and the absence of a permanent decant ward complicates this further, particularly for ongoing repairs or upgrades. **Governance Development at Place Level:** Self-assessments indicate that Halton is in the early stages of its place-based governance development, while Warrington is more established. There is a need for further development to ensure that both boroughs can benefit from potential future autonomy

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Phased redevelopment plan	Develop phased redevelopment plan with support from architects and cost advisors	Funding reallocation supported by Trust Board. Formally reallocate funding via CPG and FSC. Commission/appoint team to develop plan. Awaiting release of funding prior to commencing work Project manager post to support phased redevelopment plan approved at executive EC panel and will be advertised in September 25. Post appointed to fixed term, work commenced November 2025	Lucy Gardner	31/12/2026	
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	Complete

Board Assurance Framework

Risk ID	115	**Executive Lead**	Chief Nurse	**Rating**	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description:	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.			**Initial**	20 (L5xC4)
				Current	16 (L4xC4)
				Target	8 (L2xC4)
CQC Domain(s)	**Safe and Caring**				
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. • Daily audit of gold command and safecare compliance to monitor completion of twice daily acuity scores and the adding of professional judgement, gaps highlighted weekly to the Senior Nursing Team. • Temporary staffing requested via NHS Professionals, process in place to fill shifts via bank prior to escalation to agency with authorisation only by Chief Nurse, Deputy Chief Nurse or Associate Chief Nurse for Corporate Nursing. • 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 the remaining areas with outstanding vacancy. • Open advert for RN/HCSW recruitment • Sickness absence being manged in line with Trust policy. • Weekly review of bank use/staffing challenges by Chief Nurse/ Deputy Chief Nurse/Director of Governance • Gant Chart mapping projections of Maternity Leave and Supernumerary Staff with the information taken from E Roster. • Twice daily Acuity Recording on Safe Care **Assurances** • Increase in registered nursing establishment in the Emergency Department, November 2024. Ongoing recruitment, with regular shortlisting and interviews which has reduced band 5 vacancy rate to 32.74 WTE. • Since April 2025 ED has recruited 30 registered nurses. • Nursing: Overall Registered Nurse vacancy for November 2025 is 8.35% which is below the Trust benchmark of 9%				

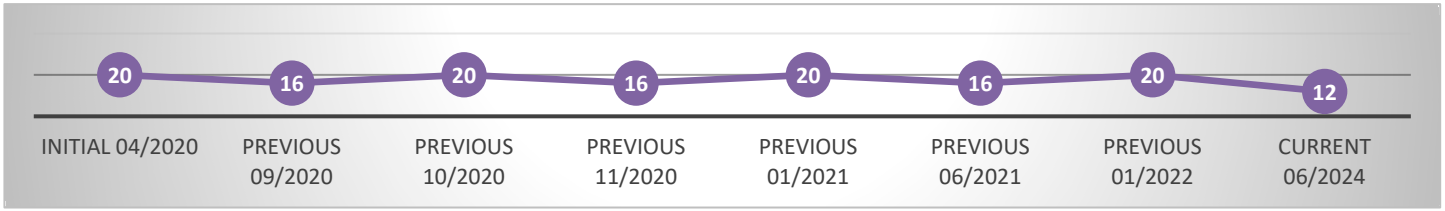
	• Since April 2025 the average Overall CHPPD has been 7.5 • Overall Healthcare Support Worker vacancy for November is 14,20% which is above the Trust benchmark of 9% • There is ongoing recruitment with regular shortlisting and interviews for both Registered and Unregistered staff. • Support and guidance to student nurses from the beginning of their training to qualifying through the STEPP programme. • CSWD 5 cohorts of 15 CSWDs will be deployed throughout 2025 with 15 commencing their 6-month training programme within the Trust in January 2026 • 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 • 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. • In September 2025,15 wards achieved the 90% fill rate on day shifts and 23 ward achieved 90 % fill rates on nights
Assurance Gaps	• Increased operational capacity and demand results in the need to open additional areas to provide patient care, increasing the staffing need e.g. Treatment/MDT rooms on B14, B18 & A4; accelerated transfers and boarding out of hours – there were 297 escalated beds during October 2025 this increased to 312 in November 2025 • Increased requests to provide enhanced care. • Necessity to consistently use Temporary Escalation Spaces with up to 2 extra patients and to ensure safety is maintained • The winter of ward A10 closed in June 2025 and was utilised for one week in August 2025 for escalation. Ward A10 re-opened 2 November 2025 for escalation as part of the winter plan and closed on 22 December 2025. Discharge Lounge is bedded overnight when required with patients being discharged the following day to support flow. • Time to post when recruiting new staff. • There were 610 Red Flags reported in October 2025, and this decreased to 569 reported in November 2025- Red Flags were linked to escalation areas and enhanced care • In Quarter 3 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. • Increase in paediatric ED staffing gaps in Q3 2025 due to vacancies and sickness, requirement to use paediatric ward staffing to maintain safety

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Recruitment	Continued recruitment into registered and unregistered vacancy	• Completion of the local vacancy tracker • Rolling adverts for both registered & unregistered staff with regular shortlisting & interviews • Monthly meetings with ward managers to support their recruitment & ward managers part of the interview panels • Attendance to all student nurse engagement sessions to support to qualifying & employment	• Deborah Hatton – Lead Nurse for Nurse Staffing • Lisa Miles – Workforce Improvement Lead	March 2026	

		• Support flexible working, job share & substantive posts for maternity cover			
Student Nurse Associate (SNA) Programme	Continued support to the SNA programme and 4 places per cohort	Support recruitment to each cohort and placement of SNA's and RNA's	• Jennie Shearn - Practice Education Facilitator (PEF) • Deborah Hatton - Lead Nurse for Nurse Staffing • Lisa Miles - Workforce Improvement Lead	March 2026	
NHSP Care Support Worker Development Programme (CSWD)	Continued support of the NHSP CSWD Programme	• Allocation of each cohort into unregistered vacancy • Support to CSWD's at the end of programme into Trust vacancy	• Charlotte Plant - NHSP • Deborah Hatton - Lead Nurse for Nurse Staffing • Lisa Miles - Workforce Improvement Lead	January 2026	
Transfer process	Promote Trust transfer process to aid turnover/leavers	• Continue to share and support the Trust's internal transfer process	• Deborah Hatton - Lead Nurse for Nurse Staffing • Lisa Miles - Workforce Improvement Lead	March 2026	
Over recruitment	Support the over recruitment process	• Review leaver & turnover data & set over recruitment targets for each CBU • Support flexible working, job share & substantive posts for maternity cover	• Deborah Hatton - Lead Nurse for Nurse Staffing • Lisa Miles - Workforce Improvement Lead	December 2026	

Preference rostering	Roll out of preference rostering	• Continue to roll out preference rostering to all areas • Submit Charitable Funding Bid for additional staff to support timely roll out of the project	• Adam Harrison-Moran • Associate Chief People Officer: Strategic Workforce Development & Culture • Nikki Chesters - E Rostering Team • Deborah Hatton - Lead Nurse for Nurse Staffing • Lisa Miles - Workforce Improvement Lead	March 2026	

Board Assurance Framework

Risk ID	1134	**Executive Lead**	Chief People Officer	**Rating**	
Strategic Objective	**Strategic Objective 2:** We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.				
Risk Description	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff			**Initial**	20 (L4xC5)
				Current	12 (L3xC4)
				Target	8 (L2xC4)
CQC Domain(s)	Caring and Safe				
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Control & Assurance Details	**Sickness Absence** The rolling 12-month sickness absence rate is 6.16% as at December 2025 and is showing a slight decrease from October 2025 (6.19%). Trust target from April 2025 is 5% as approved by the Strategic People Committee following a benchmaking exercise across the C&M region and consideration of health inequalities in the community we recruit staff from. **Controls** • Supporting Attendance Policy implemented in February 2022 and reviewed post 6 months implementation, updated policy implemented April 2023. Review of Supporting Attendance Policy and processes in progress August 2025 taking into account benchmarking the policy and best practice. • Supporting Attendance clinics held in partnership with HR Business Partners and CBU areas to provide an overview of policy, associated paperwork and interventions to support managers. • Support continues within areas of high sickness and low compliance WBC figures. Providing coaching support to managers, compliance audits and communication campaigns focusing on staff to ensure they have a WBC so their wellbeing is supported. • Occupational Health and Wellbeing triangulation meetings with HR colleagues to review and progress individual cases under the formal stages Supporting Attendance Management. • Focused welcome back conversation recording and internal audit • Following an MIAA Audit, the HR team have worked with CBUs to develop an audit framework to provide greater assurance regarding compliance with the Supporting Attendance policy by managers. • Sickness absence, turnover and attraction workstreams have been reviewed in line with the ICB letter and action plans updated to ensure all actions from the letter have been considered. • New stage 3 absence process has been successfully piloted to provide a compassionate and dignified exit out of the organisation on the grounds of ill health capability. Review of absence data by OH to ensure all relevant cases have been referred to OH. • There is a regional and executive-level call to action initiated in May. The 'Improving Attendance Together' initiative is a strategic response to reduce sickness absence by 1%. Led by the People Directorate, it addresses persistent high absence impacting teams, care, and budgets. It is a strategic priority for the Board and part of the People Plan. Due to high and persistent sickness absence across the Trust and the pressure absence places on teams, patient care, and financial resources. • The WHH Improving Attendance Plan aims to foster a supportive and healthy work environment that encourages staff to maintain their well-being and attendance. This initiative is designed to address the challenges of absenteeism and promote a culture where employees feel valued and motivated to be present at work. Objectives of the programme are as follows:				

Board Assurance Framework

	• **Enhance Employee Well-being:** To embed a systematic and compassionate approach to health and wellbeing. • **Reduce Absenteeism:** To demonstrate clear grip and control over staff absence trends and interventions and ensure compliance with regulatory, financial and operational obligations • **Promote a Positive Work Culture:** To enable Board-level scrutiny and accountability on staff experience and productivity where employees feel appreciated and motivated to attend work regularly. • Improving attendance action plan summary: • Promoting Health and Wellbeing: Mental health responders, wellbeing champions, physiotherapy, OH services. • Absence Management: Data deep dives, reduction targets, review of dashboards, intervention packages. • Training: Stress risk assessments, OH referrals, leadership modules. • Support Mechanisms: Culture of belonging phased return, redeployment. • Policy Review: Compassionate language, updated triggers, alternative leave options. • WHH Chief People Officer has agreed to be SRO for a regional C&M led reducing sickness absence policy and WHH Chief Finance Officer has agreed to provide the financial overview and scrutiny of the regional project. Actions to date: • A project plan with key milestones is under development • A data gathering exercise is underway focusing on absence data, reasons, policy and interventions **Assurance** • The Trusts wellbeing offers continue to be well utilised, supporting people to remain in work. The Trust has received national recognition from NHS Employers for our Check In Conversation, and local recognition for our Health and Wellbeing Hub. • The Trust has benchmarked itself against the NHS Wellbeing Framework and benchmarks well, with minor areas for improvement, being picked up through the Improving Attendance Task and Finish group. • The Trust has seen a significant improvement in long term sickness absence rates since the full implementation and transition on to the new Supporting Attendance policy reducing from 4.39% in April 2022 to 3.16 % in December 2025. An MDT review in collaboration with HR and OH to review all long term sickness absence cases over 100 days continues to ensure absences are being managed in accrodance with Trust policy and that a plan is in place to welcome the individual back to work or exit the organisation. • Pro-active health interventions offered to support staff to remain well including cardiac clinic and wellbeing day with referrals to smoking cessation, G.P.'s and counsellors as appropriate. Well attended by staff. • Deep dive focus into Nursing and Midwifery sickness absence currently taking place due to rates being higher according to Model Hospital data. • HR and OH identifying areas with high sickness absence, and target interventions, such as specialist OH support for leaders. • Welcome Back Conversations annual compliance was 89.41% in December 2025. **Turnover and Attraction** • Turnover in December 2025 remains below the limit of 13% at 11.58%, a 1% decrease from the figure reported in February 2025. Turnover of permanent staff in December 2025 was 10.87%. • Retirements, relocation work/life balance remain the main reason for leaving. • The Trust's December 2025 vacancy rate is 6.05%, the Trust limit is 9%. **Controls** • Exit Interview process - collation and analysis of data captured enables themes to be identified and targeted actions implemented. This information is available on the Trust Workforce Information Dashboard for all managers to review. • Further review of the leavers process is underway with the development of a SOP for stay conversations and an options appraisal review of the current exit interview process. • Rugby League Cares have been supporting WHH since July 2021 and have been working in areas offering drop-in sessions and tailored programmes to support teams and individuals to keep well in workwith funding secured to continue with this programme. • Grief and Menopause cafes implemented to support individuals • Social media accounts have been created to support recruitment attraction across a number of social media platforms

Board Assurance Framework

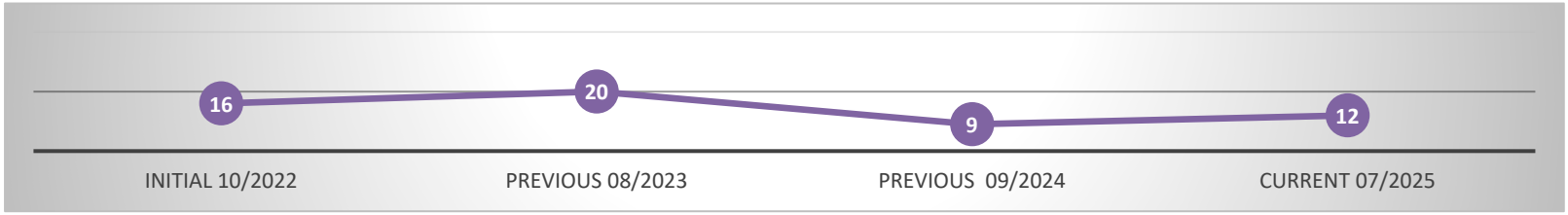
	• Financial wellbeing resources have been implemented to support the workforce and retention including Wagestream
	• A dedicated area to supporting Agile/Flexible working is available on the extranet, and as part of the culture plan, an improved approach to agile and flexible working has been lauched through the #MYFlex campagin which incldues two wards going live with preference rostering from Jan 2025.
	• Implementation of VCP panels throughout the organisation ensuring vigorous scruitiny of vacancies across the Trust. Promoting internal recruitment and secondment opportunities and also collaborative ring fenced opportunites for Bridgewarer staff and vice versa.
	• To support with attraction, the Trust has adopted a coordinated approach to recruitment which has included:
	  • Enhanced HCA recruitment events
	  • Investment in TRAC (Recruitment system)
	  • Enhanced Student Nurse recruitment
	  • Enhanced wellbeing benefits package (financial and mental)
	  • Improvements in agile/flexible working
	  • Enhanced retirement support/offers
	Widening Participation Team well established to support attraction from the wider community into different roles at the Trust as well as supporting apprenticeships to support staff development and retention.
	
	Assurances
	• The Trusts wellbeing offers continue to be well utilised, supporting people to remain at WHH.
	• As a result of analysis of exit interviews, a theme identified was working hours and flexible working. #MYFlex campaign has been launched with a central recording of flexible working requests enabling greater understanding/scrunity.
	• The responses to Exit Interviews are positive, only 11.98% as at December 2025 of questions answered are negative, with looking forward to going to work receiving the highest proportion of negative responses.
	• Staff completing apprenticeships is above the 2.3% target.
	
	Temporary Staffing and Agency spend
	Bank and Agency reliance in December 2025 is 10.48% . The Trust limit is 9%. Bank reliance is 7.44% and agency reliance is 1.55%.
	
	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:
	  ○ VCP process for non-clinical vacancies, overtime and medical agency.
	• NHSP bank rates have reduced to the bottom of the banding pay scale and all other AFC bank rates will be mirroring this apporach from Oct-25.
	• Medical bank rate card was implemented in Oct-24 and alongside a rate escaltion SOP, which is currently under review to ensure it is algined to the C&M approach.
	• Top earning workers, are reported to the care groups monthly, so enable mitigation plans to be developed.
	
	Assurances
	• Compliance against our processes and rate cards is monitored through the Finance and Sustainability Committee
	• To support agency controls, a refined VCP process has been introduced.
	• Compliance with Job Planning, Rostering Levels of Attainment and Workforce Reporting against the nationally expected standards have been shared with Executives.

Assurance Gaps	• Sickness absence continues to be above target. It is demonstrating no significant change. This is reflective of sickness absence regionally. • Bank and agency reliance continues to be above target and is demonstrating no significant change. • Lack of assurance regarding reduction of unplanned bed capacity which impacts temporary staffing and agency spend. • Exit interview completion rates are low, currently reviewing process to improve completion rates.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Delivery of an Improving Attendance action plan	Establish a range of actions to address gaps in the Trusts approach	• Development of an evidence-based actin plan to inform	Laura Hilton	31/03/2026	

	to managing absence and improving attendance. Actions will range from quick wins to long term actions; the full action plan can be made available as evidence.	system and process improvements. • Development of actions to support the improvement of the Trusts wellbeing offer. • Develop actions to attempt to address the limitations of the current systems in use to manage absence (ESR and E-Rostering).			
Benchmark WHH against the NHS Wellbeing Framework and refine the Trusts Wellbeing offer.	Completion of the NHS Wellbeing Framework to inform refining the WHH Wellbeing offer.	• Complete the NHS Wellbeing Framework • Report findings to the Improving Attendance Task and Finish Group • Refine the Trusts Wellbeing offer following the benchmarking results. • Launch the refined Wellbeing Offer	Carl Roberts and Caroline Eardley	31/03/2026	
Launch a targeted attendance improvement approach.	Develop and launch a targeted approach to improving attendance in areas of high temporary staffing spend linked to sickness absence.	• Define the targeted areas, by reviewing temp staffing spend due to absence. • Engage an MDT to offer targeted support to the areas identified. The MDT will include, HR, OH, OD, Workforce Analysts and the Trust CPO. • The targeted approach will include a check and challenge with the CPO, deep dive into all absences within the areas to ensure the policy is being adhered too, piloting the e-WBC form and further analysis of all workforce KPIs to understand the wider culture.	Laura Hilton	31/12/2025	31/12/2025

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 2022-2025 • 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 Cheshire & Merseyside Rate Card to incentivise and secure adequate medical staffing during periods of medical IA. • IA Task and Finish group completed organisational preparedness for IA - policies and procedures ratified and FAQ documents 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 • Updated 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. • 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 did take place 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 2022-2025 industrial action has been embedded into Trust policy and planning for industrial action • Learning identified from the July 2025 experience will be embedded into any future instances of action, a debrief was carried out to capture the learning • Resident Doctor's industrial action took place 14th November – 19th November 2025 without safety incidents and with >93% activity delivered • Further round of Resident Doctor industrial action 17th December – 22nd December 2025 without safety incidents and with >95% activity delivered				

Board Assurance Framework

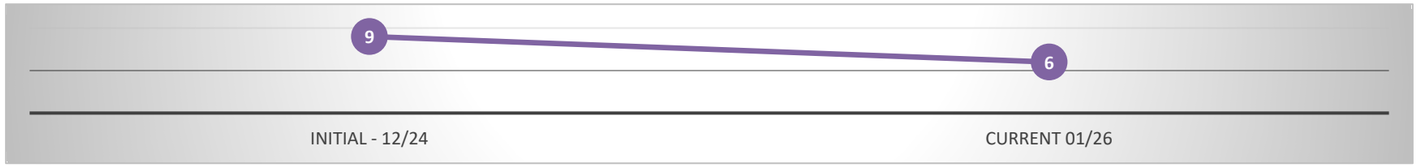
	• The Industrial Action Response Group was in place with five planning meetings ahead of the planned action, this group will continue to monitor the preparation for future rounds of action. • A robust Trust plan was shared ahead of the Resident Doctors Industrial Action. • Elective cancellations were approved by exception with sign off through the Director of Operations and Performance. • A debrief has been shared to capture any lessons identified and these will be embedded into future rounds of planning. • Services were asked to ensure any planned cover for the period of November action was sustainable and financial considerations were acknowledged.
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 further IA for Resident Doctors open till 2nd February (current strike mandate expires January 2026) • Ballot for FY1 closed on 6th October. 97% of respondents voted in favour of industrial action, with a 65% turnout indicating a mandate for action. • 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 • Financial implications of cancelled activity, mitigation plans and safe staffing plans • Currently there is no scheduled date for the next instance of industrial action and the current mandate for Resident Doctor IA expires in January 2026 – the next phase could possibly occur during a more significant period of winter pressure . Planning will be initiated once the notice has been received.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Monitor whether the trust is experiencing or aware of any forthcoming: • Industrial action or strike activity. • Ballots in progress or planned Other related actions which may impact service delivery	Continue to monitor the intelligence surrounding any industrial action that may impact services across the trust and within the ICS	Coordinate the Trust response to any planned industrial action	Paul Fitzsimmons, Executive Medical Director Supported by Rachel Clint, Head of EPRR	30/1/2026	
Use Trust standard operating policy to respond to any planned instance of industrial action	Embed learning from previous instances of industrial action to support planning for future events	Capture learning through the debrief process	Paul Fitzsimmons, Executive Medical Director Supported by Rachel Clint, Head of EPRR	30/1/2026	
Collaborate with Union Representatives and the people Directorate to plan for any workforce related challenges	Ensure there is collaborative planning as part of the Trust response to Industrial Action	Trade Union Representatives engaged as part of the planning process.	Paul Fitzsimmons, Executive Medical Director Supported by Rachel Clint, Head of EPRR	30/1/2026	

Board Assurance Framework

Take direction from ICB / NHS England	Where there is system, regional or national guidelines available, ensure these are acted upon. This includes the derogation of services and agreement on payment structures	Act on any communications or actions received via the ICB or SCC.	Paul Fitzsimmons, Executive Medical Director Supported by Rachel Clint, Head of EPRR	30/1/2026	

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. In addition, following the completion of due diligence work, there is an increased risk that previously unidentified financial, operational, or regulatory issues may remain unaddressed, then it could compromise the enlarged organisation's ability to deliver safe, effective, and sustainable services if integration does not proceed.			**Initial**	9 (L3 x C3)
				Current	6 (L2 x C3)
				Target	2 (L1 x C2)
CQC Domain(s)	**Well-Led**				
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Assurance Details	The integration programme- "Better Care Together" has been established. Each workstream has developed a delivery plan and is 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 on 1st April 2026. **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 • 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 • Draft FBC shared with both Boards for feedback • NHSE transaction amber rating received at strategic case stage • Full Business Case approved by both Boards				
Assurance Gaps					

Recommendation	**Action Description**	**Actions Required**	**Responsible Officer**	**Deadline Date**	**Completion Date**
Implement a more integrated governance structure to support timely and effective decision making	Develop, agree and implement a joint integrated governance structure	Develop, agree and implement a joint integrated governance structure.	John Culshaw	01.08.2025	Joint committees FSPCiC and SPCiC established, along with Joint Committee of the Board
Transaction to become a single organisation accelerated to 1st April 2026	Both Boards approved strategic case and accelerated transaction timeline July 25 FBC in development	FBC due diligence and NHSE review	Lucy Gardner	31.07.2025 FBC – 5.12.2025	Complete

Appendix 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk Appetite Statement

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

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

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

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

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

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

<u>Quality</u>
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.

<u>People</u>
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.

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

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

Regulation

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

Reputation

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

General Risk Appetite Principles

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

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

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

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

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/26/02/153**			
SUBJECT:	**Integrated Performance Report**			
DATE OF MEETING:	**4 February 2026**			
AUTHOR(S):	Janet Parker – Deputy Chief Finance Officer Andrew Hatfield – Performance and Systems Development Lead			
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons – Executive Medical Director Alison Kennah – Chief Nurse Michelle Cloney – Chief People Officer Jane Hurst – Chief Finance Officer Dan Moore – Chief Operating Officer and Deputy Chief Executive			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	ü		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	ü		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	ü		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): ***(Please DELETE as appropriate)***	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**
				ü
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				ü
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				ü
	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 **four indicators that are both failing and have special cause variation of a concerning nature**, these are: • **1. Open Incidents (over 40 days)** - Target 0% • **8. VTE Assessment** – Target 95% • **58. Capital Programme –** % delivered against plan • **59. Better Practice Payment Code –** % cumulative performance There are **two 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 **two indicators that consistently fail 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 Six of these metrics were also highlighted in the escalated metrics section at the October 2025 Trust Board meeting, and none have been removed from reporting. Two new metrics are Open Incidents (over 40 days) and VTE assessment. **Financial Position** At Month 9 the Trust has recorded a deficit position of £31.6m (before deficit support) which is £0.4m worse than plan due to the impact of integration costs. The Trust is currently forecasting deficit of £41.6m (£40.7m excluding the CIP risk adjustment) compared to an original plan excluding deficit support funding of £28.7m. The main drivers are the stretch CIP shortfall of £11.2m and the impact of integration of £0.8m. This is £0.5m better than the extrapolated year to date run rate of £42.1m. The Trust underlying deficit is £45.3m which includes some risk regarding non recurrent CIP.		
PURPOSE: ***(please select as appropriate)***	Approval ✓	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Note the changes to capital contingency as supported and approved by the Finance, Sustainability and Performance Committee in Common. 2. Note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance, Sustainability and Performance Committee in Common	
	Agenda Ref.	FSPCiC/26/01/178 (vi)	

	Date of meeting	26/01/2026
	Summary of Outcome	Changes to the capital contingency supported and approved.
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	AGENDA REF:	BM/26/02/153

1. BACKGROUND/CONTEXT

1.1 IPR Indicators

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

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

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

- Quality
- Access and Performance
- Workforce
- Finance and Sustainability

2. KEY ELEMENTS

2.1 Making Data Count Assurance and Variation Categories

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

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

Table 1: KPIs by Assurance and Variation Categories

	 Special Variation of a Concerning Nature	 Common Cause Variation	 Special Variation of an Improving Nature	 No SPC/Not Enough Datapoints/NA
 **Consistently Fails the Target (based on the last 7 months)**	**CONSISTENTLY FAILING TARGET & DECLINING PERFORMANCE** **Quality** 1.Incidents ↓ 8. VTE Assessment ↓ **Finance** 58. Capital Programme ***(£5.1m - £18.9m target)*** 59. Better Payment Practice Code ***(56% - 95% target)***	**CONSISTENTLY FAILING TARGET & VARYING PERFORMANCE** **Quality** 11. Medication Safety - Reconciliation within 24 hours 15. Complaints over 6 months 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 22. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1h of diagnosis ↓ 26. MUST nutritional assessment completion **Access & Performance** 27. A&E Wait Times - % patients waiting under 4 hours (including WUTC) 28. A&E Wait Times - % patients waiting under 4 hours (excluding WUTC) 29. A&E Wait Times – % patients waiting longer than 12 hours from arrival to admission, transfer, or discharge 31. Ambulance Handovers within 15 minutes 32. Ambulance Handovers within 30 minutes 33. Ambulance Handovers within 45 minutes 39. 28 Day Faster Cancer Diagnosis Standard 41. Cancer 62 Days First Treatment 51. Capped Theatre Utilisation **Workforce** 52. Supporting Attendance	**CONSISTENTLY FAILING TARGET & IMPROVING PERFORMANCE** **Access & Performance** 37. Referral to treatment Open Pathways ↑ 38. RTT - Number of patients waiting 52+ weeks ↑ **Workforce** 55. PDR compliance	**CONSISTENTLY FAILING TARGET & NO SPC** **Finance** 61. Cost Improvement Programme (recurrent forecast) – % delivered against plan 63. Bank Reduction

	INCONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE	**INCONSISTENTLY PASSING TARGET & VARYING PERFORMANCE**	**INCONSISTENTLY PASSING TARGET & IMPROVING PERFORMANCE**	**INCONSISTENTLY PASSING TARGET & NO SPC**
 **Inconsistently Passes/Fails the Target**	**Access & Performance** 45. Elective Outpatient Activity ↓	**Quality** 2.Healthcare Acquired Infections (MRSA) 4. Healthcare Acquired Infections (CDI) 5. Healthcare Acquired Infections (Ecoli) 6. Healthcare Acquired Infections (Klebsiella) 7. Healthcare Acquired Infections (PA) 9. Inpatient Falls & harm levels 10. Pressure Ulcers 23. Acute Kidney Injury 24. Maternity Postpartum Haemorrhage **Access & Performance** 35. Patients seen in the Fracture Clinic within 72 hours 50. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation	**Access & Performance** 36. Diagnostic Waiting Times 6 Weeks ↑	**Finance** 62. Agency Reduction
	CONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE	**CONSISTENTLY PASSING TARGET & VARYING PERFORMANCE**	**CONSISTENTLY PASSING TARGET & MAINTAINING/IMPROVING PERFORMANCE**	**CONSISTENTLY PASSING TARGET & NO SPC**
 **Consistently Passes the Target (based on the last 7 months)**		**Quality** 16. Friends and Family (Inpatients & Day cases) **Access & Performance** 40. Cancer 31 Days First Treatment 49. Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicator was in progress at the time of reporting. **Finance** 60. Cost Improvement Programme – In year performance to date (£m)	**Workforce** 53. Turnover 54. Core/Mandatory Training	
	NO ASSURANCE SPC &	**NO ASSURANCE SPC &**	**NO ASSURANCE SPC &**	**NO ASSURANCE SPC &**

	DECLINING PERFORMANCE	VARYING PERFORMANCE	IMPROVING PERFORMANCE	NO SPC
No SPC **No SPC/Not Enough Datapoints/Not Applicable**	**Quality** 13. Mortality ratio – HSMR 14. Mortality ratio - SHMI	**Quality** 3. Healthcare Acquired Infections (MSSA) 25. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT)) **Access & Performance** 30. Average time in department ED 34. Type 5 attendances 46. Super Stranded Patients 47. No Criteria to Reside (NCTR) 48. % Patients discharged to their usual place of residence	**Access & Performance** 42. Reduction in Outpatient Follow Ups	**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 December 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 unidentified system wide savings (£11.2m) (level 3 CIP).
- Delivery of the high risk CIP (£3.2m) from the level 1 & 2 CIP plan. This risk has reduced by £1m since the previous month, if financial performance continues the remaining £3.2m will be mitigated in year by month 12.
- Ability to mitigate risk in CIP plans has been reduced due to needing to use these schemes to offset the July Industrial Action and pay award costs in excess of plan due to additional funding not being received.
- Achieving the income plan through core capacity (improved productivity) and risk of overperformance not being funded.
- Receipt of deficit support funding.
- Cash level and ability to access revenue cash support.

These risks as well as the current level of non recurrent CIP (£8.4m equating to 39% full year) also present a challenge to future sustainability if they are not addressed.

The Trust is currently forecasting deficit of £41.6m (£40.7m excluding the CIP risk adjustment) compared to an original plan excluding deficit support funding of £28.7m. The main drivers are the stretch CIP shortfall of £11.2m and the impact of integration of £0.8m. This is £0.5m better than the extrapolated year to date run rate of £42.1m.

The Trust underlying deficit is £45.3m which includes some risk regarding non recurrent CIP. This assumes that the 2025/26 non-recurrent CIPs are mitigated by the full year effect of the part year recurrent CIPs, which is a significant risk to the current plan.

Cash

The cash balance at the end of October is £13m of which £5.4m relates to capital creditors. Given the current cash position and the planned deficit for 2025/26 the Trust approved a cash drawdown of £13.237m for Q4, of which £3.317m was received in January. Funding for Industrial Action is expected in February which will reduce the drawdown required therefore remaining within the Board approved amount.

Increased cash management measures continue in line with NHSE guidance. As a result, BPPC remains low (56% against a target of 95%, 88% cumulative position in March 2025). Cash days are at 12 days which is a deterioration from last month (13

days) due to a higher number of overdue invoices requiring payment. This is also a reduction from April 2025 (18 days) due to the decreasing cash balance.

CIP

At 31 December 2025, the Trust has delivered a CIP of £15.1m which is £20k better than plan. However, it should be noted that £7.9m has been achieved from non-recurrent vacancies and central items.

Full year CIP plans of £21.5m have been identified against the £21.5m CIP target. Of the £21.5m identified £8.4m 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 and turn current non-recurrent schemes recurrent. Providing the full year effect of schemes delivering later in the year deliver this would mitigate the non-recurrent schemes into 2026/27.

In addition to the £21.5m CIP, there is a £13.1m target relating to stretch CIP schemes. To date there are plans to deliver £1.25m against the revenue to capital part of the target and £0.5m against the PDC dividend charge part of the target. Work continues at Executive and Board level to support delivery of this CIP target with a long list of difficult decisions being worked through to determine any additional savings above what is required to deliver the BAU CIP.

Capital Programme

The Trust total capital funding consists of £12.44m Capital Departmental Expenditure Limit (CDEL) and £10.71m external funding, a total of £23.15m. The Trust also has £1.49m IFRS16 CDEL.

The Trust capital spend for month 9 is £5.1m which is £13.81m below the plan of £18.91m. This is mainly driven by EPR delays, ward refurbishment paused and replaced with smaller schemes, 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 9		**120**
Proposed changes in month		
Previously supported addendum no longer required		
Appleton Ventilation – Theatre Recovery		**75**
Requests supported at CPG		
Cardiac Catheter Suite replacement trolleys	- 23	
Haematology and Biochemistry Centrifuge	- 16	
Osmometer analyser	- 17	
Sub Total		**- 56**
Emergency schemes:		
Nurse call bells TES	- 35	
Nurse call bells A4	- 19	
Sub Total		**- 54**
Contingency as at end of month 9		**85**

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. Note the changes to capital contingency as supported and approved by the Finance, Sustainability and Performance Committee in Common.
2. Note the contents of this report.

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

- Special Cause Variation of a improving nature.
- Common Cause (Normal Variation).
- Special Cause Variation of a concerning nature.
- Consistently passes the target
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		Latest				Previous		
	QUALITY	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	**Assurance**
1	Incidents	0	84	Dec-25		36	Nov-25	
2	Healthcare Acquired Infections (MRSA)	0 (for 2025/26)	0	Dec-25		0	Nov-25	
3	Healthcare Acquired Infections (MSSA)	no threshold set	4	Dec-25		0	Nov-25	No SPC
4	Healthcare Acquired Infections (CDI)	60 (for 2025/26)	5	Dec-25		8	Nov-25	
5	Healthcare Acquired Infections (Ecoli)	79 (for 2025/26)	0	Dec-25		7	Nov-25	
6	Healthcare Acquired Infections (Klebsiella)	28 (for 2025/26)	2	Dec-25		3	Nov-25	
7	Healthcare Acquired Infections (PA)	8 (for 2025/26)	1	Dec-25		1	Nov-25	
8	VTE Assessment	95.00%	91.84%	Dec-25		93.19%	Nov-25	
9	Inpatient Falls & harm levels	10% reduction from 2024/25	45	Dec-25		28	Nov-25	
10	Pressure Ulcers	20% reduction from 2024/25	15	Dec-25		16	Nov-25	
11	Medication Safety Reconciliation within 24 hours	80.00%	33.22%	Dec-25		32.70%	Nov-25	
12	Staffing - Average Fill Rate	90.00%	N/A - grouped indicator	Dec-25	No SPC	97.77%	Nov-25	No SPC
13	Mortality ratio - HSMR	No target set	94.31	Dec-25		94.45	Nov-25	No SPC

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14	Mortality ratio - SHMI	No target set	105.48	Dec-25			105.48	Nov-25	
15	Complaints	Zero complaints open over 6 months old/in the backlog	1	Dec-25			1	Nov-25	
16	Friends and Family (Inpatients & Day cases)	95.00%	97.35%	Dec-25			97.66%	Nov-25	
17	Friends and Family (ED and UCC)	87.00%	72.62%	Dec-25			70.23%	Nov-25	
18	Mixed Sex Accommodation Breaches (ITU)	0	15	Dec-25			2	Nov-25	
19	Sepsis - % screening for all emergency patients.	90.00%	70.00%	Dec-25			66.00%	Nov-25	
20	Sepsis - % screening for all inpatients	90.00%	68.00%	Dec-25			60.00%	Nov-25	
21	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag	90.00%	52.00%	Dec-25			54.00%	Nov-25	
22	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90.00%	72.00%	Dec-25			72.00%	Nov-25	
23	Acute Kidney Injury	Less than previous month	132	Dec-25			168	Nov-25	
24	Maternity Postpartum Haemorrhage	3.70%	4.73%	Dec-25			4.81%	Nov-25	
25	Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	19%	Dec-25			12%	Nov-25	
26	MUST nutritional assessment completion	above > 85%	73.01%	Dec-25			75%	Nov-25	

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		Latest				Previous		Assurance
	ACCESS & PERFORMANCE	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
27	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (excluding WUTC).	78%	62.62%	Dec-25		65%	Nov-25	F
28	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (including WUTC).	78%	67.48%	Dec-25		69%	Nov-25	F
29	A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	22.37%	Dec-25		23.3%	Nov-25	F
30	Average time in department ED	No Target	373	Dec-25		397	Nov-25	No SPC
31	Ambulance Handovers within 15 minutes	65%	40.64%	Dec-25		35.51%	Nov-25	F
32	Ambulance Handovers within 30 minutes	95%	72.63%	Dec-25		67.58%	Nov-25	F
33	Ambulance Handovers within 45 minutes	100%	79.88%	Dec-25		77.22%	Nov-25	F
34	Type 5 attendances	No Target set	2016	Dec-25		2225	Nov-25	No SPC
35	Patients seen in the Fracture Clinic within 72 hours	95%	83.80%	Dec-25		68%	Nov-25	?
36	Diagnostic Waiting Times 6 Weeks	95.00%	96.55%	Dec-25	H	96.88%	Nov-25	?
37	Referral to treatment Open Pathways	92.00%	61.10%	Dec-25	H	60.54%	Nov-25	F
38	Referral to treatment - Number of patients waiting 52+ weeks	0	929	Dec-25	L	1089	Nov-25	F
39	28 Day Faster Cancer Diagnosis Standard	75%	76.70%	Nov-25		75.50%	Oct-25	F

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40	Cancer 31 Day Wait	96%	96.90%	Nov-25		97.40%	Oct-25	P
41	Cancer 62 Day Wait	85%	84.00%	Nov-25		85.60%	Oct-25	F
42	Reduction in Outpatient Follow Ups compared to 19/20 activity	No Target set	84%	Dec-25	L	85%	Nov-25	No SPC
43	Elective Recovery Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC
44	Elective Recovery Diagnostic Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC
45	Elective Outpatient Activity	104%	86%	Dec-25	L	85%	Nov-25	?
46	Super Stranded Patients	Trajectory	123	Dec-25		127	Nov-25	No SPC
47	No Criteria to Reside (NCTR)	No Target set	188	Dec-25		173	Nov-25	No SPC
48	% Patients discharged to their usual place of residence	No Current Threshold	96%	Dec-25		96%	Nov-25	No SPC
49	Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicators was in progress at the time of reporting.	Less than 2%	1.26%	Dec-25		0.78%	Nov-25	P
50	Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Please note: Validation for this indicators was in progress at the time of reporting.	0	6	Dec-25		3	Nov-25	?
51	Capped Theatre Utilisation	85%	76.64%	Dec-25		80%	Nov-25	F

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		Latest				Previous		Assurance
	WORKFORCE	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
52	Supporting Attendance	5.00%	6.41%	Dec-25		6.34%	Nov-25	
53	Turnover	Below 13%	11.58%	Dec-25		12%	Nov-25	
54	Core/Mandatory Training	85.00%	91.20%	Dec-25		90.66%	Nov-25	
55	PDR compliance	85.00%	80.69%	Dec-25		81.59%	Nov-25	

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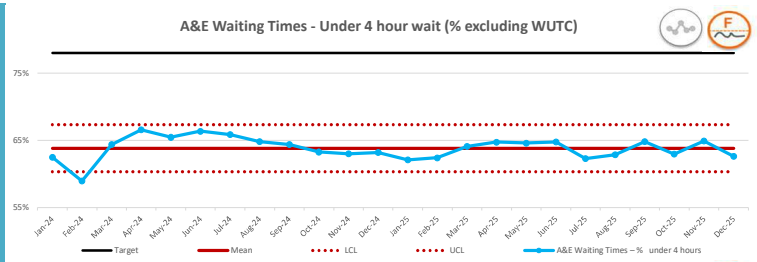
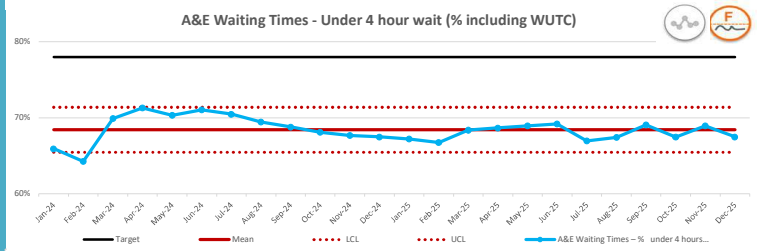
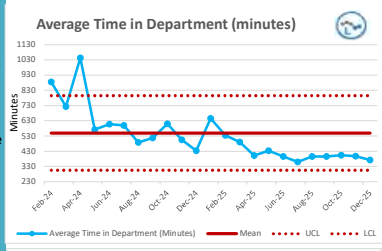
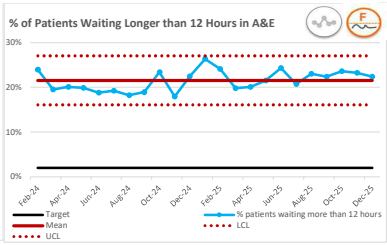
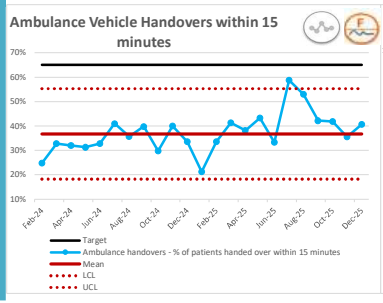
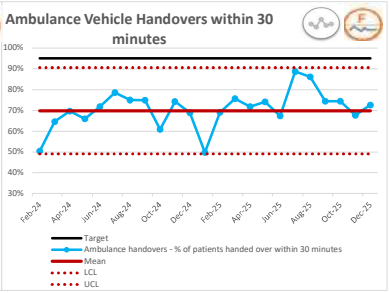
		Latest				Previous		Assurance
	FINANCE & SUSTAINABILTY	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
56	Trust Financial Position (£m)	-£3.01	-£2.61	Dec-25	No SPC	-£4.36	Nov-25	No SPC
57	Cash Balance (£m)	£2.86	£13.00	Dec-25	No SPC	£13.36	Nov-25	No SPC
58	Capital Programme (£m)	£18.91	£5.10	Dec-25	L	£4.23	Nov-25	F
59	Better Payment Practice Code	>95%	62%	Dec-25	L	68%	Nov-25	F
60	Cost Improvement Programme - In year (£m)	90% of plan	100%	Dec-25		100%	Nov-25	P
61	Cost Improvement Programme (recurrent) – In year (£m)	90% of plan	48%	Dec-25	No SPC	45%	Nov-25	F
62	Agency Reduction (£m)	£2.18	£2.20	Dec-25	No SPC	£1.23	Nov-25	?
63	Bank Reduction (£m)	£20.52	£24.03	Dec-25	No SPC	£15.58	Nov-25	F

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

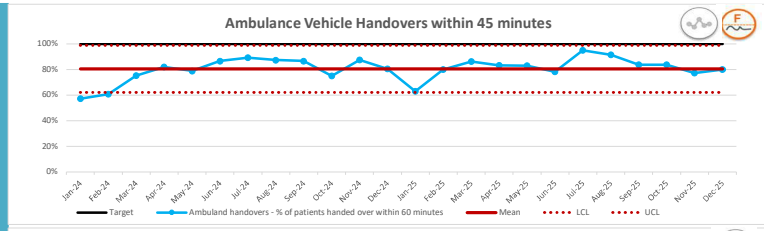
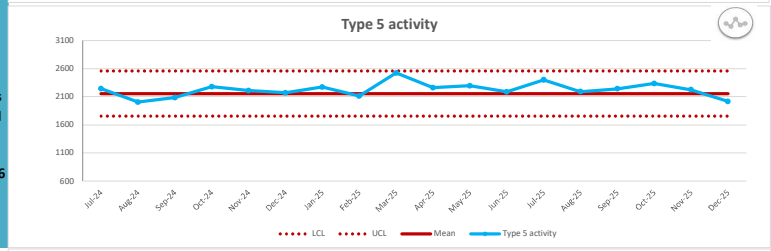
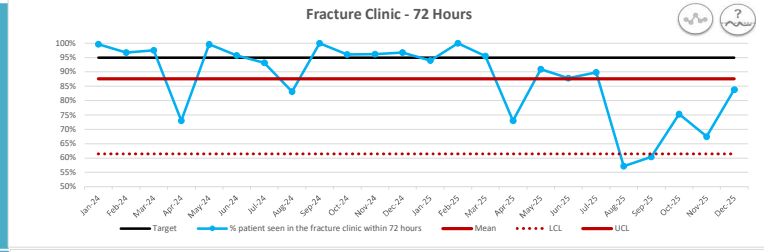
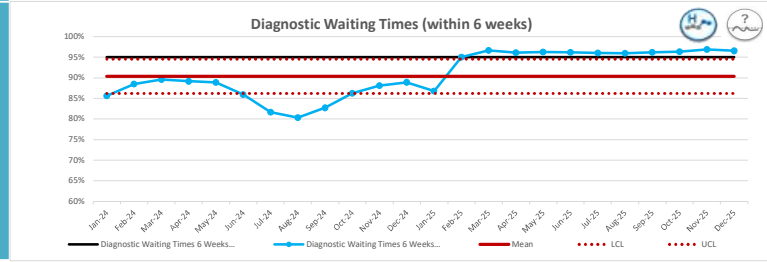
Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
27. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Not including WUTC)	**The Trust achieved 62.62% excluding Widnes UTC in month.** **The target is set at 78%, which is the national aspiration for 2025/26**		**Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) variation**	**Performance continues to be negatively impacted by wait to be seen in ED, long length of stay and a overall high bed occupancy.** **The in year Trust target of 78% includes Widnes Type 3 activity which typically contributes a further 4.5%.** **The national constitutional standard remains at 95%.**	**• An action plan of short and long term actions has been established and is monitored weekly via the executive chaired ED Improvement Group. Delivery externally is monitored via the bi-weekly NHSE Tiering meetings.** **• Daily MDT NCTR meetings are in place to support reducing delays** **• More intensive support has been provided by the senior leadership to support a reduction in wait to be seen and time to treatment which will support the 4 hour compliance** **• A review of the ED staffing model to realign rota's with demand using the ECIST methodology has been completed. The new rota template is set to start 1st January 20026**
28. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Including WUTC) Target: 78%	**The Trust achieved 67.48% including Widnes UTC in month.** **The target is set at 78%, which is the national aspiration for 2025/26**		**Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) variation**		
29. Average time in department ED No Target	**22.37% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 373 minutes.**	 	**Assurance: No Target set** **Variation: There is special cause of improving nature.** **Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) Variation.**	**12 hour performance continues to be challenged. Key themes for the breaches is the high bed occupancy restricting flow through ED and Patients waiting Mental health assessment and placement comprises our longest delays in ED. Non admmitted breaches have been improving supported by the ED improvement group**	**The Trust will continue to monitor and manage compliance around the 12 hour standard and is now one of 4 key indicators in the 2024/25 tiering of Urgent Care performance for ICBS. A service improvement for group for ED for 2025/26 has been relaunched to support improvement** **A reduction in non admitted breaches has been realised however admitted breaches continue to be a pressure**
30. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge. Target: 2% or less					
31. Ambulance Vehicle Handovers within 15 minutes Target: 65%	**In month the Trust achieved:** **- 40.6% Ambulance Handovers within 15 minutes (65% target)**		**(15) Assurance: The Trust consistently fails the target.** **Variation: There is Common Cause (normal) Variation.**		
32. Ambulance Vehicle Handovers within 30 minutes Target: 95%	**- 72.6% Ambulance Handovers within 30**		**(30) Assurance: The Trust consistently fails the target.** **Variation: There is Common Cause (normal) Variation.**	**The Trust continues to work with NWAS to support improving this metric. Main areas of concern are out of hours and at times of surge.** **Please note that ambulance handover metrics are now measured to the point of vehicle handover, rather than patient handover.**	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

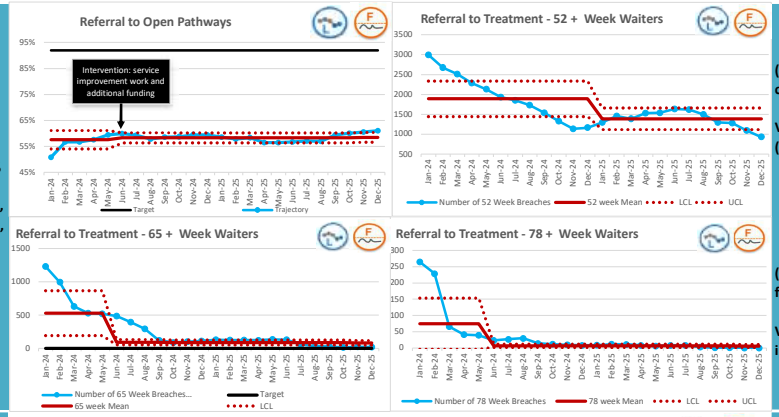
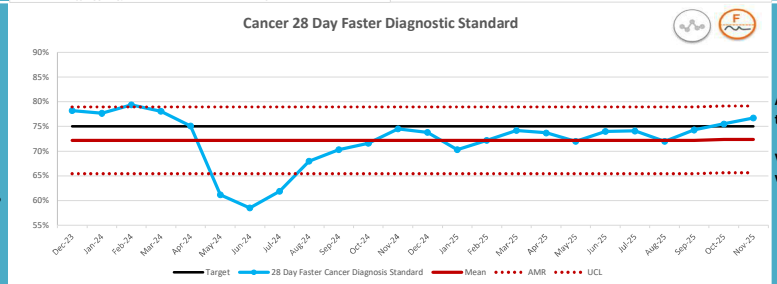
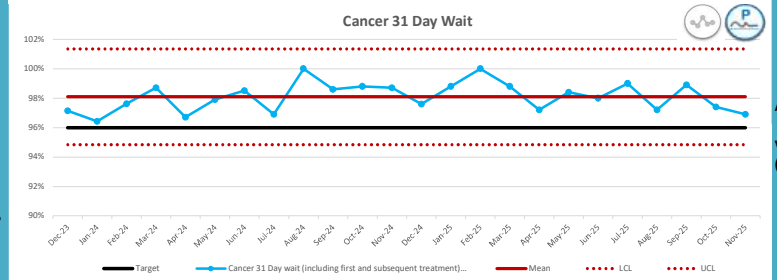
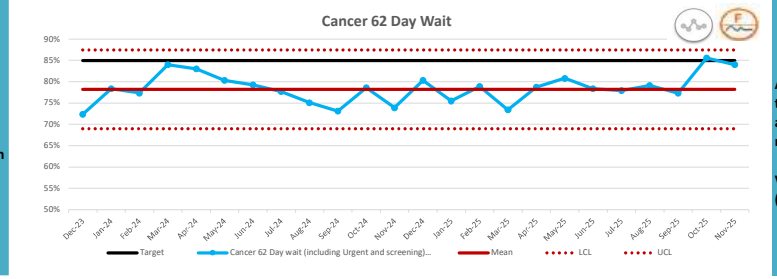
Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
33. Ambulance Handovers within 45 minutes Target: 100%	minutes (95% target) - 79.9% Ambulance Handovers within 45 minutes (100% target)		(45) Assurance: The Trust consistently fails the target. Variation: There is Common Cause (normal) Variation.		
34. Type 5 activity No Target	Pre-November 2024 activity has been estimated as attendances that would be considered a 'Type 5' attendance. In month there were 2016 Type 5 Attendances.		'Type 5' activity includes SDEC and ACC activity. FAU, GAU and PAU are also included within Type 5 Activity from July 2024. Assurance: N/A Trajectory Not Agreed. Variation: There is Common Cause (normal) Variation.	Type 5 activity includes SDEC, FAU, PAU, GAU and Ed ambulatory	
35. Patients seen in the Fracture Clinic within 72 hours Target: 95%	In month, the fracture clinic saw 75.3% of patients within 72 hours.		Assurance: The Trust inconsistently passes and fails the target. Variation: There is Common Cause (normal) Variation.	Compliance was challenged in August due to workforce constraints, this continues to be a pressure	This improvement is being sustained by the introduction of the Virtual Fracture clinic (VFC) and E-Trauma, Workforce constraints have added pressure on this service during the summer
36. Diagnostic Waiting Times 6 Weeks Target: 95%	The Trust achieved 96.36% in month.		Assurance: The Trust consistently passes the target. Variation: Special Cause variation of improving nature.	The diagnostic target has been maintained for 11 consecutive months	This recovered position will continue to be monitored through Performance review group to ensure continued achievement.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
37. Referral to treatment Open Pathways Target: 92% 38. RTT - Number of patients waiting 52+ weeks Target: 0	The Trust achieved 61.1% in month. There were 929, 52 week breaches, 0, 78 week breaches and 22, 65 week breaches.		(Open Pathways) Assurance: The Trust consistently fails the target. Variation: There is common cause (normal) variation. (52+) Assurance: The Trust consistently fails the target. Variation: There is special cause of improving nature.	RTT performance - 52 weeks is behind trajectory, mainly in unplanned care. 65 weeks has continued to reduce with 1 declared for December.	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 2025/26 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. These theatres have opened in November.
39. 28 Day Faster Cancer Diagnosis Standard Target: 75%	The Trust achieved 76.7% in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	Performance for the Faster Diagnosis Standard is at 76.7% 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, the revised recovery plans if delivered will give >80% performance by March 26 Under the changes to Cancer Waiting Times standards that come into force on 1st October 2023 the operational standard will remain at 75% with a view to delivering 80% by March 2026 and an interim target of 77% by March 25.	The Trust will continue to monitor and review performance of this standard via the Performance Review Group (PRG). A recovery trajectory has been developed to monitor recovery.
40. Cancer 31 Day wait Target: 96%	The Trust achieved 96.9% in month for Cancer 31 Day Wait.		Assurance: Target met consistently. Variation: There is Common Cause (normal) Variation.	The Trust achieved the 31 day target.	
41. Cancer 62 Day wait Target: 85%	The Trust achieved 84% in month for Cancer 62 Day Wait.		Assurance: The Trust consistently fails the target. There is a commitment to achieveing 70% at March 25 required nationally. This is currently being met. Variation: There is Common Cause (normal) Variation.	62-day wait for first treatment performance is at 84%. The 62-day referral to treatment target has seen a significant imrovment. From 1st October 2023 this standard was combined with 62-day screening and 62-day Consultant Upgrades. Whilst the operational standard remains at 85%, Operational Planning guidance for the this financial year indicates a commitment to reach 75% by March 2026, and a trajectory has been developed with the Cancer Alliance to achieve this.	

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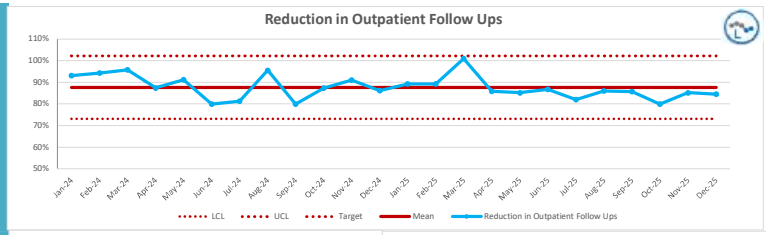
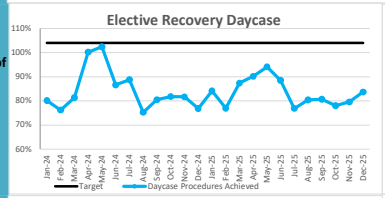
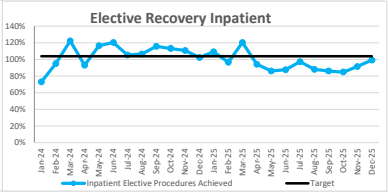
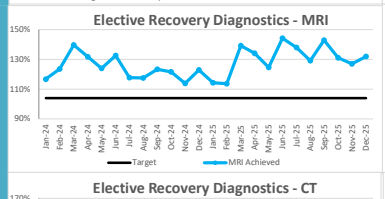
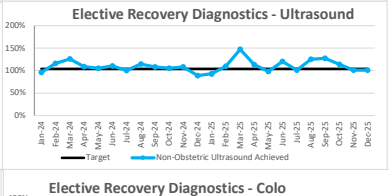
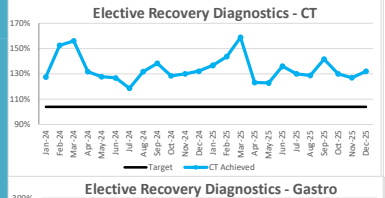
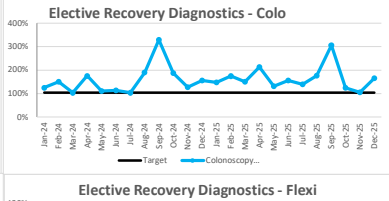
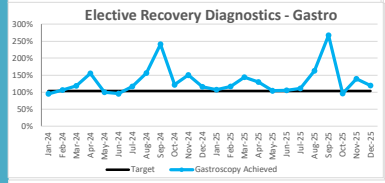
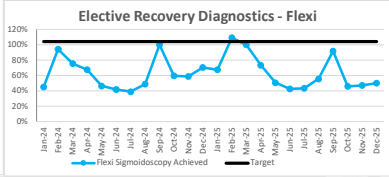
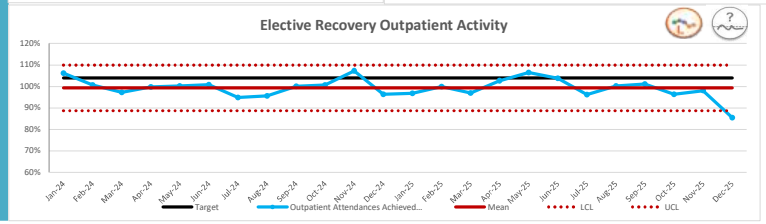
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
42. Reduction in Outpatient Follow Ups compared to 19/20 activity Target: 75% or less based on 2019/20 activity	**Outpatient follow ups have reduced to 84.49% of 19/20 activity in month.**		**Assurance: N/A Trajectory Not Agreed.** **Variation: Special Cause variation of improving nature.**	**Outpatient follow ups is in line with the agreed trajectory as part of annual planning.**	
43. Elective Recovery Activity Aggregate Target: 104% % activity is against activity in the same month in 2019/20	**In month, the Trust achieved the following % of activity against 2019. This included 84% of Daycase Procedures and 99.24% of Inpatient Elective Procedures.**	 	**N/A - Grouped indicator.**	**Day case is behind plan predominately as a result of referrals not being received into the Endoscopy Hub this is being addressed through the C&M diagnostic network , T&O and Gynae are also behind plan, this is as a result of workforce constraints**	**The Trust monitors progress weekly via Performance Review Group. Additional activity via Waiting List Initiative and Insourcing methods to undertake additional activity is being undertaken.**
44. Elective Recovery Diagnostics Aggregate Target: 104% % activity is against activity in the same month in 2019/20	**In month, the Trust achieved the following % of activity against 2019.** **This included:** **132% of MRI** **132% of CT** **101% of Non-Obstetric Ultrasound** **50% of Flexi Sigmoidoscopy** **165% of Colonoscopy** **120% of Gastroscopy**	     	**N/A - Grouped indicator.**	**Radiology modalities remain fully recovered, Challenges in cardiorespiratory remain.**	**The Trust continues to restore clinical services in line with the national operating guidance.** **Additional insourcing support for Echo is being progressed to help reduce waiting times.** **Underperformance modalities are monitored at PRG with recovery trajectories in place for each service**
45. Elective Recovery Outpatient Activity Aggregate Target: 104%	**In month, the Trust achieved 85.5% of Outpatient activity.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Special Cause variation of concerning nature.**	**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.** **New patients 98.99% of plan** **FU patients 89.98% of plan - impacted by IA** **OC Procs 78.33% - not finalised postion**

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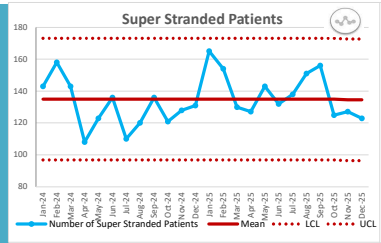
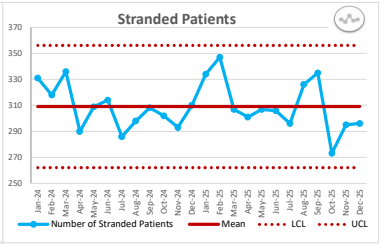
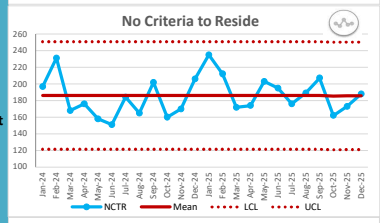
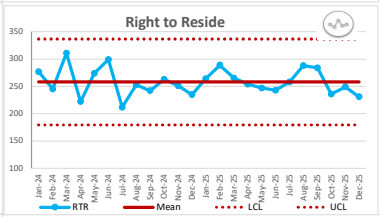
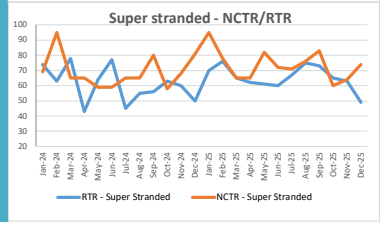
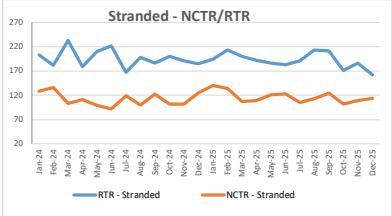
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
46. Super Stranded Patients Target: Trajectory 47. No Criteria to Reside (NCTR) **There were 296 stranded and 123 super stranded patients 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.**

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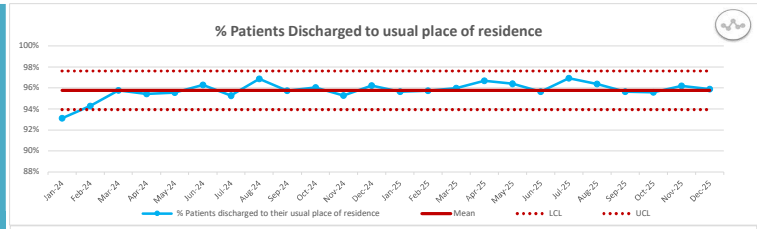
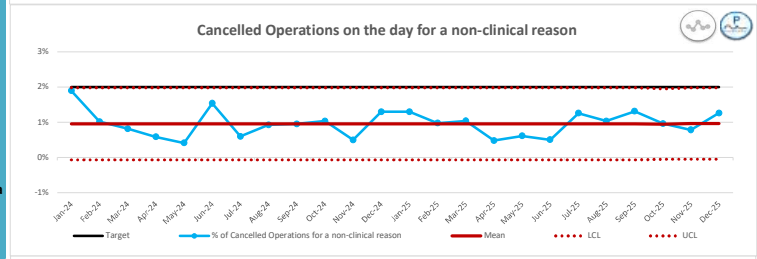
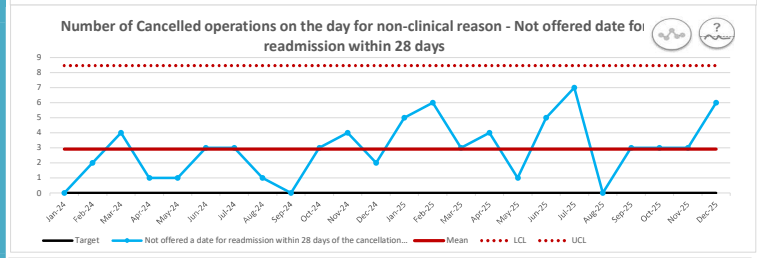
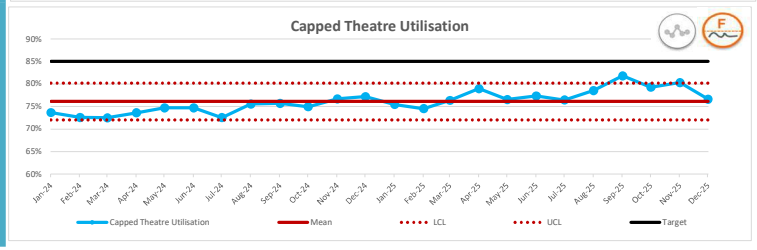
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
48. % Patients discharged to their usual place of residence Target: No Current Threshold	**95.89% patients in month were discharged to their usual place of residence.**		**Assurance: N/A Trajectory Not Agreed.** **Variation: Special Cause Variation of an improving nature.**		
49. Cancelled Operations on the day for a non-clinical reason Target: Less than 2%	**Cancelled operations for a non-clinical reason was 1.26% in month. 6 cancelled operation were not offered a date for readmission within 28 days.**		**(Cancelled - non-clinical reason) Assurance: The Trust consistently passes the target.** **Variation: Common Cause (normal) variation.**	**A change in reporting following identification of a DQ issue has caused the variation in numbers, this remains inline with Peers.**	**Recovery of elective activity continues to be monitored via Performance review group. A discrepancy in reporting has been identified by analytics this will mean an increase in reporting, it is anticipated that this will keep us in line with peers, this is reflected in the increase in position.**
50. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Target: ZERO			**(Not offered 28 days) Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (normal) variation.**		
51. Capped Theatre Utilisation Target: 85%	**Capped Theatre Utilisation was 76.64% in month**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) Variation.**	**Capped theatre utilisation is improving following intensive transformation work, challenges remain on the Nightingale site whilst the working out of a reduced theatre template due to the completion of estates work, all theatres have become fully operational from 12/11**	**The Planned Care Transformation Group is working on aligning the activity to the British Association of Day Surgery and the opportunities to increase day case rates.** **Areas of focus are on Urology, Urology & Gynaecology. The transformation team is working with the CBUs and clinical teams to increase the rates.**

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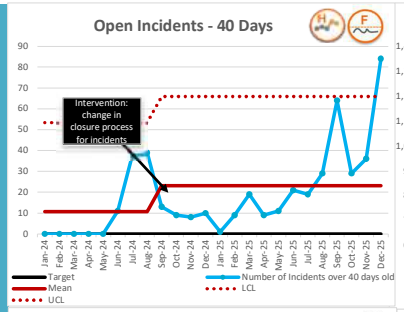
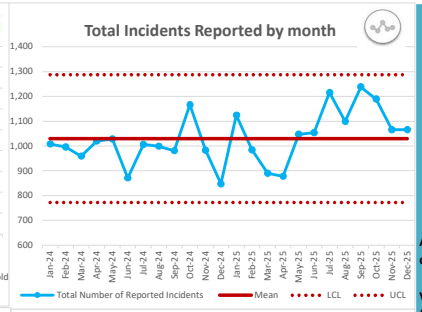
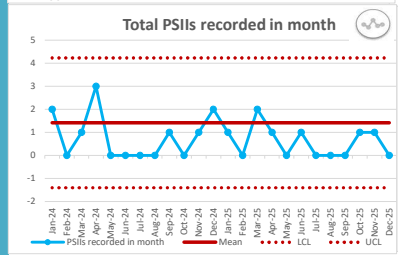
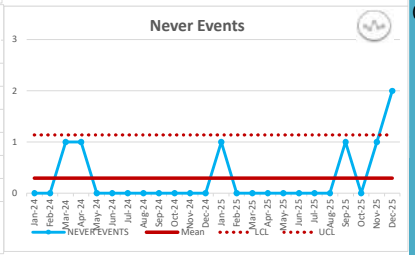
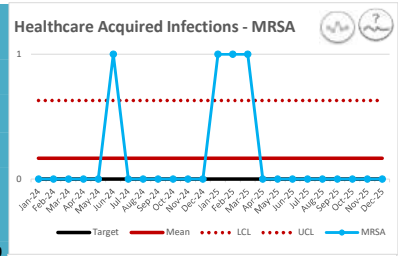
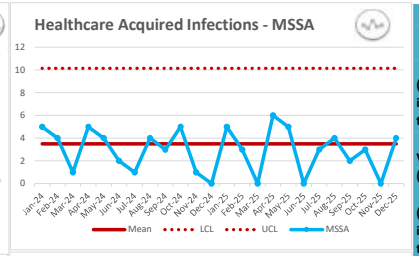
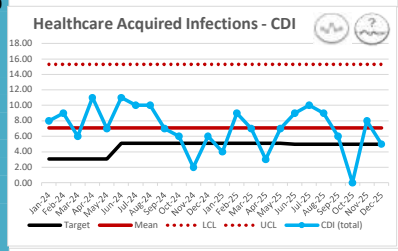
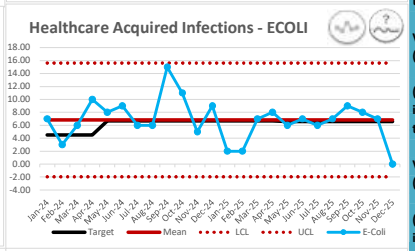
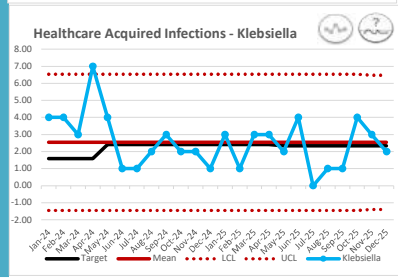
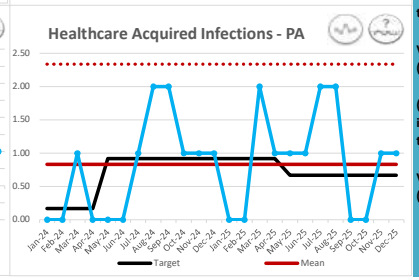
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
1. Incidents (over 40 days) Target: ZERO Open incidents outside 40 day	There was 84 incident over 40 days old.	   	Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	In December 2025, no Patient Safety Incident Investigations (PSIIs) were declared; however, two Never Events occurred: one involving a retained foreign object post-procedure and the other wrong site surgery, both classified as National Priority Never Events. At the time of reporting, 46 learning response reviews (including After Action Reviews, MDT reviews and swarm huddles) were underway. No incidents were reported to MNSI during the month, and as of 5 January 2026, 84 incidents had remained open for more than 40 days. The organisation experienced the impact of recent leadership changes on incident management performance, as new leaders continued to build their understanding of processes and reporting requirements, which contributed to delays and inconsistencies in how low-level, no-harm incidents were progressed.	A weekly governance dashboard is overseen by the Executive Team, monitoring reporting trends and triangulating incidents, complaints, claims and inquests, with each CBU supported by a designated Governance Team member to ensure consistency. The position on incidents overdue 40 days is escalated daily to the relevant triumvirates, with this work prioritised, and a focused improvement action plan is in place to reduce the backlog through targeted support, enhanced oversight and clearer accountability for timely progression. Datix system alerts at a lower 30-day threshold now provide earlier visibility and additional support, and a daily report outlining learning response and action positions is in place to support Care Group Triumvirate oversight. Weekly Governance Recovery Meetings are held between the Deputy Chief Nurse, Governance leads and Care Group triumvirates to maintain focus and drive improvement. New leaders are now fully aware of the established processes and have agreed trajectories in place to meet all incident management requirements by mid-February 2026. In relation to PSIIs, weekly monitoring continues through the Executive-led Safety Oversight Meeting with appropriate escalation to CBU leads.
2. Healthcare Acquired Infections (MRSA) 3. Healthcare Acquired Infections (MSSA) Threshold for 2025/26: no threshold set 4. Healthcare Acquired Infections (CDI) Threshold for 5. Healthcare Acquired Infections (Ecoli) Threshold for 2025/26:79 6. Healthcare Acquired Infections (Klebsiella) Threshold for 7. Healthcare Acquired Infections (PA) Threshold for 2025/26: 8	MRSA cases YTD annual threshold exceeded by 0 MSSA 27 cases YTD no threshold set CDI 57 cases YTD annual threshold exceeded by 0 E. coli 58 cases YTD annual threshold exceeded by 0 Klebsiella spp. 20 cases YTD annual threshold exceeded by 0 P. aeruginosa 9 cases YTD annual threshold exceeded by 1 cases	     	(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.	Revised national reporting rules introduced in April 2024, which use the decision to admit date rather than the admission date, have resulted in more HCAI cases being apportioned to acute Trusts. Regionally and nationally, C. difficile cases have increased, with UKHSA declaring this rise a national standard incident; however, the Trust remained a low outlier for C. difficile to the end of August 2025 compared with other Northwest organisations. A national increase in MSSA cases has also been noted, and NHSE is reviewing this trend with further guidance awaited; the Trust is not currently flagging as a high outlier, and many cases have multiple primary sources, including deep seated infections that are likely unavoidable. Changing local population demographics, with a growing proportion of older adults, may also be contributing to the rise in GNBSI cases. There has been a reduction in E. coli bloodstream infections following focused QI work, and the Trust has reported no MRSA bacteraemia cases since April 2025.	The MRSA/MSSA Prevention Action Plan remains on track, supported by a programme of training for peer ANTT assessors and strengthened competency assessments across the Clinical Business Units. Additional support has been requested from the Quality Academy to identify barriers to completing peripheral cannula insertion documentation and to provide targeted improvement support. The CDI Prevention Action Plan also continues to progress, with a slight reduction in cases in December following a spike in November 2025. Antimicrobial Stewardship activity has increased following the return of substantive Consultant Microbiology staffing, with ward-round activity now restored to baseline levels. Further plans include exploring the use of probiotics for CDI prevention and delivering training for GPs. The GNBSI Prevention Group continues to drive improvements with strengthened medical engagement, focusing particularly on wards reporting two or more GNBSI cases per month. A Quality Improvement project to support the timely removal of catheters following surgery is underway within the Surgical Specialties CBU, alongside ongoing work to reduce catheter use in elective joint replacement surgery

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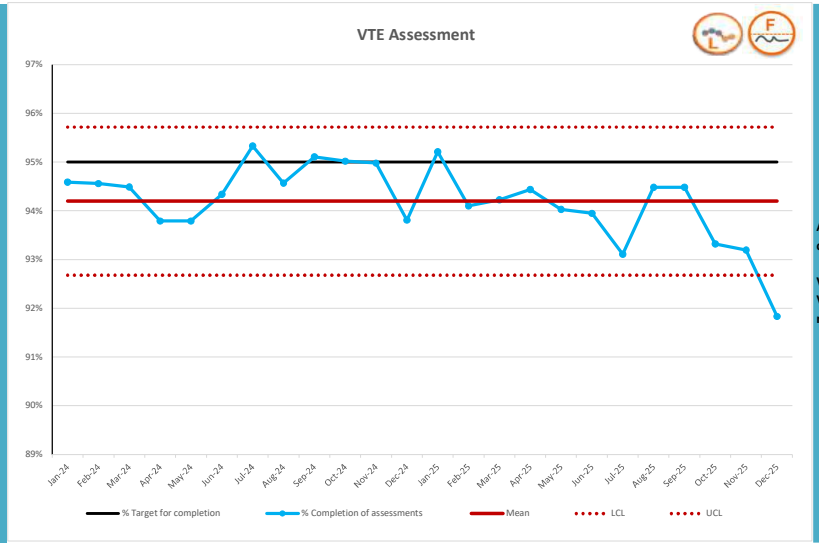
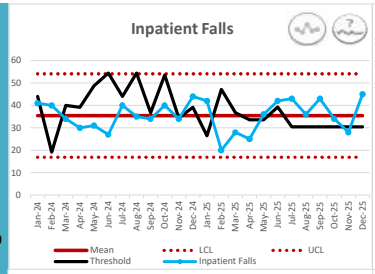
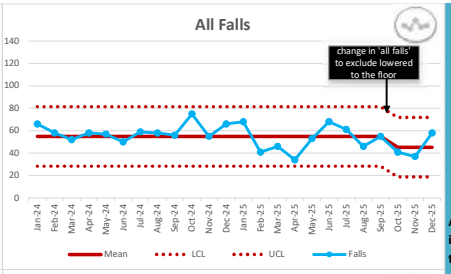
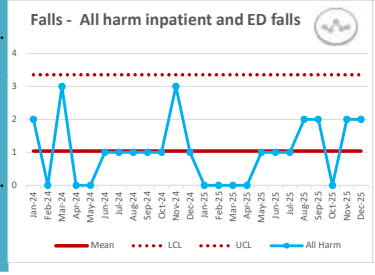
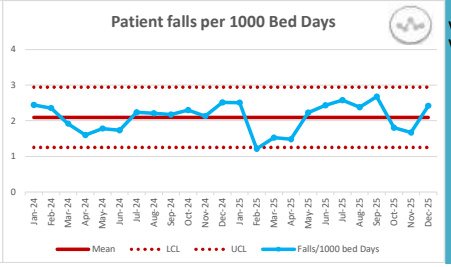
8. VTE Assessment **Target: 95% (quarterly position)**	**The Trust did not achieve the required target at 91.84% for VTE assessments in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a concerning nature.**	**VTE risk assessment performance for December 2025 was below the mandatory threshold, achieving 91.84% compliance (150 additional assessments would have been required to meet the standard, based on data accessed on 12 January 2026). There is no single identifiable reason for the reduction in performance**	**Actions already taken to improve VTE RA compliance** **Several actions have already been implemented to strengthen VTE risk assessment (RA) compliance across clinical areas. Ward based teams are now encouraged to use real time data available through the GIRFT Inpatient Ward Productivity Dashboard to identify and complete outstanding VTE risk assessments. In addition, feedback is being sought from Clinical Business Units (CBUs) using data from the VTE Risk Assessment Dashboard, which is embedded within the monthly CBU Clinical Governance agenda, to help address areas of non compliance. Clinical leads, Clinical Directors, CBUs, and care groups are also informed directly at the end of each month to highlight performance and encourage focused improvement within their respective areas.** **Further improvement actions for VTE RA compliance** **To further enhance compliance, CBUs have been asked to work with ward managers and ward clerks to make routine use of real time data from the ward productivity dashboard. They are asked to ensure that outstanding "VTE not completed" entries are reduced to zero during morning board rounds on all working days, supporting the achievement of the mandatory >95% target. Patient Safety Nursing Team is also helping to raise awareness, including sharing information with ward areas including escalation areas and through a trust wide safety brief in January 2026 regarding mandatory VTE RA requirements. The Thrombosis Group will continue to monitor data trends and use these insights to inform ongoing improvement plans.**
9. Inpatient Falls & harm levels **Target: 10% reduction from 2024/25**	**58 total falls were reported in month. 45 of these were inpatient falls.** **There was 2 fall(s) in month with harm.** **There were 176 total falls in 2023/24. There have been 689 total falls YTD in 2024/25.** **We are expecting a 12% decrease in falls from last year.** **There were 115 inpatient falls in 2023/24. There have been 405 inpatient falls YTD in 2024/25.** **We are expecting a 12% decrease in falls from last year.**	   	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause Variation.**	**In December there were 45 inpatient falls and 7 within the ED. Of the inpatient falls 2 resulted in moderate harm to the patient, 11 as low harm and 32 with no harm. Both falls with moderate harm were unaviodable.**	**1.The Turun falls alarm representative will visit the organisation during February and March, with prioritisation of clinical areas guided by the Patient Safety Improvement Nurse (PSIN) to ensure targeted support is focussed to areas requiring more support. The PSIN team continues to contribute to the Deconditioning Task and Finish Group, recognising that while encouraging patient mobilisation may increase the risk of falls, the overall risk associated with deconditioning is greater; therefore, a coordinated multiprofessional approach remains essential for effective harm prevention and reduction. Work is also underway to digitalise the post fall SWARM process, with plans for trial implementation within Lorenzo during January 2026. In addition, as part of the emerging Enhanced Therapeutic Observations and Care (ETOC) programme, the PSINs are conducting a scoping exercise across inpatient areas to understand current approaches to managing patients requiring enhanced observation, with the aim of informing a more standardised and consistent model of care.**

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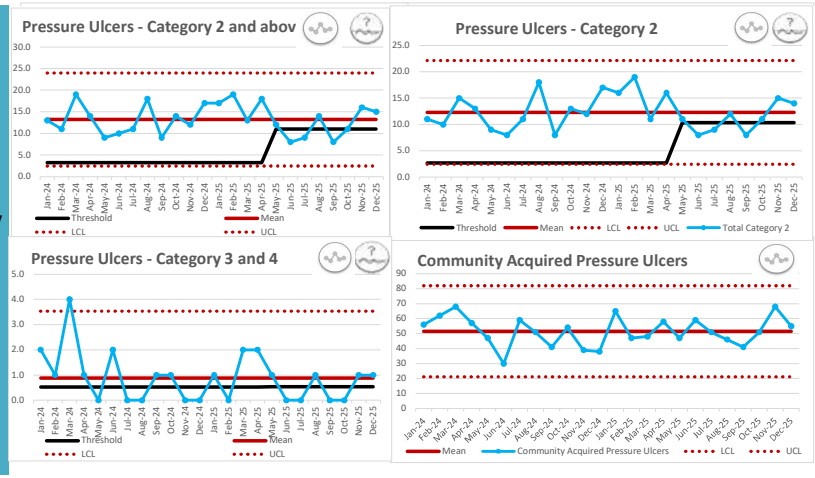
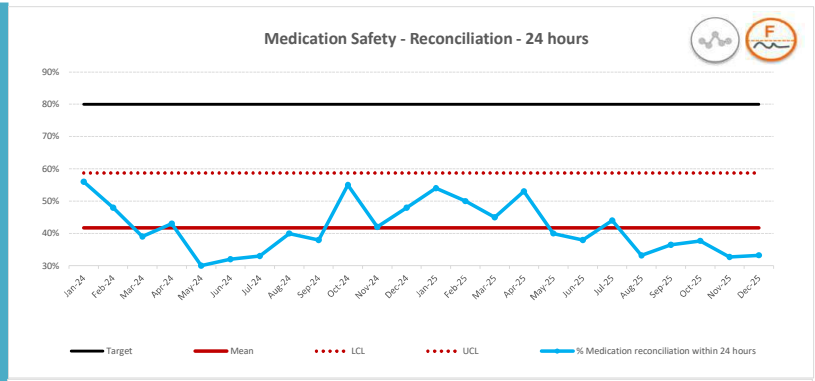
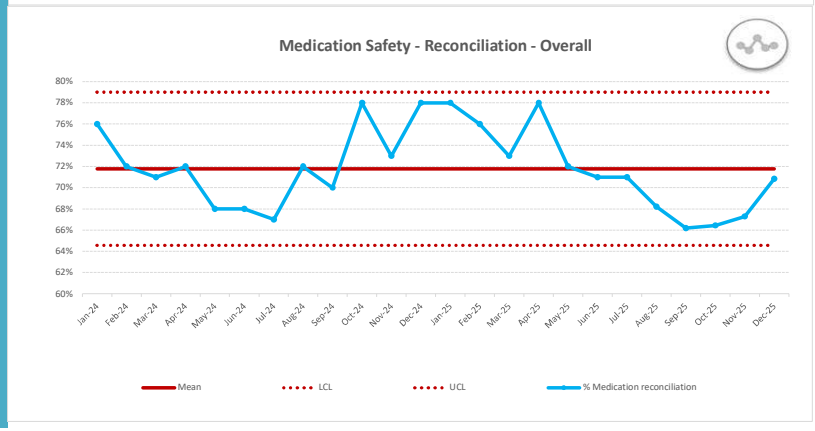
10. Pressure Ulcers (Category 2 and above) **Target: 20% reduction from 2024/25**	**In month there were 14 hospital acquired category 2 pressure ulcers, 1 Category 3 pressure ulcers and 0 Category 4 ulcers in month.** **There were 55 community aquired pressure ulcers in month.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**In December 2025, there were 14 Category 2 pressure ulcers reported across the Trust. Two minimum Category 3 pressure ulcers were recorded, one of which had originally been reported in November as a Category 2 with suspected deep tissue injury (DTI) before evolving to Category 3 and therefore appears in November's dataset. A focused improvement programme, led by the Deputy Chief Nurse, continues to target areas with higher incidences of pressure ulcers and will remain in place until sustained improvement is achieved. While no single theme has emerged, a couple of recurring themes have been identified, including inconsistent repositioning practice and lapses in the use of pressure-relieving equipment. Additionally, there were two device-related pressure ulcers in December, both resulting from patients wearing slippers in bed.**	**A comprehensive set of actions has been implemented to strengthen the organisation's position on pressure ulcer prevention and management. Swarms are now undertaken instead of traditional After-Action Reviews, enabling immediate, real time learning with teams at the point issues are identified. Essential Healthcare has increased on site technician capacity to allow more frequent checks of mattress pumps and timely replacement of faulty equipment. In ED, film dressings are being applied to patients' heels to minimise friction and shear injury, and a Trust wide message has been circulated via the Trustwide Safety Brief regarding the correct use of TED stockings, supported by a Single Point Lesson. Additionally, a QI pressure ulcer collaborative has commenced across AMU, A4, A8, B18, ITU and ED, led by the Associate Chief Nurses, to drive sustained improvement and shared learning.**
11. Medication Safety **Reconciliation within 24 hours** **Target: 80%**	**Medicines reconciliation was completed within 24 hours of admission for 33.22% of patients. 70.84% of patients had MR completed during inpatient stay.**	 	**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**Improvemetns have been noted despite Pharmacy staffing levels not allowing full coverage of all inpatient areas, so resources are deployed according to patient activity and acuity, with ED, AMU, ICU and ACCU prioritised, and lower acuity areas such as elective surgery and maternity receiving less routine pharmacy input. Audit data supports this deployment model. Overall, 62% of patients on one or more high risk medicines received medicines reconciliation (MR) within 24 hours, increasing to 91% at any point during admission. Of those who did not receive MR, 65% were in W&C and SS CBUs primarily maternity patients in birth suite and Maternity Led Unit. Previous reviews show around 90% of women in this cohort are on no regular medication. For surgical specialties, 69% of patients who did not receive MR were discharged on day 2, meaning pharmacy input earlier in admission would not represent best use of limited resource; however, medicines are reconciled by pharmacy during the TTO clinical check process.**	**Midwife recording of medicines reconciliation commenced in November 2025 and has already resulted in an increased number of reconciliations completed in maternity areas, with further actions to strengthen this progress were agreed at a meeting in December. To support a more risk based approach to workload, the pharmacy prioritisation tool has now been deployed across all Pharmacy Teams, enabling staff to identify and focus on the highest risk patients across the organisation rather than working solely by clinical area. Ongoing oversight and monitoring of these improvements is maintained through the Pharmacy Performance Meeting and the Medicines Safety and Optimisation Group.**

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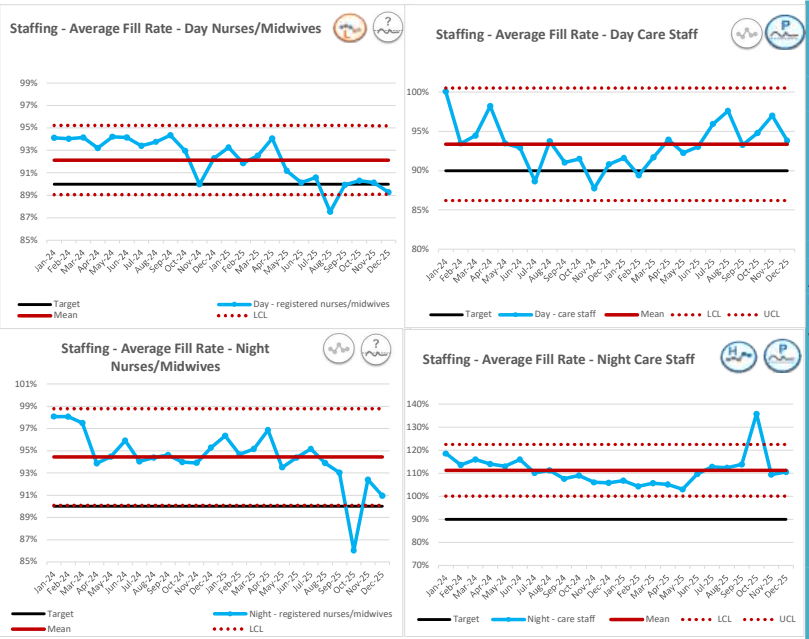
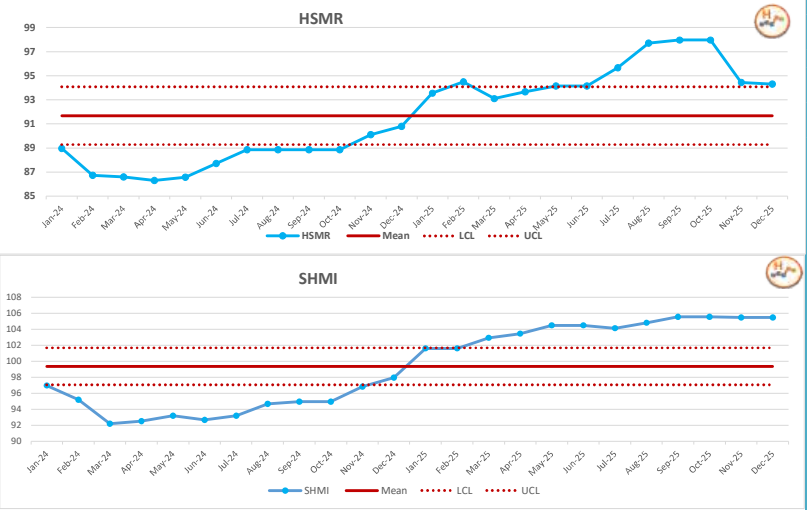
12. Staffing - Average Fill Rate **Target: 90%**	**In month, the average staffing fill rates were:** **Day (Nurses/Midwife) 89.27%** **Day (Care Staff) 93.82%** **Night (Nurses/Midwife) 90.95%** **Night (Care Staff) 110.56%**		**Assurance: N/A Grouped Indicator** **Variation: N/A Grouped Indicator**	**The Trust continues to experience significant operational pressure, with additional inpatient beds opened across multiple areas due to increased demand in ED, high patient acuity, a substantial number of patients who have no criteria to reside, and the need to maintain escalated capacity**	**Staffing is reviewed twice daily by the Senior Nursing Team, with patient acuity and activity monitored to ensure safe care at all times. All wards continue to have senior nurse oversight from Matrons and Lead Nurses. The Trust's registered nurse vacancy rate for November 2025 is 8.35%, a slight increase from 8.02% in October but remaining below the 9% target. This rise is largely attributed to the increased ED establishment, with 25.0 WTE Band 5 vacancies remaining; these posts continue to be re advertised. Most third year students appointed to the Trust have now commenced, and remaining gaps predominantly within ED, with smaller pockets across other areas are being supported through specialist recruitment. Six HCAs commenced in early December, with further vacancies scheduled for readvertisement. Additionally, 12 NHSP CSWD staff are due to begin their six month training programme in January 2026.** **For unregistered staff, the vacancy rate for December 2025 has improved to 12.37% from 14.20% in November, against the Trust target of 9%. Monthly recruitment, specialist campaigns, and the onboarding of NHSP CSWD staff continue to support workforce recovery.**
13. Mortality ratio - HSMR **Target: Plan** **14. Mortality ratio - SHMI** **Target: Plan**	**SHMI and HSMR are not within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 94.31. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 105.48.**		**(HSMR) Assurance: NA - no target** **Variation: Special Cause Variation of a concerning nature.** **(SHMI) Assurance: NA - no target** **Variation: Special Cause Variation of a concerning nature.**	**The overall SHMI for Warrington is slightly above 100, but within expected limits using an over-dispersed funnel plot. It had been increasing since month ending January 2024 but has now stabilised and has seen a slight recent drop. Adjusting for palliative care slightly reduces the SHMI which suggests possibly a more complex patient case mix.**	**Mortality indicators, including SHMI and HSMR, are routinely monitored through the Mortality Review Group, which reports to the Quality Assurance Committee. This process provides oversight and assurance, ensuring that any emerging areas of concern are identified promptly. Where necessary, detailed 'deep dive' reviews are undertaken to understand the underlying factors and inform improvement actions.**

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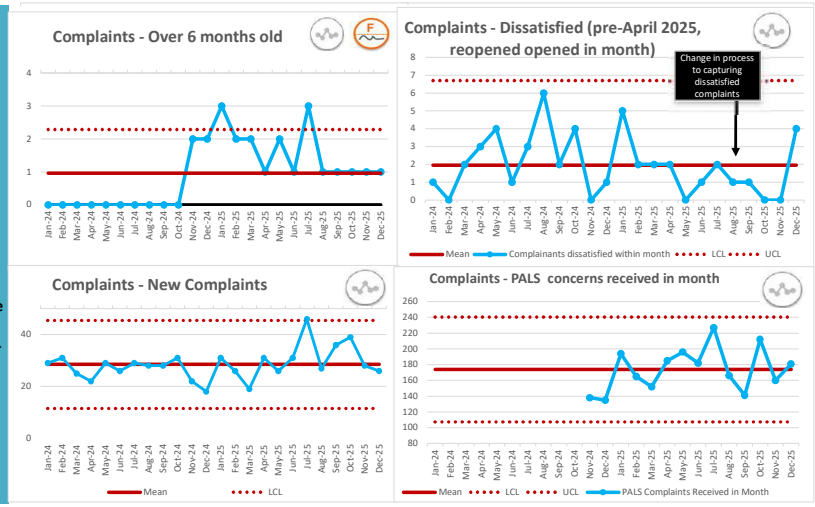
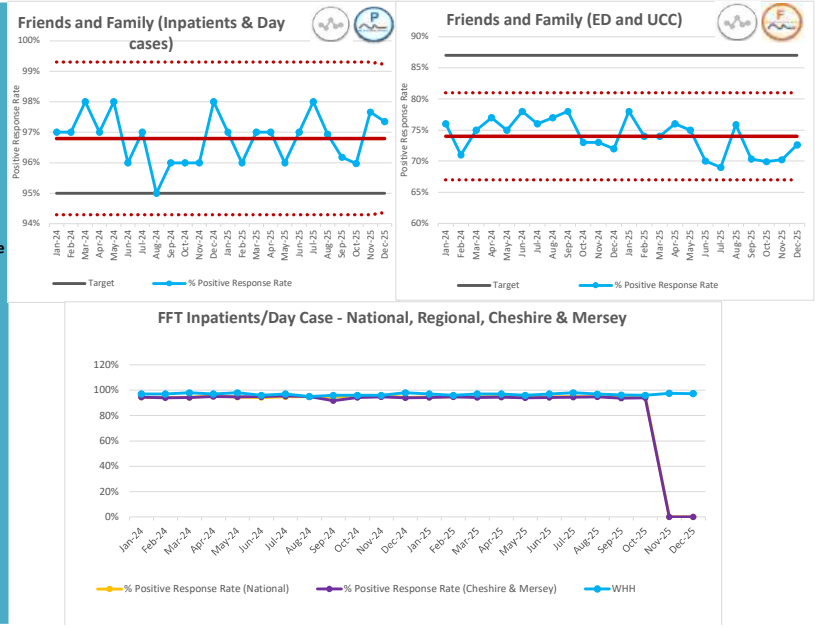
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
15. Complaints **Target: Zero complaints open over 6 months old/in the backlog**	**In month, 46 new complaints were received to the Trust which was an increase of 15 from the previous month. There was 1 case reopened in month, which is the same as the previous month.** **7 PHSO cases were open at the time of reporting, these were not linked to a specific area or theme.**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.** **Please note: Prior to April 2025, the Complaints 'dissatisfied' graph reported 'reopened complaints'.**	**The Trust continues to maintain strong performance in the timely completion of complaints. In December 2025, four complainants returned requesting additional information. There is currently one complaint that has exceeded the six-month timeframe; this is due to a 'stop the clock' being implemented at the family's/patient's request, as the patient has been in hospital and unable to attend the scheduled meeting**	**The Trust currently has 86 open complaints at the time of reporting. All complaints continue to be closely monitored to ensure timely responses are achieved. Where appropriate, concerns are redirected to PALS for local resolution.** **All complainants are offered an initial meeting with the relevant clinical teams, with follow-up meetings arranged upon receipt of the initial response letter. Each clinical business unit has a designated complaints case handler in place to support consistency and oversight throughout the complaints process.** **A new approach is being proposed to strengthen family engagement by introducing designated times for senior nursing and clinical teams to meet directly with families.** **Weekly themes and associated actions from closed complaints are being monitored to identify any areas requiring additional support or improvement.**
16. Friends and Family (Inpatients & Day cases) **Target: 95%** **17. Friends and Family (ED and UCC)** **Target: 87%**	**The Trust achieved 97.35% in month for Inpatient & Day case FFT and 72.62% for ED/UCC FFT.**		**(IP/DC) Assurance: The Trust consistently passes the target.** **(IP/DC) Variation: Common Cause (Normal) variation.** **(ED/UCC) Assurance: The Trust consistently fails the target.** **(ED/UCC) Variation: Common Cause (Normal) variation.**	**Inpatient/Day Case** **The Trust achieved a 97% positive Friends and Family Test (FFT) response rate for December 2025, continuing to exceed the recommended target. Throughout 2025, the Trust's average positive response rates remained consistently higher than both the regional and national averages for the available data.** **Emergency Department/Urgent Care Centre (ED/UCC)** **The Trust recorded a 73% positive FFT response rate in December 2025. This reflects an improvement on previous months, showing recovery following a period of decline, and aligns with the Trust's average rate over the past 12 months. However, performance remains below both the national and regional averages.** **The main themes driving negative feedback in December 2025 were consistent with the previous month and include staff attitude, waiting times, the care environment, and communication**	**Ongoing monitoring of themes at Trust and Clinical Business Unit (CBU) level is undertaken through the FFT dashboard to identify improvement opportunities and share best practice at the Patient Experience and Inclusion Sub-Committee. Actions are identified for each relevant area.** **Observations from Trust Board, Governors, Senior Leaders, PLACE, and the Patient Experience Team are fed back to wards and departments, with action plans developed and monitored through established governance structures.** **A Quality Priority has been set in relation to the Accessible Information Standard (AIS) to strengthen support for patients requiring reasonable adjustments.** **The Patient Experience and Inclusion Team is progressing FFT developments in line with contract renewals and ongoing integration work**

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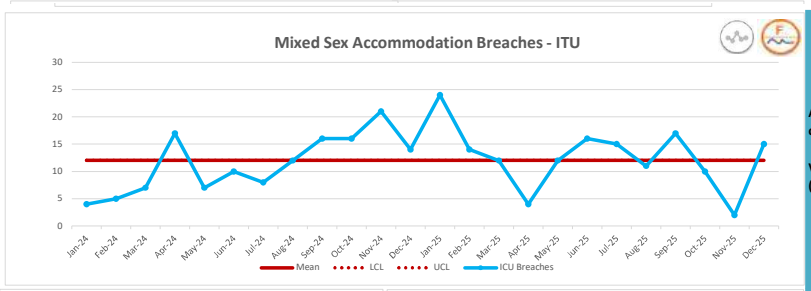
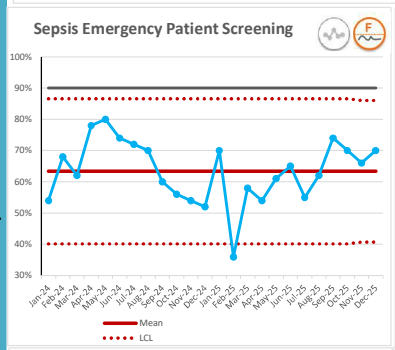
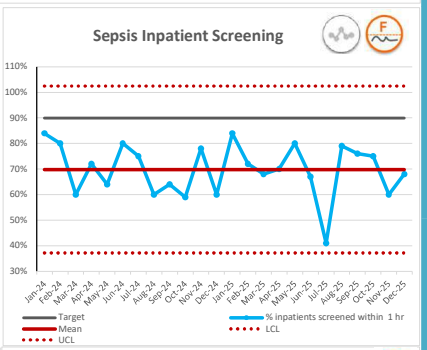
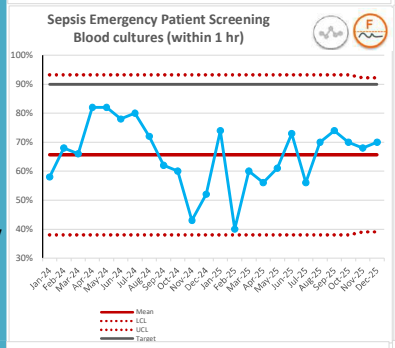
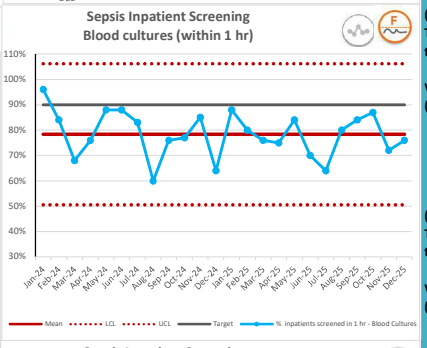
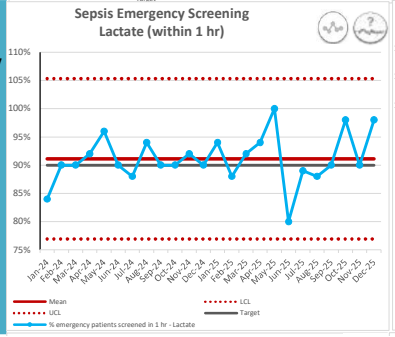
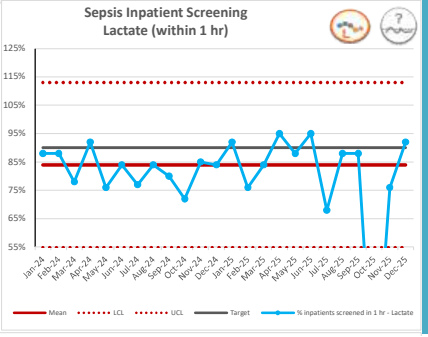
18. Mixed Sex Accommodation Breaches (ITU Only) **Target: Zero** There were 0 mixed sex accommodation (MSA) incident(s) outside of the ITU in month. There were 15 MSA incident(s) within the ITU.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation	There were 15 mixed-sex accommodation breaches in December 2025, an increase of 13 compared to November 2025. All breaches occurred within the Intensive Care Unit. Any delays in discharge are escalated to the Patient Flow Team and the Tactical Manager of the day, and are reviewed at each bed meeting throughout the day to support timely resolution. There were no mixed-sex breaches reported in any other ward areas	Work continues within the Care Group and Patient Flow teams to ensure that prioritisation is given to ITU for the step-down of level 1 patients to the most appropriate ward areas. Several reasons for delays have been identified, and action plans are currently being developed to address these contributory factors. The high number of patients with no criteria to reside across the Trust remains a significant factor impacting patient flow and the timely step-down of ITU patients. A review of the Trust's Mixed-Sex Accommodation Policy is currently underway to ensure it reflects operational needs and supports ongoing improvement in compliance
19. Sepsis - % screening for all emergency patients. **Target: 90%** The Trust achieved: • 70% Sepsis screening for all emergency patients with suspected sepsis within 1 hour. • 68% screening for all inpatients with suspected sepsis within 1 hour.	 	(Emergency) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation	In December 2025, the lower percentage of patients receiving blood cultures in both the Emergency Department (ED) and inpatient areas is likely linked to the high volume of attendances during the winter period and staffing challenges associated with the junior doctors' strike. Emergency Department (ED) In November 2025, sepsis screening compliance in ED was 66%, with 68% of patients having blood cultures taken within one hour. Both metrics remain within expected variation but show a reduction compared to the previous month. Compliance for lactate measurement within one hour remained strong at 90%. The high levels of attendance and occupancy in ED continue to affect the ability of clinical teams to complete sepsis screening within the recommended timeframe. Inpatient Areas In November 2025, audit results for inpatient areas showed sepsis screening compliance at 60%, blood culture completion at 72%, and lactate measurement within one hour at 76%. All metrics demonstrated a decline compared to October 2025. A review of the data indicates that this deterioration is not isolated to any specific ward or Clinical Business Unit, suggesting a Trust-wide impact likely influenced by increased patient acuity, flow pressures, and staffing constraints	**Trust-Wide Actions** Sepsis Improvement Group (SIG): The SIG continues to lead on Trust-wide sepsis improvement work, reviewing data monthly, monitoring performance variation, and coordinating actions across Clinical Business Units. The group is strengthening oversight of one-hour antibiotic pathways and ensuring alignment with national guidance. Focused Pathway Review: A review of the one-hour antibiotic pathway has been initiated to identify bottlenecks, including delays in triage, escalation, clinical assessment, or prescription. Findings will inform targeted improvement plans. Enhanced Education and Training: Additional staff training is being delivered on sepsis recognition, escalation protocols, and the importance of timely antimicrobial administration. This includes refresher sessions, bite-size learning, and real-time coaching. Improved Documentation & Visibility: Sepsis screening tools and prompts are being updated to support clearer documentation and faster identification of sepsis triggers. Workforce Resilience Measures: Actions include increasing cross-cover arrangements, improving access to senior clinical decision-makers, and reviewing rota support during periods of anticipated pressure (e.g. winter, industrial action). **ED-Specific Actions** Rapid Assessment and Treatment (RAT) Strengthening: Work is underway to stabilise RAT processes and ensure early senior decision-making to support timely initiation of treatment, including antibiotics. Real-Time Monitoring: ED has introduced real-time oversight at bed meetings and huddles to highlight patients requiring sepsis screening and time-critical interventions, including antibiotics. Pharmacy Support: Pharmacy teams are increasing their presence in ED during peak hours to expedite medication preparation and support clinical teams.
20. Sepsis - % screening for all inpatients **Target: 90%** Blood Cultures: • 70% screening for Emergency patients with suspected sepsis within 1 hour. • 76% screening for Inpatients with suspected sepsis within 1 hour.	 	(Inpatient) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.		
Lactate: • 98% screening for Emergency patients with suspected sepsis within 1 hour. • 92% screening for Inpatients with suspected sepsis within 1 hour.	 			

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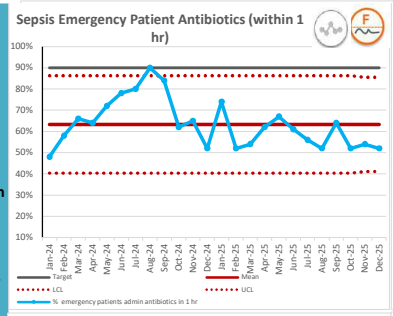
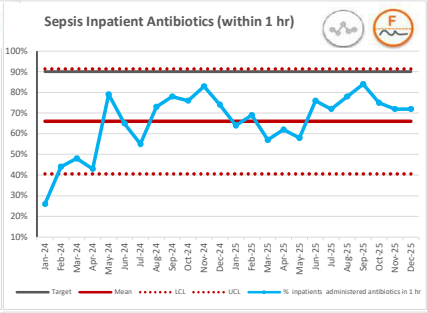
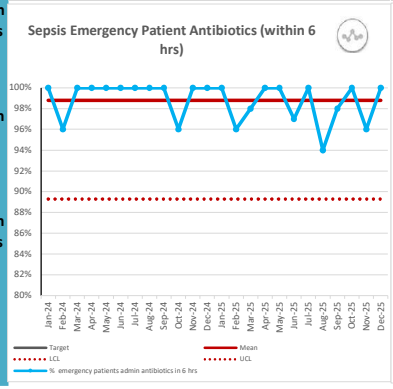
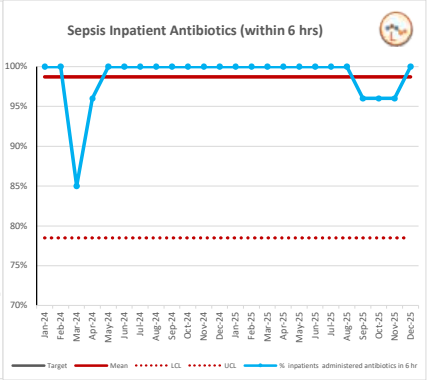
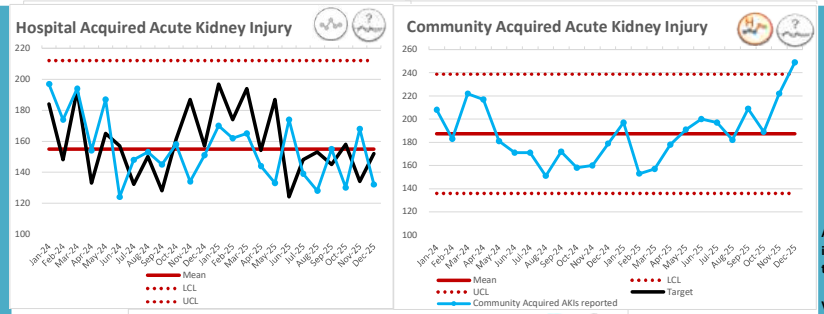
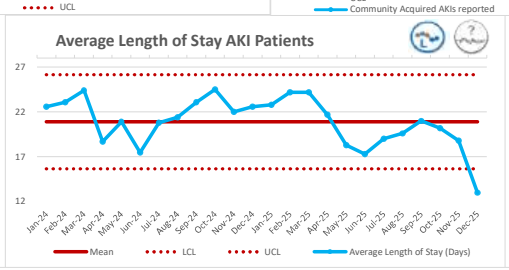
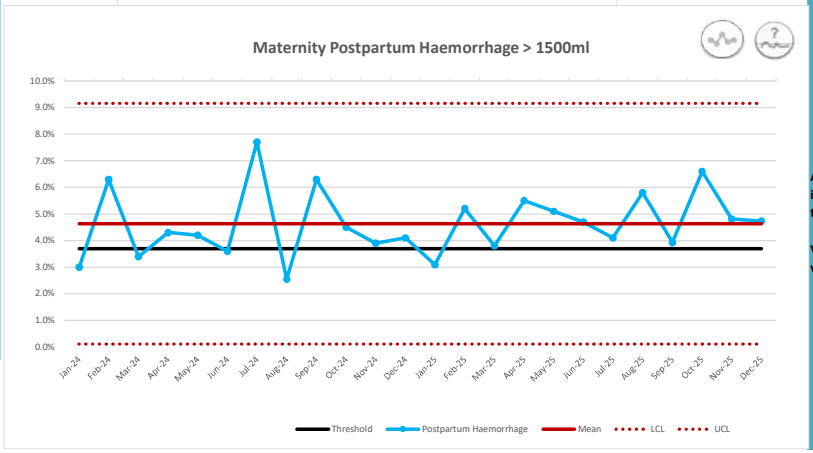
Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
21. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag **Target: 90%**	**The Trust achieved:** **• 52% of emergency patients with suspected sepsis were administered antibiotics within 1 hour of a diagnosis of sepsis being made.** **• 100% of emergency patients with suspected sepsis were administered antibiotics within 6 hours of a diagnosis of sepsis being made.** **• 72% of inpatients had antibiotics administered within 1 hour of a diagnosis of sepsis being made.** **• 100% of inpatients had antibiotics administered within 6 hours of a diagnosis of sepsis being made.**	   	**(Emergency 1hr) Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) cause variation.** **(Inpatient 1hr) Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of an improving nature.**	**In December 2025, Emergency Medicine achieved 72% compliance for blood cultures within one hour and 90% for lactate measurement. Higher lactate compliance reflects the wider workforce trained to undertake lactate sampling, whereas blood cultures can only be taken by trained clinicians and a small number of competency-assessed HCSWs. In inpatient areas, 76% of patients had blood cultures and 92% had lactate tests completed within one hour.** **Clinician review within 30 minutes in ED was achieved in 38% of cases, with senior review within one hour in 60%. These areas remain key priorities for improvement.** **NICE introduced three new sepsis guidelines in November 2025 (NG254, NG255, NG256), replacing NG51. The Trust's Sepsis Leads are reviewing these changes, updating policy, and have briefed clinical leaders, including a presentation to the Medical Cabinet on 7 January 2026**	**Audit figures from November and December 2025 were presented in January 2026 to the Medical Cabinet by the Medical Lead for Sepsis, attended by Clinical Leads and Clinical Business Unit (CBU) Leads. This continues to reinforce the importance of timely antibiotic prescribing and administration.** **To improve the timeliness of antibiotic administration, the following actions are being implemented:** **Audit feedback is being shared with CBUs to support local learning and targeted discussions with clinical teams.** **The Tests of Change are reviewing communication processes between prescribers and administering staff to reduce delays between prescription and administration.** **The Medical Lead for Sepsis has delivered training to Resident Doctors on the Sepsis Six KPIs, with further sessions planned for Consultants and Registrars.** **Through PSIN audit findings, doctors who did not prescribe the STAT dose have been contacted individually to reinforce expectations.** **Patient Safety Improvement Nurses (PSINs) are supporting clinical areas by providing real-time feedback, reinforcing correct processes, and promoting timely escalation and response for suspected sepsis cases.** **Services are being encouraged to launch the Sepsis Tool at first suspicion of sepsis to support timely decision-making, with Trust-wide promotion of a single-point lesson on accessing the tool.** **The new e-learning package is being actively promoted, and laptop job aids on how to launch the tool have been recirculated.** **Compliance data is shared monthly with Lead Nurses and discussed at the Operational Patient Safety Group and the Sepsis Improvement Group to maintain oversight and drive improvement.**
22. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis **Target: 90%**					

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality Improvement - Trust Position

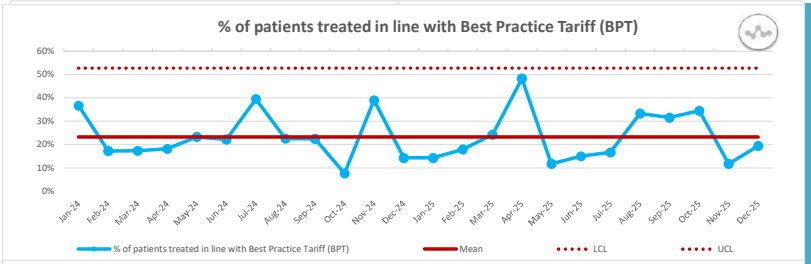
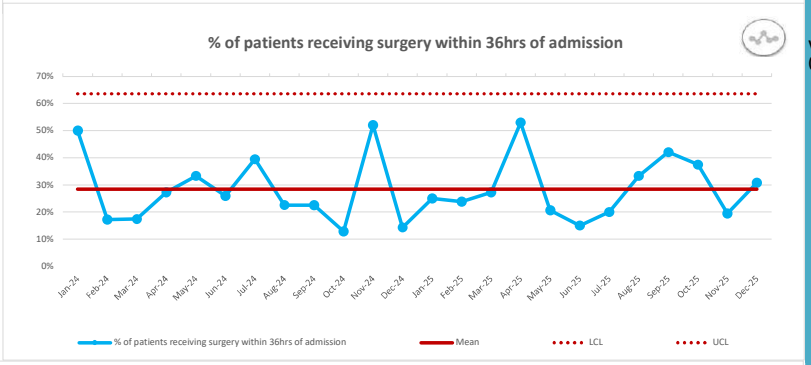
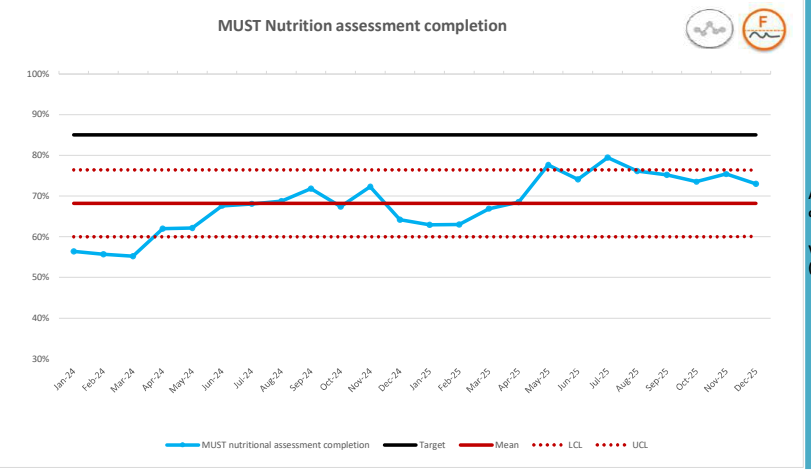
Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
23. Acute Kidney Injury **Target: Less than month in previous year**	**There were 132 acute kidney injuries reported in month compared to 168 last month.**	 	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**Length of stay (LOS) has improved compared to previous months. Hospital-acquired acute kidney injury (HA-AKI) is currently 35%, which is slightly above the national target of 33%**	**December showed improved Length of Stay (LoS) performance compared to previous months. However, when reviewing the full year, both LoS and hospital-acquired AKI (HA-AKI) remain slightly above target. HA-AKI is currently 35%, just above the national target of 33%.** **Several improvement actions are underway to address this:** **Improving discharge quality: Focus continues on achieving better discharge summaries to support safe handover of care.** **New AKI discharge pathway: A revised AKI discharge pathway is being implemented to strengthen follow-up and reduce avoidable deterioration post-discharge.** **Education for the ACT team: Regular education sessions for the Acute Care Team (delivered six times per year by the Clinical Lead) continue to reinforce best practice in AKI recognition and management.** **Strengthened medical–ACT collaboration: Work is ongoing to enhance the relationship between the ACT and the Consultant on call to support earlier review and escalation for deteriorating patients.** **Deteriorating patient bundle: The bundle is being reviewed, with consideration for implementation at the front door to improve early identification of patients at risk of AKI on arrival**
24. Maternity Postpartum Haemorrhage >1500ml **Threshold: < 3.7%**	**There were 4.73% Postpartum Haemorrhages >1500ml in month.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common cause variation.**	**Rates of PPH > 1500 ml continue to fluctuate but remain within common-cause variation. Comparator data received from the Cheshire and Mersey (C&M) LMNS identifies an average rate of 32 per 1,000 births across the network. The WHH rate is 66 cases per 1,000 births, which is notably higher than the C&M average. no single cause has been identified.**	**Cases of Postpartum Haemorrhage (PPH) greater than 1500 mls continue to be reviewed individually through established governance processes. In addition, all cases receive enhanced scrutiny via the Intrapartum Incident Review Group, which meets monthly to review patterns and themes from significant Postpartum Haemorrhage incidents.** **A dedicated Postpartum Haemorrhage Quality Improvement (QI) Group is progressing work to strengthen local processes. A new regional guideline for Postpartum Haemorrhage has recently gone live within the service. WHH colleagues contributed to the regional working group that developed the guideline, and several WHH-proposed change ideas have been incorporated.** **The Trust's position on Postpartum Haemorrhage is reported monthly to the Quality Assurance Committee (QAC), supported by an SPC chart that currently shows common-cause variation with some stability. A re-audit is planned for May, six months after implementation of the new guideline, to evaluate impact and identify any further improvement opportunities.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality Improvement - Trust Position

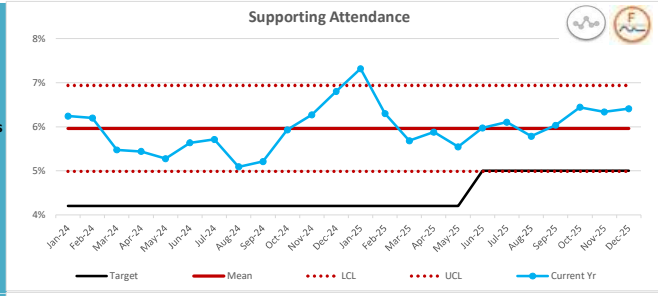
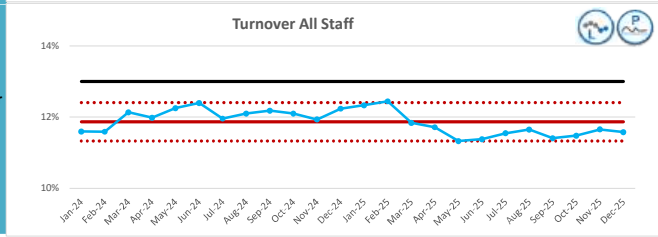
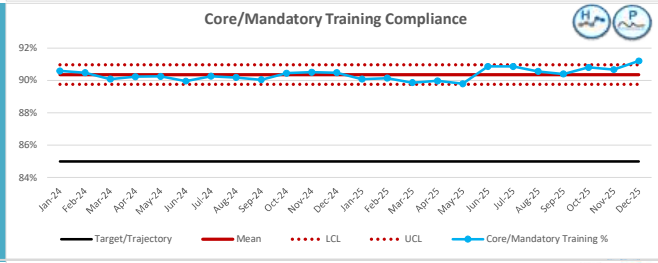
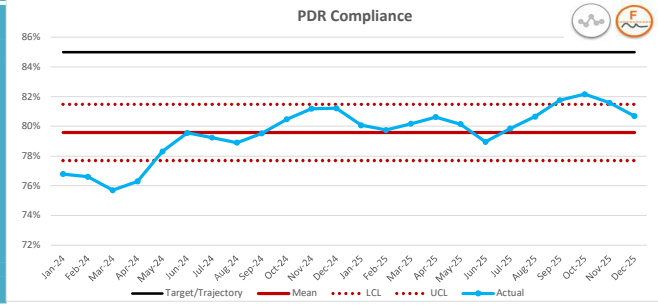
Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
25. Fractured Neck of Femur **Target: Best Practice Tariff**	**19.44% of patients were treated in line with Best Practice Tariff (BPT) in Dec-25.**	 	**Variation: Common Cause (Normal) variation.**	**For December discharges, a total of 41 patients were included in the National Hip Fracture Database, of which 36 patients met the criteria for Best Practice Tariff (BPT). Most patients discharged in December were admitted either in November or December (38 out of 41).** **Performance improved in relation to direct admissions, with 93% of patients admitted straight from A&E to the Orthopaedic ward. In addition, 100% of outlying patients were transferred to A6 during their stay.** **Timeliness to surgery remains a challenge, with 33% of eligible patients operated on within the recommended timeframe, although this does represent an improvement on the previous month. Senior Orthogeriatric review within 72 hours decreased slightly to 71%, reflecting limited consultant in-reach capacity due to annual leave.** **Day-one post-operative mobilisation improved, with 82% of patients mobilised on the day after surgery**	**Performance against NOF KPIs and Best Practice Tariff (BPT) continues to be monitored regularly, with data presented to both the NOF Group and the Patient Safety and Effectiveness Committee (PSEC). A detailed action plan has been submitted to PSEC to support improvements in key outcome measures.** **A new NOF Escalation Standard Operating Procedure (SOP) is now available on the intranet, designed to support more timely access to surgery within 36 hours. Bed escalation is also being incorporated into this SOP to facilitate quicker admission to the Orthopaedic ward.** **Plans are underway to introduce a Hip Fracture Awareness Day to enhance staff understanding of the importance of high-quality NOF care. The ACP Lead recently attended the Hip Fracture Summit, where it was widely acknowledged that direct admission to an Orthopaedic ward significantly improves outcomes for hip fracture patients. In alignment with this evidence, the Hip Fracture Lead is working closely with the Planned Care Triumvirate and Trust Executives to explore opportunities to strengthen pathway performance.**
26. MUST nutritional assessment completion **Target: above 85%**	**MUST Nutrition assessment completion was 73.01% in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**MUST compliance continues to show steady improvement, supported by ongoing work with clinical teams. Since the introduction of the LiON dashboard in 2023/24, there have been sustained increases across all assessment intervals: a 5% improvement in 6-hour assessments, 14% in 24-hour assessments, and 29% in 7-day assessments.** **A small dip in December has been noted; however, this reflects natural variation and does not change the overall upward trend in compliance.**	**The addition of MUST as a clinical indicator on Lorenzo has supported ward teams in more easily identifying patients who require an initial MUST assessment or a reassessment. The indicator turns orange 24 hours before the 7-day reassessment is due, providing an early prompt for staff and contributing to the significant improvement seen in this metric.** **The Nutrition, Food and Hydration monthly meeting continues to drive a strong multi-disciplinary approach to improving nutritional support for patients. Clinical Business Units and key stakeholders produce high-level briefing papers, outlining local improvement actions and quality improvement initiatives that can be shared across the Trust.** **MUST remains a Quality Priority for 2025/26, with ward teams presenting compliance data and improvement plans at Quality Summits. MUST is also embedded within the PSIRF approach to harms such as falls and pressure ulcers, given the strong association between nutritional risk and patient deterioration.** **A plan to enhance MUST training, particularly for the HCA workforce, is being developed for implementation in 2026. This will focus on increasing awareness of MUST and its links to wider patient care, supporting earlier identification of nutritional risk and timely intervention.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

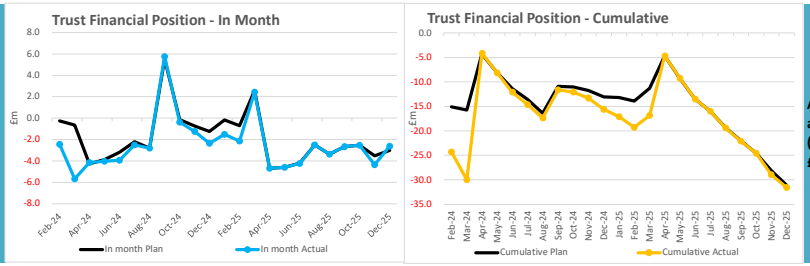
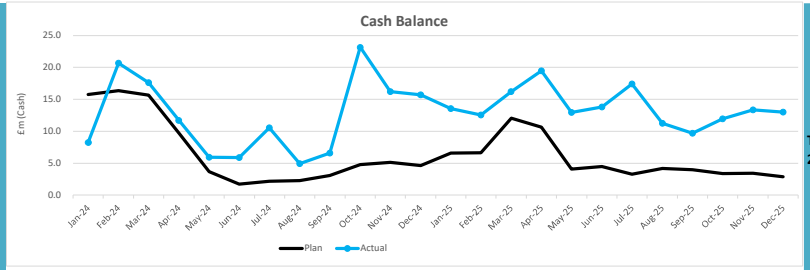
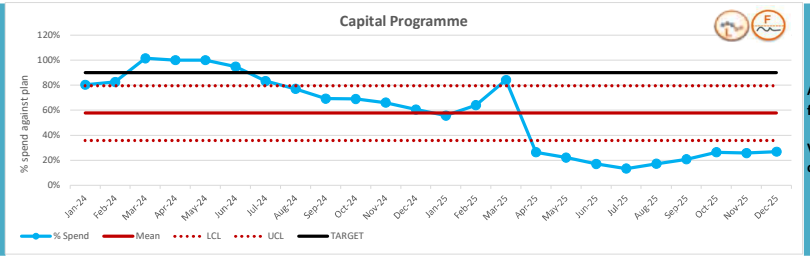
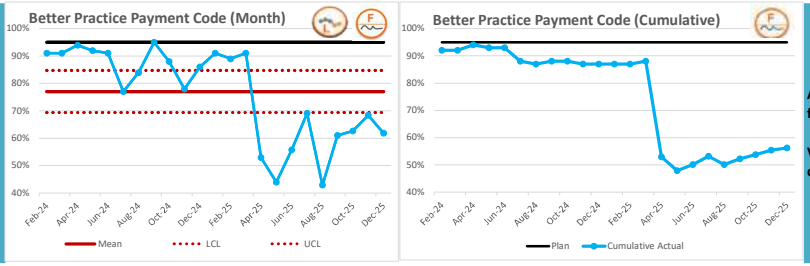
Workforce - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
52. Supporting Attendance **Target: Below 5%**	The Trust's sickness rate was 6.41% in month.		Assurance: The Trust consistently fails the target. Variation: Common cause (normal) variation.	The Trust has seen a significant improvement in long term sickness absence rates following transition on to the new Supporting Attendance policy, reducing from 4.39% in April 2022 to 3.15% in December 2025. Short-term sickness absence is of concern with data analysis undertaken to identify areas of specific concern across the Trust. Sickness absence is part of the National Oversight Framework (NOF).	The organisation has launched the "Be Present, Be Here, Be WHH" campaign, and has engaged in discussions with Trade Unions regarding implementing a new regional Supporting Attendance Policy, to further strengthen attendance management. A targeted approach has focused on the top 10 areas with the highest absence-related temporary staffing costs. These areas have received enhanced HR and Occupational Health support, including: detailed case reviews, KPI monitoring, and leadership engagement. Additional initiatives include wellbeing sessions, manager training on workforce intelligence, and practical guidance to promote compassionate leadership. Specialist OH Nurses work with HR colleagues to review areas of high absence rates. An enhanced MDT approach is being piloted to further support areas with high absences which create high temporary staffing spend.
53. Turnover **Target: Below 13%**	The Trust's turnover of all staff was 11.58% in month.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Turnover is showing an improving nature and performing in line with Trust target and monthly average. It consistently passes the Trust target of 13%.	Service leads continue to monitor progress against the Workforce Plan, and are required to outline their future plans when completing the Vacancy Control Process (VCP). Work/life balance remains the main reason people leave WHH. The #MyFlex campaign continues to support this. Following successfully launching an e-preference rostering approach in two Ward areas and preference rostering into two further clinical areas, options to rollout this approach have been developed, and the Trust awaits a decision from a national charity bid on potential resources available to support.
54. Core/ Mandatory Training **Target: 85%**	Core/Mandatory training compliance was 91.2% in month.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of a improving nature.	CSTF Mandatory Training compliance is consistently above the Trust target and shows an improving nature.	Training is compliance is monitored by Education Governance Group, MLOG and Operational People Committee with actions required by Care Groups to ensure minimum standards are met. Training is reviewed periodically to ensure time on training is kept to a minimum and in line with training overheads. Any requests for new training or changes to training is overseen by Mandatory Learning Oversight Group and receives EMT sign off.
55. PDR **Target: 85%**	Annualised PDR compliance was 80.69% in month.		Assurance: The Trust consistently fails the target. Variation: Common cause (normal) variation.	PDRs have continued to consistently to fail to meet the 85% target. A number of corporate areas and staff groups are now achieving 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.	Significant actions have been taken to strengthen appraisal compliance and improve quality. Three new Appraisal Guides have been developed to support managers and staff. The Appraisal Roadshow is actively engaging teams to drive consistency and uptake. A Group Appraisal test of change is being implemented, and an options analysis has been completed.

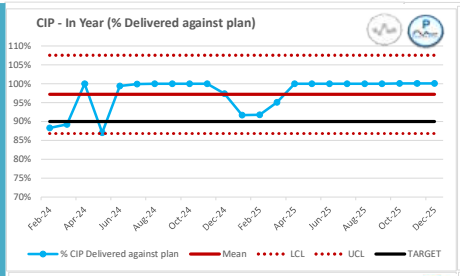
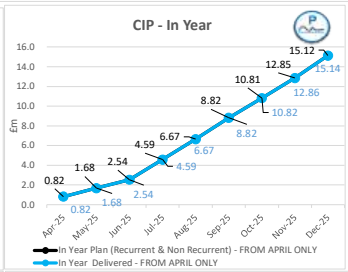
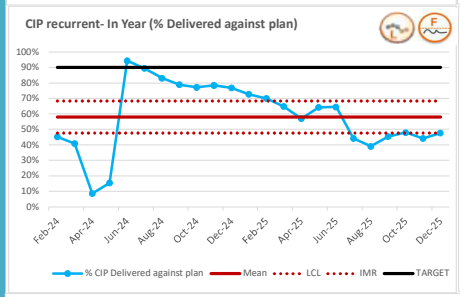
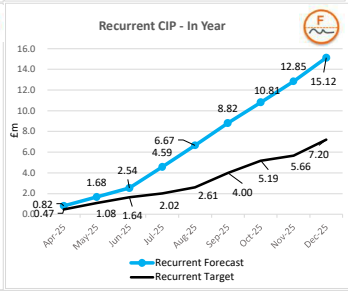
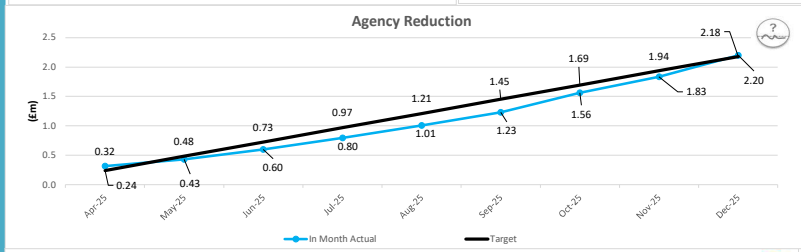
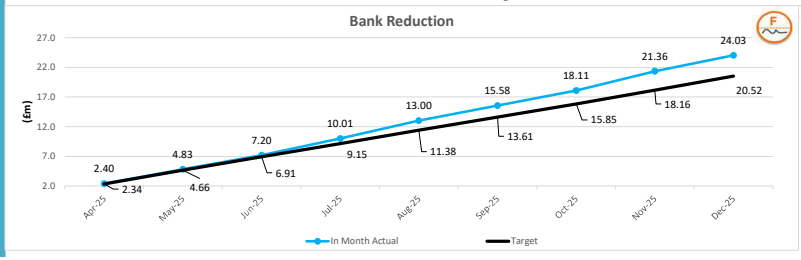
Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance and Sustainability - Trust Position

	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
56. Trust Financial Position **Target: Plan**		At month 9 the Trust has recorded a deficit position of £31.6m (before deficit support) which is £0.4m worse than plan.	At month 9, the deficit position is £0.4m worse than plan due to the impact of integration costs.	The Trust is in discussion with the ICB around the level of funding for the integration costs. Work is also ongoing to identify additional CIP schemes, reduce cost pressures and increase activity delivery.
57. Cash Balance **Target: On or better than plan**		The cash balance at 31 December 2025 is £13m.	The current cash balance is £13m which is £10.1m higher than the cash plan. This is predominantly due to a larger than planned cash balance at the end of 2024/25 and the implementation of cash management measures for 2025/26. Of the £13m cash, £5.4m is related to capital creditors.	The deficit position has led to the Trust requiring external cash support. £13.237m has been approved for Q4, of which £3.317m was received in January. Funding for Industrial Action is expected in February which will reduce the drawdown required therefore remaining within the Board approved amount. 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.
58. Capital Programme **Target: On plan 90%-100%**		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a declining nature.	Capital expenditure at the end of month 9 is £5.1m against a plan of £18.9m. This is mainly driven by EPR delays, ward refurbishment paused and replaced with smaller schemes, and late confirmation of additional capital. The plan is expected to be fully delivered by year end.	The reason for the year to date variance is due to timing and is expected to be fully delivered by year end. The risk associated with delivering the 2025/26 capital plan is being monitored at CPG and reported to FSPCiC.
59. Better Payment Practice Code **Target: Cumulative performance 95%**		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a declining nature.	Cumulative BPPC performance is 56% which is below the national target of 95%. The main reason for this is due to cash management measures put in place to mitigate against the Trust's worsening cash position.	BPPC is being closely monitored, especially due to cash shortages. This includes daily cash monitoring, ensuring wherever possible we pay SME. BPPC won't reach the 95% target given the cash position of the Trust and only three months remaining in the year.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Finance and Sustainability - Trust Position

	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
60. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date **Target: >90% plan delivered YTD**	 	**Assurance: The Trust consistently passes the target.** **Variation: Common cause (normal) variation.**	**At month 9, CIP is £20k better than plan due to delivering earlier than planned.**	**CIP progress is reviewed internally and externally on a weekly and monthly basis with oversight from the Delivery Unit. The Medical Director and Director of Strategy and Partnerships are leading the Improvement programme with the Operational Teams supported by Finance and the Improvement Leads to drive greater efficiency across the Trust. Work continues on identification of additional schemes to mitigate against high risk schemes.**
61. Cost Improvement Programme (recurrent) – In year performance to date **Target: >90% plan delivered YTD**	 	**Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) variation.**	**£7.2m CIP has been delivered recurrently against the target of £15.1m.** **The Trust aims to deliver CIP recurrently wherever possible and challenges if CIP is not recurrent. Providing the full year effect of schemes delivering later in the year deliver this would mitigate the non-recurrent schemes into 2026/27.** **Where recurrent CIP has not been realised, efforts have been made to deliver the CIP on a non-recurrent basis rather than not achieving at all.**	**Work continues to identify recurrent CIP schemes and turn non-recurrent schemes recurrent. To support all CBUs and Corporate Divisions with the identification of schemes, tools and benchmarking information such as Model Health and GIRFT are being used.**
62. Agency Reduction **Target: 30% reduction of 2024/25 plan**		**Agency expenditure is £2.2m at month 9 which is in line with plan.**	**There is no variation at month 9, agency expenditure is in line with plan.**	**Although agency expenditure remains in line with plan it is increasing each month primarily driven by higher usage of nursing shifts. Agency expenditure continues to be reviewed to ensure that it stays below the target set.**
63. Bank Reduction **Target: 10% reduction of 2024/25 plan**		**Bank expenditure is £24m at month 9 compared to a plan of £20.1m.**	**At month 9 bank expenditure is overspent by £3.5m. £2.5m is due to the impact of Industrial Action in July, November and December. The remainder is mainly driven by A&E medical staffing vacancies and sickness.**	**A number of additional controls have been put in place as a result of the PwC work including bank sign off by the Chief Nurse and Deputy Chief Nurse. The nurse bank rate was reduced during 2024/25 and has reduced again from 1 May 2025. Substantive recruitment into medical posts has taken place and is expected to continue which will reduce the medical bank spend.**

Appendix 3 – Trust IPR Indicator Overview

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

				occur over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction. Pressure ulcers are reported by Category (2,3 & 4).
		Community Acquired Pressure Ulcers		
Medication Safety	**11**	Medication reconciliation within 24 hours.	>=80%	Overview of the current position in relation to medication, to include:
		Medication reconciliation throughout the inpatient stay.		
Staffing Average Fill Levels	**12**	Staffing - Average Fill Rate - Day nurses/midwives		Percentage of planned verses actual fill rates for registered and non-registered staff by day and night. The data produced excludes CCU, ITU and Paediatrics.
		Staffing - Average Fill Rate - Day care staff		
		Staffing - Average Fill Rate - Night nurses/midwives		
		Staffing - Average Fill Rate - Night care staff Staffing - CHPPD Benchmarking		
HSMR Mortality Ratio	**13**	Hospital Standardised Mortality Ratio (HSMR 12 month rolling). The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in- hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups.	Plan	
SHMI Mortality Ratio	**14**	Summary Hospital-level Mortality Indicator (SHMI 12 month rolling). SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	Plan	
Complaints		Number of new complaints.		
	15	Total number of cases over 6 months old in month.	0	
		Dissatisfied complaints in month (pre April 2025 classed as 'reopened in month')		
		Number of PALS complaints received and closed in month.		
Friends and Family Test (Inpatient & Day Cases)	**16**	Percentage of Inpatients and day case patients responding as "Very Good" or "Good". Patients are asked - Overall, how was your experience of our service?	95%	
		National, Regional, Cheshire & Mersey positive response rates for Benchmarking		
Friends and Family (ED and UCC)	**17**	Percentage of AED (Accident and Emergency Department) patients responding as "Very Good" or "Good". Patients are asked - Overall, how was your experience of our service?	87%	
Mixed Sex Accommodation Breaches (ITU)	**18**	Number of MSA Breaches in month (ITU).	0	Due to no Mixed Sex Accommodation breaches being recorded outside of ITU over the past 24 months, it will be more effective to monitor ITU breaches.

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

Access & Performance

Under 4 hour A&E Wait time Target and ICS Trajectory (excluding WWIC)	**27**	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge.	>78% (national objective)	
Under 4 hour A&E Wait time (including WWIC)	**28**	All patients who attend A&E should wait no more than 4 hours from arrival to admission, transfer or discharge.	>75%	because of the pandemic, the commissioning changes didn't happen. As such, it has been confirmed that WHH's 4-hour position is to still benefit from the Widnes UTC 50% split. This gives WHH's "All Type 4 hour" position is to still a c5% positive increase. Now this has been confirmed, we have re-formatted the 4-hour performance reports to show an including and excluding Widnes UTC position.
Average Time in Department (ED)	**29**	How long on average a patient stays within the emergency department (ED).		
A&E Waiting Times – % patients waiting under 12 hours from arrival to admission, transfer or discharge.	**30**	% of patients who has experienced a wait in A&E longer than 12 hours from arrival to admission, transfer or discharge.	<=2%	
Ambulance Vehicle Handovers within 15 mins	**31**	% of ambulance handovers that took place within 15 minutes (based on the data recorded on the HAS system).	>65%	National guidance has redefined ambulance handover completion as the point when clinical handover is finished, the patient is on hospital equipment, and the crew is released. In line with this, NWAS has updated its KPIs to measure handover from arrival to vehicle handover (A2VH), replacing the previous arrival to patient handover (A2PH) metrics. These changes aim to improve consistency, operational clarity, and performance reporting.
Ambulance Vehicle Handovers within 30 mins	**32**	% of ambulance handovers that took place within 30 minutes (based on the data recorded on the HAS system).	>95%	
Ambulance Vehicle Handovers within 45 mins	**33**	% of ambulance handovers that took place within 45 minutes (based on the data recorded on the HAS system).	100%	
% of zero-day length of stay admissions (Type 5)	**34**	Type 5 activity		Following guidance from NHS Digital, since November 2023 we have been recording 'SDEC attendances' as a Type 5 A&E attendance instead, to include within ECDS. Type 5 attendances are for same day emergency care, they are not the same as an attendance at an Urgent Care Centre or Accident and Emergency department.

Fracture Clinic	**35**	Fracture Clinic - patients seen within 72 Hours	>95%	The British Orthopaedic Association recommends that patients referred to fracture clinic are thereafter reviewed within 72 hours of presentation of the injury.
Diagnostic Waiting Times – 6 weeks	**36**	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made.	>95%	
RTT Open Pathways and 52 & 65 week waits	**37**	Referral to open pathways	>92%	The elective recovery plan was published in February 2022 and sets targets to reduce long waits for elective treatment – namely, to eliminate waits of over 104 weeks by July 2022, waits of over 78 weeks by April 2023, 65 week waits by March 2024, and 52 week waits by March 2025.
	38	Number of patients waiting over 52 weeks.	0	
		Number of patients waiting over 65 weeks.	0	
		Number of patients waiting over 78 weeks.	0	
Cancer 28 Days	**39**	Cancer 28 Day Faster Diagnostic Standard	>75%	All patients need to receive their first appointment for cancer within 14 days of urgent referral. All patients who are referred for the investigation of suspected cancer find out, within 28 days, if they do or do not have a cancer diagnosis. All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.
Cancer 31 Day wait	**40**	Cancer 31 Day wait	>96%	All patients to receive treatment for cancer within 31 days of decision to treat.
Cancer 62 Day wait	**41**	Cancer 62 Day wait	>85%	All patients to receive treatment for cancer within 62 days of decision to treat.
Reduction in Outpatient Follow Ups	**42**	% reduction in Outpatient follow ups compared to 19/20 activity.	<=75%	
Elective Recovery Activity	**43**	% of Elective Activity (Inpatients)	104%	
		% of Elective Activity (Day cases)	104%	
Elective Recovery Diagnostics	**44**	% of Elective Diagnostic Activity - MRI	month in previous year	
		% of Elective Diagnostic Activity - Non-Obstetric Ultrasound	month in previous year	
		% of Elective Diagnostic Activity - CT scans	month in previous year	
		% of Elective Diagnostic Activity - Flexi Sigmoidoscopy	month in previous year	
		% of Elective Diagnostic Activity - Gastroscopy	month in previous year	

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

Workforce

Supporting Attendance	**52**	the monthly sickness absence % with the Trust Target (4.2%) previous year.	<5%	
Turnover	**53**	of the turnover % over the last 12 months.	<13%	
Core / Mandatory Training	**54**	of the Core/Mandatory Training Compliance, this includes:	>85%	Resolution, Equality & Diversity, Fire Safety, Health & Safety, Infection Prevention & Control, Information Governance, Moving & Handling, PREVENT, Resuscitation and most recently, safeguarding
Performance & Development Review (PDR)	**55**	of the PDR compliance rate.	>85%	
Finance				
Trust Financial Position	**56**	Cumulative operating surplus or deficit compared to plan.	Plan	
		In month operating surplus or deficit compared to plan.	Plan	
Cash Balance	**57**	The cash balance at month end compared to plan.	Plan	
Capital Programme	**58**	Capital expenditure compared to plan.	Plan	
Better Payment Practice Code	**59**	Payment of non NHS trade invoices within 30 days of invoice date compared to target.	>95%	
Cost Improvement Programme – Plans in Progress in Year	**60**	Cost savings schemes in-year compared to plan.	>90% of annual target	
		CIP - In Year	plan	
Cost Improvement Programme – Recurrent	**61**	Cost savings schemes recurrent compared to plan.	>90% of annual target	
		Recurrent CIP - In Year	Plan	
Agency Reduction	**62**	Agency Reduction	30% reduction of 24/25 plan.	
Bank Reduction	**63**	Bank Reduction	10% reduction of 24/25 plan.	

Appendix 4 - Statistical Process Control

1.0 What is SPC?

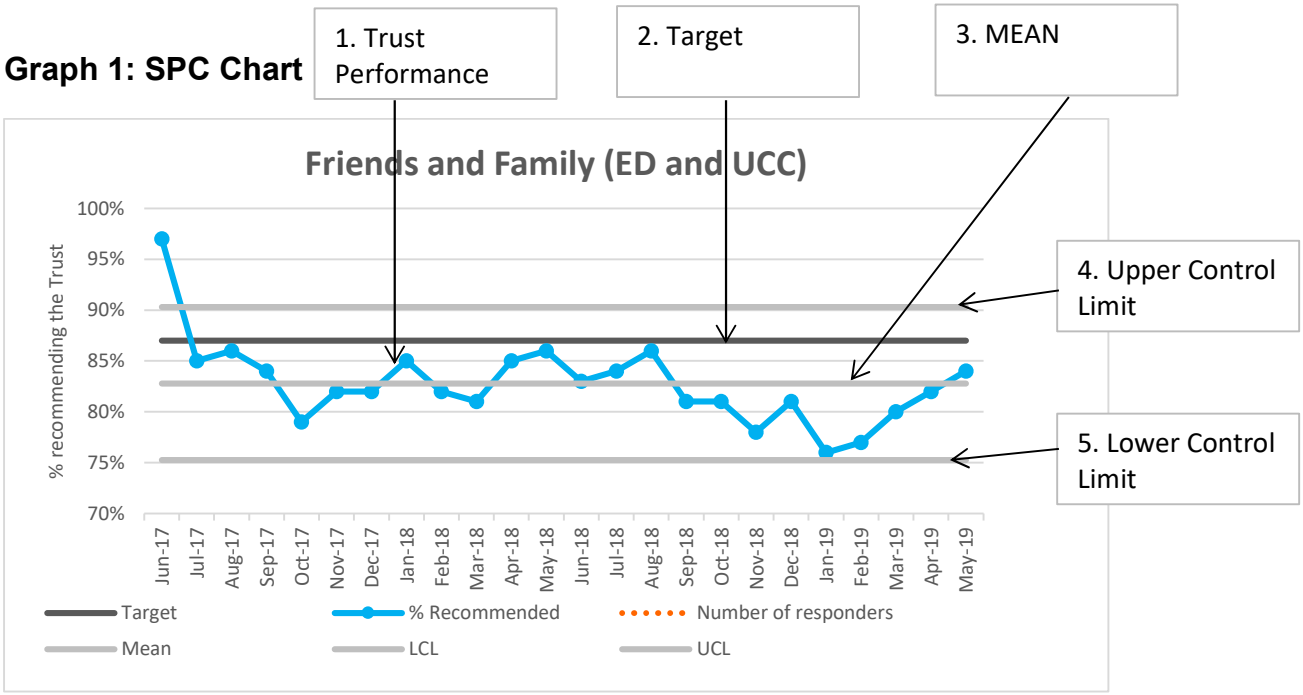
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

2.0 SPC Charts

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

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

Graph 1: SPC Chart

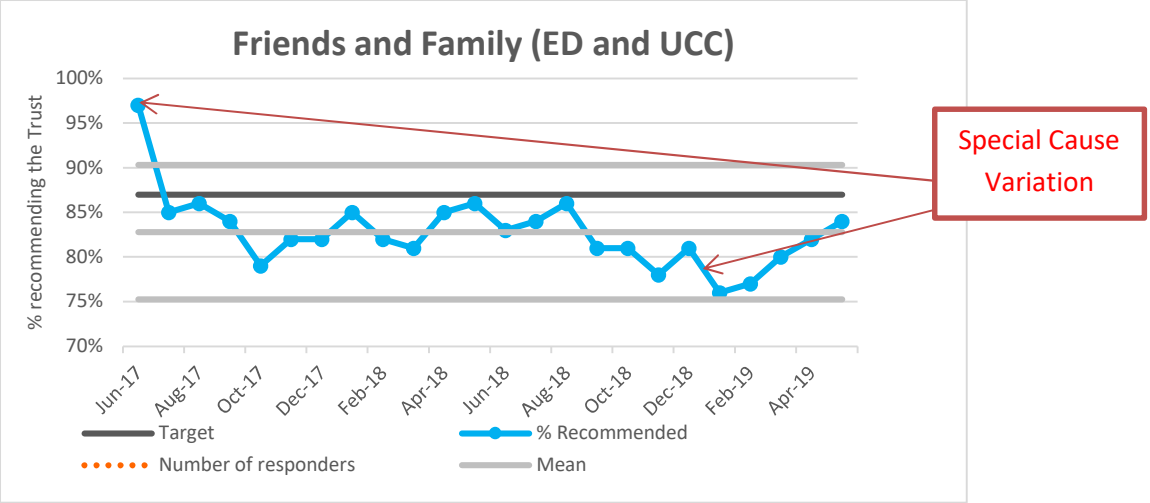


2.1 Interpreting a SPC Chart

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

1. All data points should be within the upper and lower control limits.
2. No more than 7 consecutive data points are above or below the mean line.
3. There are more than 6 consecutive points either increasing or decreasing.

Graph 2: Outlining Special Cause Variation



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

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

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

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

3.0 Making Data Count Assurance & Variation Icons

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

is based solely on the data and the SPC rules. Ideally the assurance icon should be blue “P” icon which notes the indicator is consistently passing its target over the last 7 months. Again, ideally the variation icon should be either the grey “common cause variation” icon or a blue “H” or “L” icon noting improving variation. The orange icons note potential concern.

Table 1: Making Data Count Assurance & Variation Icons

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

3.1 Business Rules

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

- Assurance icons are based on the last 7 months. E.g. if the Trust has consistently passed a target in the last 7 months the blue “P” icon will be used.
- The Variation icon is based on the last data point. If the last data point means that the one of the SPC rules described in section 2.1 of this appendix is broken, the appropriate coloured “H” or “L” icons will be used to indicate special cause variation. The variation is common cause, the grey common cause variation icon will be used.

Warrington & Halton Teaching Hospitals NHS Foundation Trust **Appendix 5**

Income Statement at 31st December 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							
Elective Inpatients	45,167	3,871	3,308	-563	33,330	29,468	-3,862
Outpatient Firsts & Procedures	34,256	2,849	2,598	-250	25,709	24,914	-795
Other Variable Activity	30,406	2,447	1,936	-511	22,827	23,297	470
Deficit Support Funding	18,327	1,527	0	-1,527	13,743	4,582	-9,161
Other income (including fixed element of contract)	238,818	19,821	21,469	1,648	179,281	178,939	-342
Sub total	**366,974**	**30,515**	**29,311**	**-1,204**	**274,890**	**261,200**	**-13,690**
Non NHS Clinical Income							
Private Patients	8	1	0	-1	5	5	0
Non NHS Overseas Patients	70	6	24	18	52	145	93
Other non protected	750	63	38	-25	563	583	20
Notional Pension Income	0	0	0	0	0	0	0
Sub total	**828**	**70**	**62**	**-8**	**620**	**733**	**113**
Other Operating Income							
Training & Education	10,663	889	1,030	141	7,997	9,371	1,374
Donations and Grants	0	0	0	0	0	0	0
Miscellaneous Income	14,919	1,245	1,413	169	11,185	13,256	2,070
Sub total	**25,582**	**2,133**	**2,443**	**310**	**19,183**	**22,627**	**3,444**
Total Operating Income	**393,384**	**32,718**	**31,817**	**-902**	**294,692**	**284,559**	**-10,133**
Operating Expenses							
Employee Benefit Expenses	-284,113	-24,153	-24,789	-636	-220,515	-222,726	-2,211
Drugs	-23,121	-1,917	-1,958	-41	-17,359	-16,875	484
Clinical Supplies and Services	-27,038	-2,460	-2,573	-112	-21,725	-21,299	426
Non Clinical Supplies	-47,403	-3,832	-4,314	-482	-35,895	-35,703	192
Depreciation and Amortisation	-17,659	-1,472	-495	976	-13,244	-12,268	976
Net Impairments (DEL)	0	0	0	0	0	0	0
Net Impairments (AME)	0	0	0	0	0	0	0
Restructuring Costs	0	0	0	0	0	0	0
Total Operating Expenses	**-399,333**	**-33,834**	**-34,129**	**-295**	**-308,738**	**-308,870**	**-132**
Operating Surplus / (Deficit)	**-5,950**	**-1,116**	**-2,312**	**-1,196**	**-14,045**	**-24,311**	**-10,265**
Non Operating Income and Expenses							
Profit / (Loss) on disposal of assets	0	0	1	1	0	29	29
Interest Income	520	43	97	54	390	1,022	632
Interest Expenses	-138	-11	3	15	-103	-88	15
PDC Dividends	-5,501	-458	-458	0	-4,126	-4,126	0
Total Non Operating Income and Expenses	**-5,119**	**-427**	**-356**	**70**	**-3,839**	**-3,164**	**675**
Surplus / (Deficit) - as per Accounts	**-11,068**	**-1,542**	**-2,668**	**-1,126**	**-17,884**	**-27,475**	**-9,590**
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	54	54	1	502	503	1
Total Adjustments to Financial Performance	**669**	**54**	**54**	**1**	**502**	**503**	**1**
Adjusted Surplus / (Deficit) as per NHSI Return	**-10,399**	**-1,488**	**-2,614**	**-1,126**	**-17,382**	**-26,972**	**-9,590**
Deficit Support Funding	-18,327	-1,527	0	1,527	-13,743	-4,582	9,161
Adjusted Surplus / (Deficit) - without deficit support funding	**-28,726**	**-3,015**	**-2,614**	**401**	**-31,125**	**-31,554**	**-428**

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

IPR – December 2025 Detail
4th February 2026

Introduction

Warrington and Halton Teaching Hospitals NHS Foundation Trust

There is **1 Indicator that has been requested via the Action Log to be monitored going forward,** This is:

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

There are **4 indicators that are both failing and have special cause variation of a concerning nature**, these are:

- **1. Open Incidents (over 40 days)** – Target 0%
- **8. VTE Assessment** – Target 95%
- **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

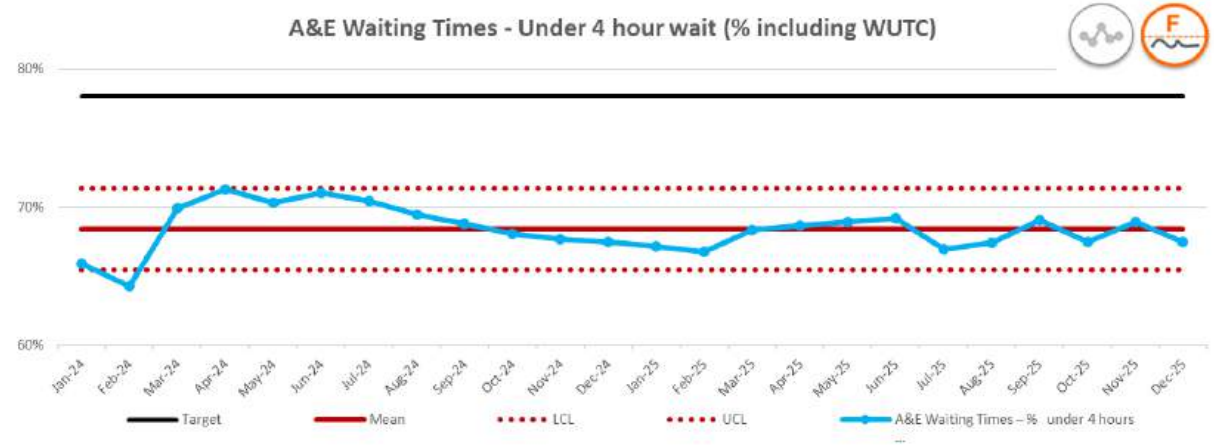
There are **2 indicators that consistently fails and cannot be measured for variation,** these are:

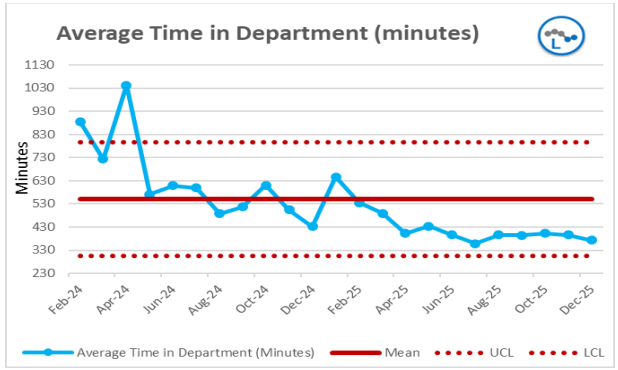
- **61. CIP (recurrent) –** delivered against plan
- **63. Bank Reduction** – delivery against 10% reduction of 2024/25 plan

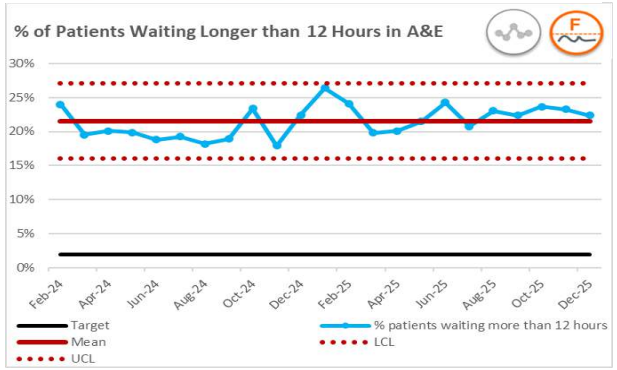
December 2025 IPR by Exception – A&E Waiting Times

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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







December performance was 67.48%. The in-year Trust target of 78% includes Widnes Type 3 activity which typically contributes 4.5%.

The national constitutional standard remains at 95%.

Performance continues to be negatively impacted by wait to be seen in ED, long length of stay and an overall high bed occupancy.

12-hour type 1 performance continues to be challenged. Key themes for the breaches is the high bed occupancy restricting flow through ED and Patients waiting Mental health assessment and placement comprises our longest delays in ED. Non admitted breaches have been improving supported by the ED improvement group.

A&E 4-hour performance*

Rank 106 out of 118

December 2025

Source: NHS England Acute Provider Table
Accessed January 2026

A&E 12-hour performance

Rank 115 out of 118

December 2025

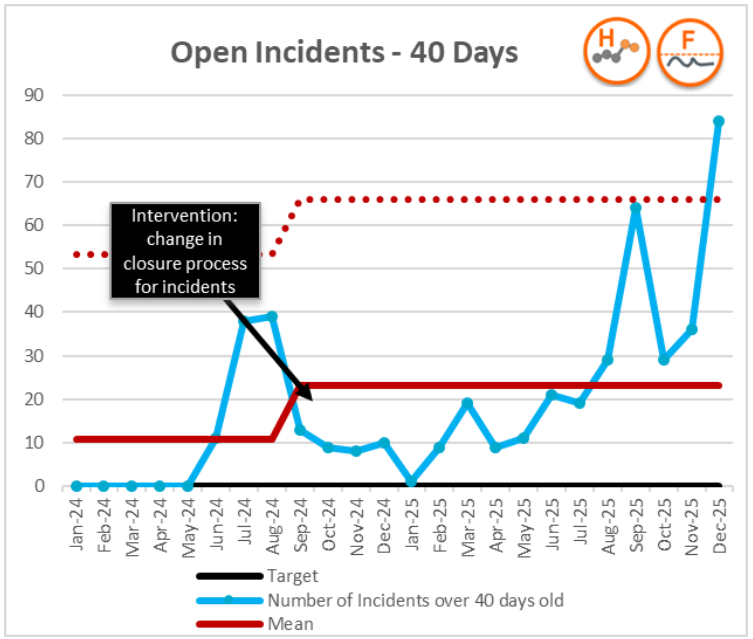
Source: NHS England Acute Provider Table
Accessed January 2026

*The addition of WUTC Type 3 activity will be added to the NHS England Acute Provider Table post integration with Bridgewater NHS Trust.

December 2025 IPR by Exception - Quality

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

1. Incidents (Over 40 days)



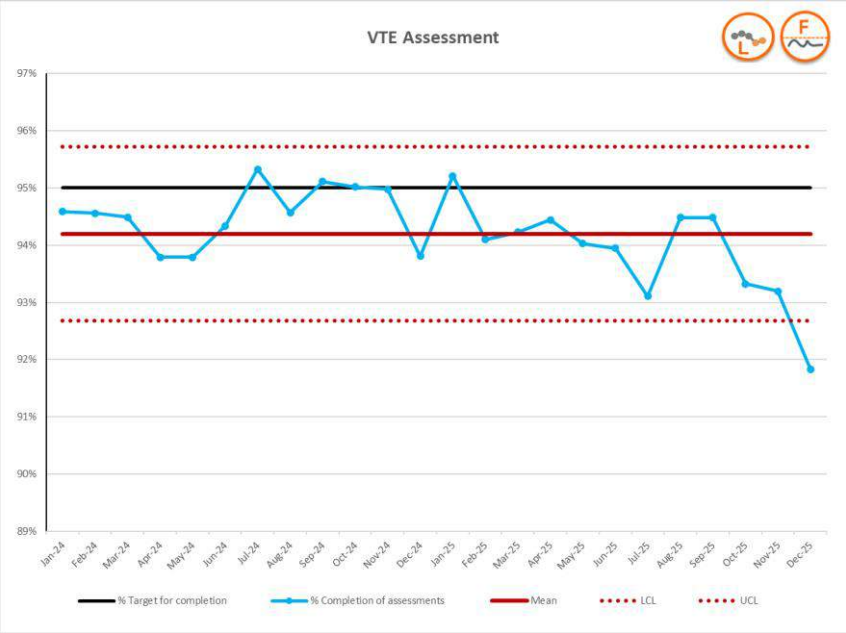
84 incidents had remained open for more than 40 days. The organisation experienced the impact of recent leadership changes on incident management performance, as new leaders continued to build their understanding of processes and reporting requirements, which contributed to delays and inconsistencies in how low-level, no-harm incidents were progressed.

A weekly governance dashboard is overseen by the Executive Team at the weekly safety Oversight Meeting , monitoring reporting trends and triangulating incidents, complaints, claims and inquests, with each CBU supported by a designated Governance Team member to ensure consistency. The position on incidents overdue 40 days is escalated daily to the relevant triumvirates, with this work prioritised, and a focused improvement action plan is in place to reduce the backlog through targeted support, enhanced oversight and clearer accountability for timely progression. Datix system alerts at a lower 30-day threshold now provide earlier visibility and additional support, and a daily report outlining learning response and action positions is in place to support Care Group Triumvirate oversight. New leaders are now fully aware of the established processes and have agreed trajectories in place to meet all incident management requirements by early February 2026.

December 2025 IPR by Exception - Quality

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

8. VTE Assessment



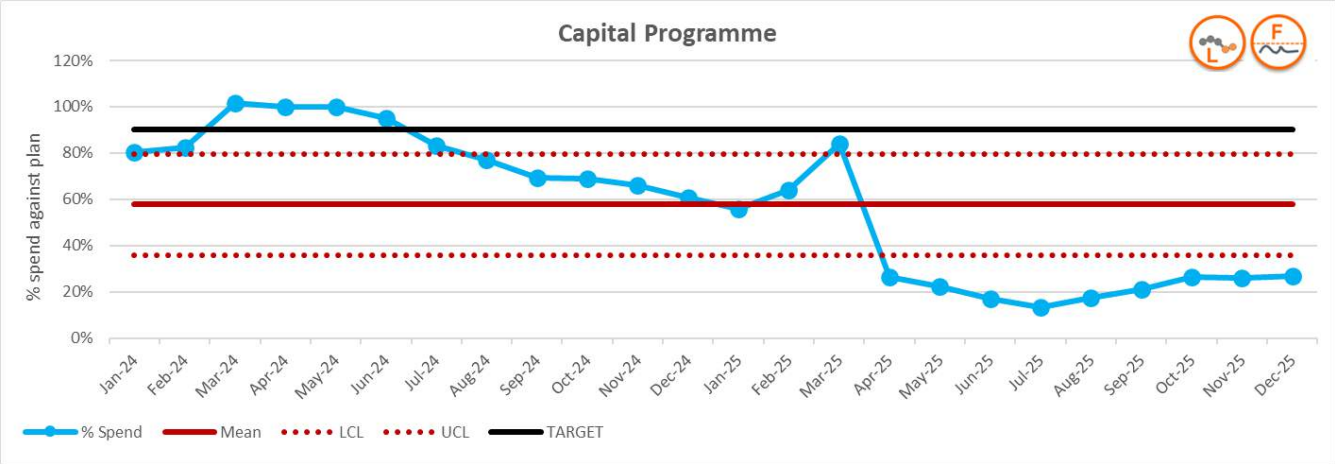
Ward teams are now using real-time GIRFT dashboard data to complete outstanding VTE risk assessments, with CBUs reviewing performance through the VTE RA Dashboard and monthly Governance Meetings. Monthly compliance updates are issued to clinical leaders to prompt focused improvement.

CBUs have been asked to ensure daily use of real-time ward data so that “VTE not completed” entries are reduced to zero during morning board rounds, supporting achievement of the >95% target. Awareness is being reinforced by the Patient Safety Nursing Team, including a Trust-wide safety brief issued in January 2026. The Thrombosis Group continues to monitor trends and guide ongoing improvement.

December 2025 IPR by Exception – Finance

58. Capital Programme – % delivered against plan

Warrington and Halton Teaching Hospitals
NHS Foundation Trust



Capital expenditure at the end of month 9 is £5.1m against a plan of £18.9m.

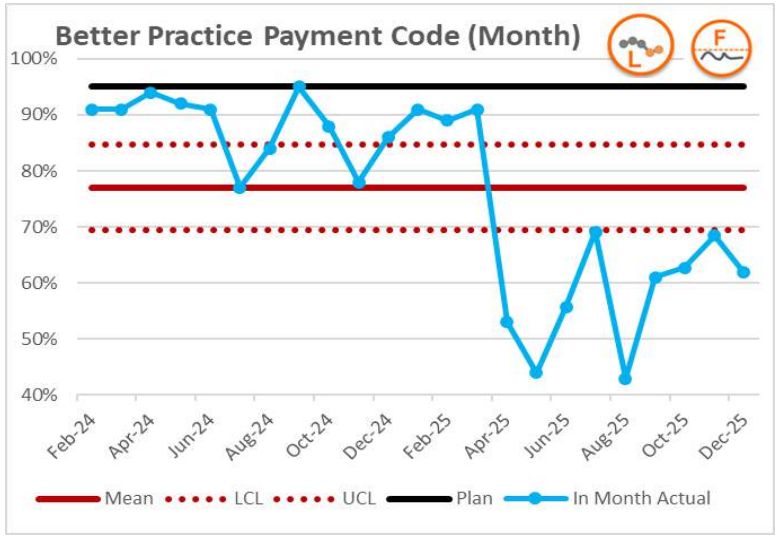
This is mainly driven by EPR delays, ward refurbishment paused and replaced with smaller schemes, and late confirmation of additional capital. The plan is expected to be fully delivered by year end.

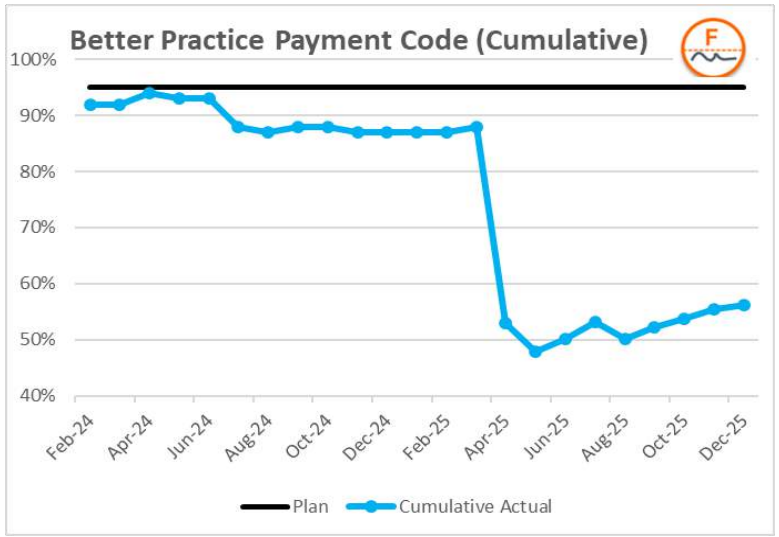
The reason for the year to date variance is due to timing and is expected to be fully delivered by year end. The risk associated with delivering the 2025/26 capital plan is being monitored at CPG and reported to FSPCiC.

December 2025 IPR by Exception – Finance

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

59. Better Practice Payment Code –% cumulative performance





Cumulative BPPC performance is 56% which is below the national target of 95%.

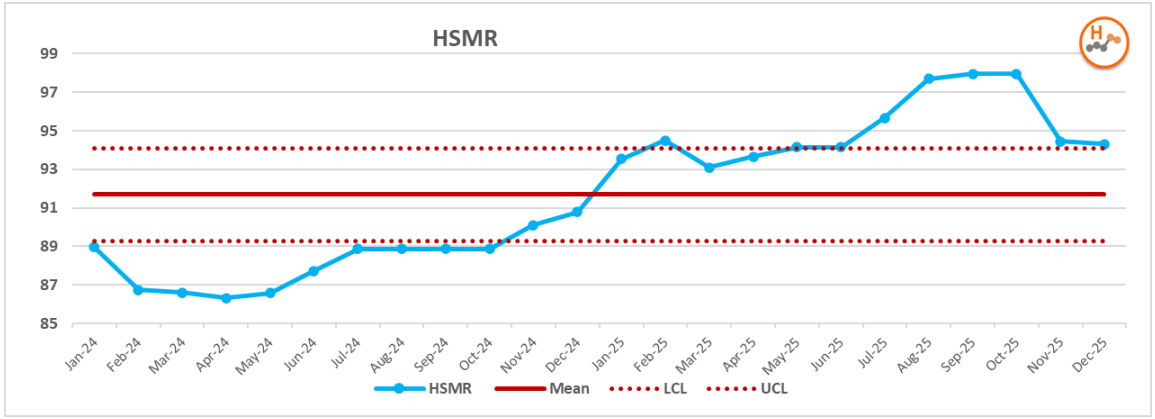
The main reason for this is due to cash management measures put in place to mitigate against the Trust's worsening cash position.

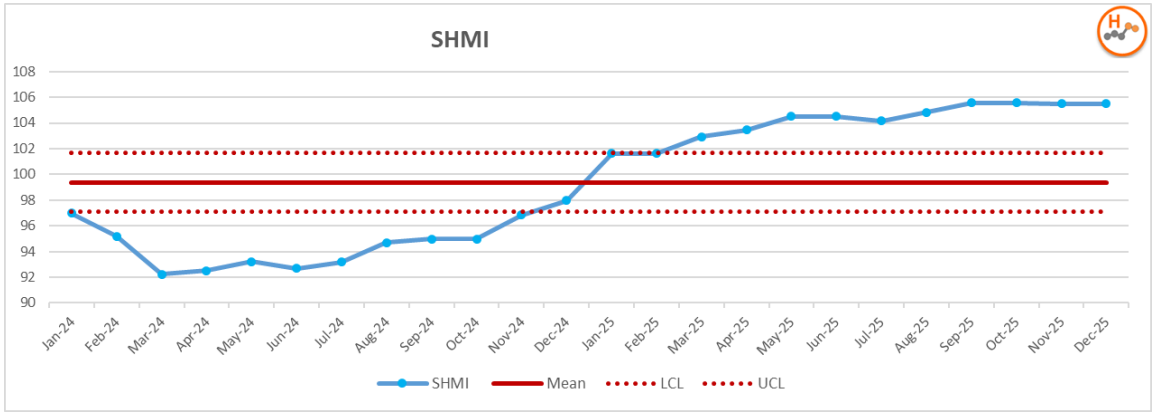
BPPC is being closely monitored, especially due to cash shortages. This includes daily cash monitoring, ensuring wherever possible we pay SME. BPPC won't reach the 95% target given the cash position of the Trust and only three months remaining in the year.

December 2025 IPR by Exception - Quality

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

13,14. Mortality ratio – HSMR and SHMI





The overall SHMI for Warrington is slightly above 100, but within expected limits using an over-dispersed funnel plot.

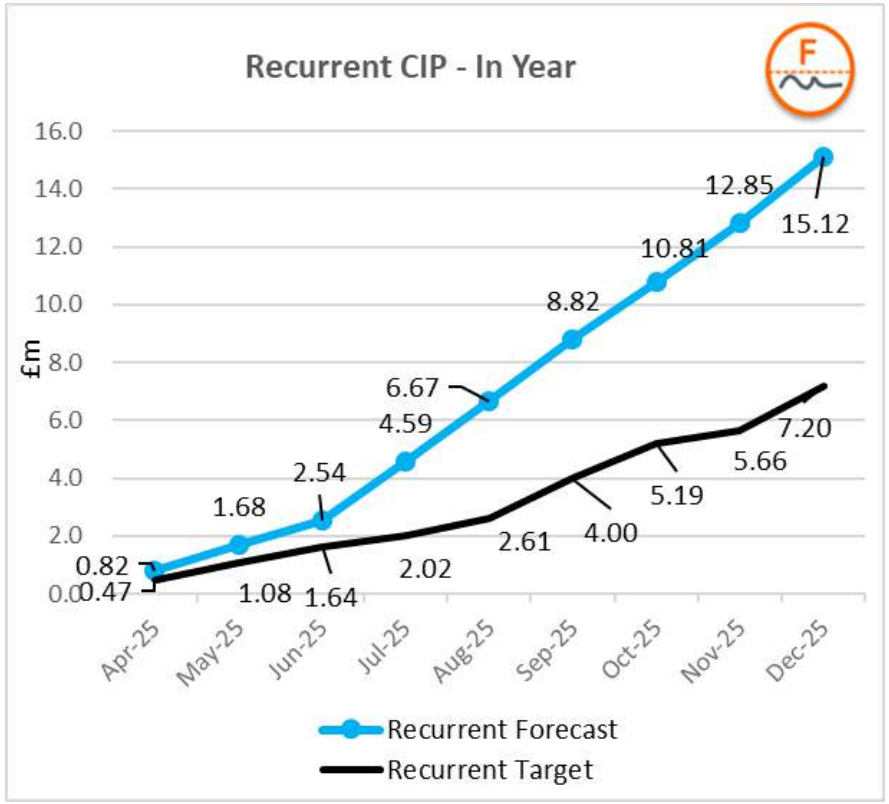
It had been increasing since month ending January 2024 but has now stabilised and has seen a slight recent drop. Adjusting for palliative care slightly reduces the SHMI which suggests possibly a more complex patient case mix.

Mortality indicators, including SHMI and HSMR, are routinely monitored through the Mortality Review Group, which reports to the Quality Assurance Committee. This process provides oversight and assurance, ensuring that any emerging areas of concern are identified promptly. Where necessary, detailed ‘deep dive’ reviews are undertaken to understand the underlying factors and inform improvement actions.

December 2025 IPR by Exception – Finance

Warrington and Halton Teaching Hospitals NHS Foundation Trust

61. CIP – % delivery against plan (recurrent)



£7.2m CIP has been delivered recurrently against the target of £15.1m.

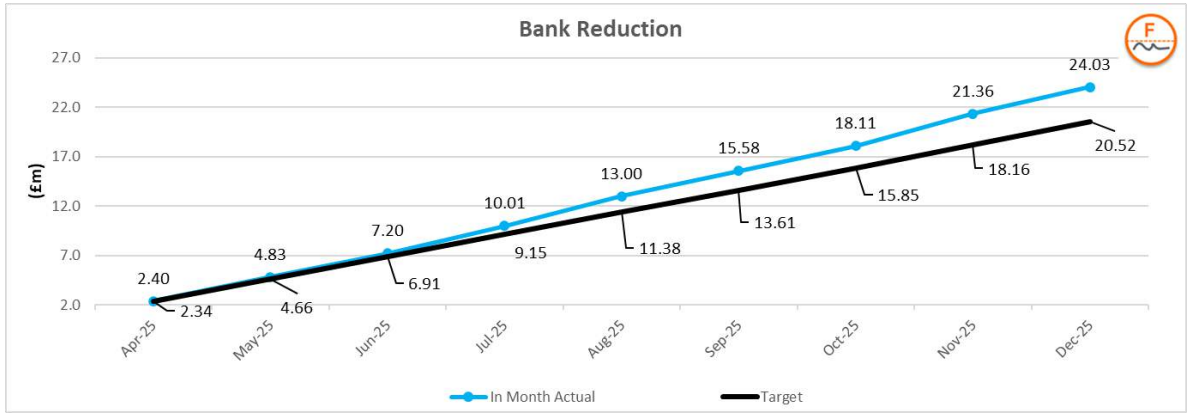
The Trust aims to deliver CIP recurrently wherever possible and challenges if CIP is not recurrent. Providing the full year effect of schemes delivering later in the year deliver this would mitigate the non-recurrent schemes into 2026/27.

Work continues to identify recurrent CIP schemes and turn non-recurrent schemes recurrent. 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.

December 2025 IPR by Exception – Finance

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

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



At month 9 bank expenditure is overspent by £3.5m. £2.5m is due to the impact of Industrial Action in July, November and December. The remainder is mainly driven by A&E medical staffing vacancies and sickness.

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.

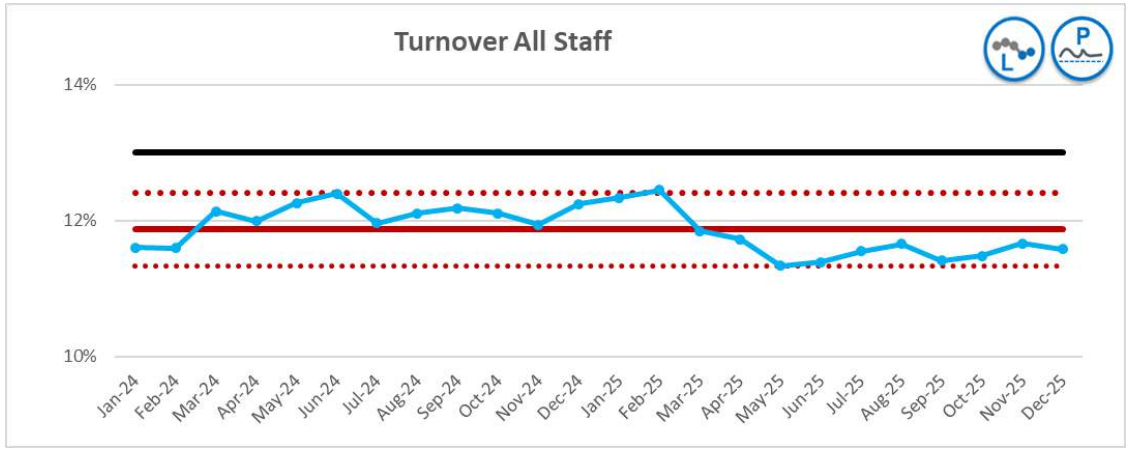
The nurse bank rate was reduced during 2024/25 and has reduced again from 1 May 2025. Substantive recruitment into medical posts has taken place and is expected to continue which will reduce the medical bank spend.

Improving metrics

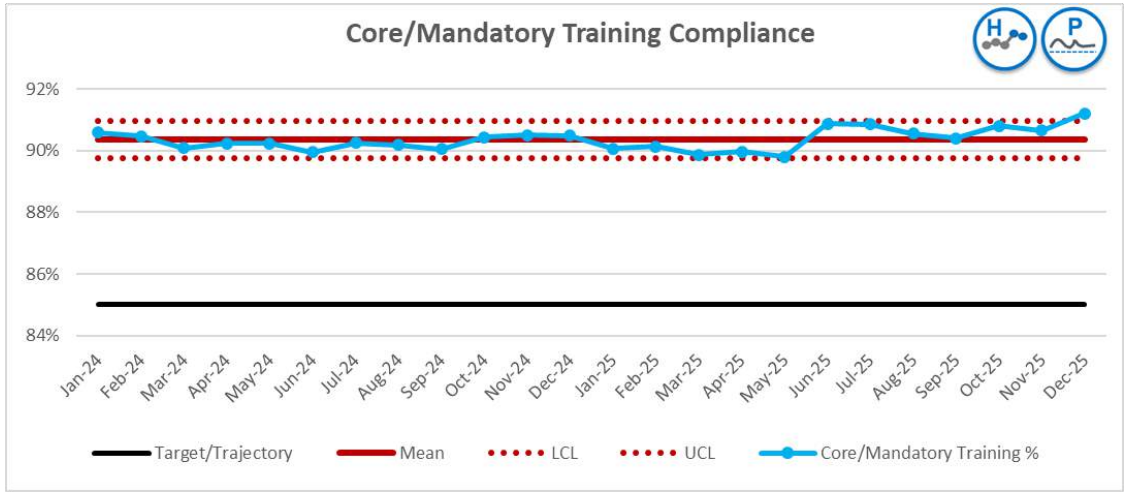
Metrics consistently passing target & maintaining/improving performance

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

53. Turnover



54. Core/Mandatory Compliance



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

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Recommendation

The Trust Board is asked to note the actions being taken in relation to these nine IPR indicators of concern and note the two improving indicators.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/26/02/153a(i)	Meeting	Trust Board	Date Of Meeting	4 February 2026

Date of Meeting	9 December 2025
Name of Meeting & Chair	Quality Assurance Committee, chaired by Jane Downey
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/25/12/199	**Hot Topic – Review of Sharps incidents**	The committee received a presentation noting • Legal requirements and moral duty in relation to sharps • Overview of Training/policies/Audits • Overview and analysis of incidents – January to July 2025 (58 incidents in total – All low or no harm) • Overview of Occupational Health Follow ups • Plan further review of data August to present. • Learning shared at key meetings – Infection Control Committee(ICC) /Chief Nurse Check In etc • Target prevention activity ongoing in areas of higher incidence • Relaunch of risk assessment on sharps safety January 2026.	**Moderate** **Plans in place need to monitor improvements.** **More detail/ progress on actions to be provided to ICC following next review of incidents.**	**Substantial: Review via Quality Assurance Committee Quarterly, monthly oversight via Safer Sharps Group reporting to Health and Safety and Infection Control Committee**	**Progress report via fragile services to QAC in December** **Monthly oversight Safer Sharps Group reporting to Health and Safety and Infection Control Committee.**
QAC/25/12/204	**Patient Safety and clinical Effectiveness Sub Committee (PSCESC) Report.**	An update from Patient Safety and Clinical Effectiveness Sub-Committee (PSCESC) was provided to the Committee. Key areas to note	**Moderate** **Assurance received, areas of concern have**	**Substantial** **Monthly oversight at QAC**	**Update to QAC January 2026**

		• Cardiology – looking to step down from fragile services– staffing issues addressed • Chronic Pain – limited progress, new clinical lead appointed, validation exercise ongoing • Cancer –SOP approved and in place • Urology – improved outpatient waiting list position. P2, 3 and 4 lists have reduced. • Plans in place to address key issues. • Rheumatology escalated into fragile service – deep dive to come back next month • Fractured neck of femur- mortality has increased to 99 centile – submitted data incomplete which can affect data, crude mortality remains high.	**plans in place and are being monitored monthly via PSCESC.**	**Executive oversight monthly of all fragile services is conducted through PSCESC**	
QAC/25/12/202	**ED Update**	The committee received a report noting • 2 improvement schemes ongoing but behind schedule • Department gone live with push model for Paediatric Assessment • A test of change has been implemented placing Emergency Frailty Team in Ed. • Increased in harm incidents recorded – medications reported as the highest theme.	**Limited** **Actions behind track – further assurance requested**	**Substantive** **Oversight at QAC monthly.**	**Update to QAC January 2025 including a deep dive on harm incidents .**
QAC/25/12/205	**Fractured neck of femur – future plan**	The committee received a report noting • November position for time to theatre has decreased to 28%. • Time to ward shows no significant improvement.	**Limited** **Despite actions being complete, further deterioration noted.**	**Substantive** **Oversight at QAC monthly.** **Monthly at Patient Safety**	**Update to QAC in December 2025. Monthly monitoring via PSCESC**

		• Average time to surgery has increased to 50 hours, representing a deterioration from previous months. • Continued deterioration in the post-operative mobilisation KPI. • Crude mortality is above the upper control limit. • The Executive Team is overseeing performance weekly		**and Clinical Effectiveness (PSEESC)**	**Capacity and demand analysis requested for next report**

The Committee also received the following items.

QAC/25/12/201 IPR metrics
QAC/25/12/203 Typing backlog update on SOP
QAC/25/12/206 Maternity update
QAC/25/12/207 Mental Health Update
QAC/25/12/208 Staffing Report-Biannual report
QAC/25/12/209 Learning from deaths review
QAC/25/12/210 Quality Strategy and Priorities update Q2
QAC/25/12/211 High level enquiries

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

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

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/26/02/153a(ii)	Meeting	Trust Board	Date Of Meeting	4 February 2025

Date of Meeting	13 January 2025
Name of Meeting & Chair	Quality Assurance Committee, chaired by Jane Downey
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/26/01/221	**Hot Topic – Radiology Reporting**	The committee received a presentation noting • Increased activity 18,333 cases since 2019 • Radiology consistently achieved DMO1 targets • Consultant shortfalls identified when plotting activity v job plans (35k reports shortfall) • Outsourcing in place to mitigate • Revenue Request in development • Increase in PALs enquiries (no=48 April – September 25)	**Moderate** **Await outcome of Revenue request , further assurance regarding long term plans.**	**Substantial: Review via Quality Assurance Committee . Paper presented to Patient safety and Clinical Effectiveness (PSCESC) November 25**	**Progress report back to QAC in 6 Months**
QAC/26/01/222	**Deep Dive into Theatre prosthesis related incidents .**	The committee received a presentation noting • Between April – Nov 25 10 related incidents. • Two incidents reported as Never Events • Overview of improvement actions were provided • Noted lack of documented evidence in some areas of plan	**Limited** **Clear timeframes requested on all outstanding actions**	**Substantial: Review via Quality Assurance Committee . Theatre Safety reported monthly to Patient Safety and Clinical**	**Update to QAC February 2026. Theatre Safety reported monthly to Patient Safety and Clinical Effectiveness Committee**

				Effectiveness Committee	
QAC/25/12/204	**Patient Safety and clinical Effectiveness Sub Committee (PSCESC) Report.**	An update from Patient Safety and Clinical Effectiveness Sub-Committee (PSCESC) was provided to the Committee. Key areas to note • Chronic Pain – Joint injections falling outside of nice guidance will cease from February 26. Validation underway assessing 900 patients on Patient Initiated Follow up list • Urology – improved outpatient waiting list position. P2, 3 and 4 lists have reduced. • Plans in place to address key issues. • Rheumatology escalated into fragile service – monitoring action plan monthly • Emerging concern re surgical site infections for prosthetic joints. – cases presently under review	**Moderate** **Assurance received, areas of concern have plans in place and are being monitored monthly via PSCESC.**	**Substantial** **Monthly oversight at QAC** **Executive oversight monthly is conducted through PSCESC**	**Update to QAC February 2026**
QAC/26/01/227	**Fractured Neck of Femur Performance Assurance & future plan**	The committee received a report noting • Progress against action plan • 37 patients treated for NOF in the month of December performance 38% patients to theatre within expected timeframe • Capacity modelling showing approximately 7 – 8 hours of theatre time short of requirements – updated detailed capacity and demand report requested	**Limited** **Actions behind track – further assurance requested**	**Substantive** **Oversight at QAC monthly.** **Executive oversight monthly of all fragile services is conducted through PSCESC**	**Update to QAC February 2025 including a capacity and demand study.**

QAC/26/01/227	**Fractured neck of femur – future plan**	The committee received a report noting • November position for time to theatre has decreased to 28%. • Time to ward shows no significant improvement. • Average time to surgery has increased to 50 hours, representing a deterioration from previous months. • Continued deterioration in the post-operative mobilisation KPI. • Crude mortality is above the upper control limit. • The Executive Team is overseeing performance weekly	**Limited** **Despite actions being complete, further deterioration noted.**	**Substantive** **Oversight at QAC monthly.** **Monthly at Patient Safety and Clinical Effectiveness (PSEESC)**	**Update to QAC in December 2025.** **Monthly monitoring via PSCESC** **Capacity and demand analysis requested for next report**
QAC/26/01/228	**Clinical Pharmacy Service Supply, Discharge and Reconciliation**	The committee received a report noting • The performance of the Clinical Pharmacy Service across medicines supply • Pharmacy screening of ward discharges had improved significantly, rising from 39% in January 2024 to 64–70% by late 2025 • Assurances seen how high-risk patients are prioritised using digital tool • Work required with Digital Teams to sustain toll	**Moderate** **Good assurance regarding mechanisms and performance to manage risk. Digital tool not sustainable in its current form required Digital Team support.**	**Substantive** **Oversight at QAC monthly.** **reported monthly to Patient Safety and Clinical Effectiveness Committee**	**Progress report back to QAC in 6 Months** **monitoring via PSCESC**

The Committee also received the following items.

QAC/26/01/233 Board Assurance Framework
QAC/26/01/224 Due Diligence Risks
QAC/26/01/225 ED Improvement
QAC/26/01/229 Maternity Update
QAC/26/01/230 Safeguarding Annual Report
QAC/26/01/231 Mortuary Licenced Activity
QAC/26/01/232 Violence reduction Strategy
QAC/26/01/234 Clinical Audit Report
QAC/26/01/235 Quality Improvement Progress Report
QAC/26/01/236 Enabling Strategy Alignment Progress Report
QAC/26/01/237 Quality Impact Assessment
QAC/26/01/238 High Level Enquiries
QAC/26/01/239 Information Governance and Records
QAC/26/01/240 Infection Control BAF

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

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

Level of Assurance	Description
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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

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NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/26/02/153b(i)	Meeting	Trust Board	Date of Meeting	4th February 2026

Date of Meeting	Wednesday 17th December 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/25/12/170	**Deep Dive – Workforce & Organisational Development Enabling Group (WEG)**	The committee received an update on the journey of the WEG and the phased approach which led to the development of the three priorities over a five-year period: 1. A Workforce Data Set and Dashboard for Warrington place. 2. A Staff Health & Wellbeing Offer and Directory for Warrington place. 3. Care Leaver employment, support and training offers for Warrington place. The WEG however faced barriers relating to engagement and turnover with no successions plans, which led to a lack of quoracy and decision making. Despite the challenges there were a number of outputs; a Care Leavers network is still operating successfully, and Wellbeing offers remain available across the organisations involved.	No assurance level provided by the Chair, due to the programme being led by an external organisation. The committees update clarified that both WHH and BCH would be stepping away from the leadership of the programme due to the lack of engagement from partners to deliver the requirements of the programme.		

		These matters affecting ongoing programme and project delivery have been escalated to Warrington Together Partnership Board. Programme on pause until Feb-26, where a decision about the future of the WEG will be made by the Partnership Board.			
SPCIC/25/12/171	**Hot Topic – TUPE**	The committee received an update on TUPE, Transfer of Undertakings (Protection of Employment) Regulations and the structured approach to ensure legal assurance and people focus. The consultation timeline and phases are: Phase 1: Open Group Consultation Meetings - Complete Phase 2: Targeted Group Consultation Meetings – Launched on 8th Dec 2025 Phase 3: One-to-One/Small Group Meetings – end of Jan/early Feb 2026 Phase 4: Mop-Up Sessions – mid Feb/end of March 2026 The committee received a summary of the key principles being followed. Consultation outcome report to be presented to SPCIC in May 2026.	The Committee received **assurance** on delivery of the TUPE process.	The Committee received **assurance** on the governance of relating to TUPE.	Jan 2026
SPCIC/25/12/172	**Chief People Officer Report(s)**	The Committee received the paper with updates on relevant programmes of work. The Committee noted the pressures on the organisation due to industrial action and the	The Committee received **moderate assurance** on delivery due to the current staff	The Committee received **assurance** on the governance of the topics reported.	Jan 2026

		assurance that risks in relation to IA are being managed well. The Committee noted the lower response rate for Staff Survey compared to last year for both WHH and BCH. The Committee also noted the challenges in encouraging the workforce to have their flu vaccine with low uptakes. The Committee acknowledged the work being undertaken by the organisation to encourage uptake. The Committee discussed current staff morale with low response rates to Staff Survey and flu vaccine a potential indicator. The Committee praised the HR Business Partnering Team who received 'Highly Commended' Award from the HPMA for their development programme. The Committee also acknowledged the award of the Menopause Friendly Accreditation.	resistance to flu vaccination and low response rate to Staff Survey.		

SPCIC/25/12/176	**Improving People Practices Report (including Employee Relations data)**	The committee received reports that provide an overview of the level of employee relations activity, areas of risks, suspensions and wider actions to improve employee relations case management performance. **WHH** The employee relations caseload is extremely high in comparison to previous years; however, the impact is yet to be seen in the timeliness of resolution. The pressure on the HR team was noted, and thanks was passed onto the team. **BCH** The employee relations caseload is higher than previous period. Lower staff engagement and satisfaction, due to workforce pressures are the themes causing the spike in employee relations cases. The committee heard about the informal Fact-Finding/Just Culture resolution approach, which resolved 26 cases, preventing formal casework. The pressure on the HR team was noted, and thanks was passed onto the team.	The Committee received **assurance** on delivery of the management of employee relations cases.	The Committee received **assurance** on the governance of how employee relations cases are managed.	

Reports received by the Committee for assurance:

- SPCIC/25/12/173 - Workforce Brief on National, Regional, ICB, or Local Workforce Issues
- SPCIC/25/12/174 - ICB Workforce Programmes Assurance
- SPCIC/25/12/175 - Better Care Together Integration Update
- SPCIC/25/12/177 - Health and Wellbeing Update (including the Health and Wellbeing Guardian Report)

- SPCIC/25/12/178 - WHH & BCH Joint Safer Staffing Report (including red flag data)
- SPCIC/25/12/179 - BCH Internal Audit Action Plans

Chairs Logs received by the Committee:

- SPCIC/25/12/180 - WHH Workforce Review Group
- SPCIC/25/12/181 - WHH Workforce Inclusion and Culture Sub-Committee

Assurance Key:

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

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

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/26/02/153b (ii)	Meeting	Trust Board	Date of Meeting	4th February 2026

Date of Meeting	Wednesday 21st January 2026
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/26/01/189	**Deep Dive – Post Transaction Implementation Plan (PTIP) – Organisation and the People Directorate**	The Committee received	The Committee received **assurance** on delivery of the PTIP.	The Committee received **assurance** on the governance relating to the PTIP.	April 2026
SPCiC/26/01/193	**ICB Workforce Programmes**	The Committee noted the report and an update was provided regarding the arrangements in place to transfer the workforce priorities that were being overseen by the Financial Control and Grip structure (FCOG) to the C&M Provider Collaborative governance arrangements, with recommendations made by the CPO Network on what should continue with delivery via the CPO group, and what was a matter for local determination.	N/A – update provided for Trust Board on regional changes	N/A – update provided for Trust Board on regional changes	Monthly

SPCiC/26/01/198	**Annual Equality Delivery System (EDS) 2025/26**	The Committee received this report for approval. It provided a summary of the results for the Equality Delivery System annual assessment, linked to the Public Sector Equality Duty requirements. The paper highlighted significant evidence which has been collated to indicate the impact of workstreams across departments to reduce inequalities in terms of access, promotion of equity and celebrating diversity. The report provided a summary review of the stakeholder engagement which has been undertaken to formally score both the patient and workforce elements of the EDS. The report details the Trust overall score as "achieving", the same as the previous year with some increase in scores. Publication of the EDS is required by 28 February 2026 on both the Trust's external website and also to NHS England's Equality, Diversity and Inclusion team. The Committee approved the report.	The Committee received **assurance** on delivery of EDS and approved the submission.	The Committee received **assurance** on the governance relating to EDS and approved the submission.	January 2027

SPCiC/26/01/199	**Safer Staffing Report (Including Q3 Red Flags)**	The Committee received this report for information. It provided an oversight of ward staffing data for November 2025. The Committee noted that vacancies for Band 5 Nurses within ED remain high. This rate has continued since the establishment was increased circa 18 months ago. Further review of data to identify when and why people leave is to be undertaken. The Trust is awaiting the outcome of a charitable bid to support the implementation of self-rostering. The Committee also noted the high rates of sickness absence in some areas and the need to focus on reducing absence.	The Committee received **moderate assurance** on the delivery of Safer Staffing.	The Committee received **assurance** on the governance of Safer Staffing.	

Reports received by the Committee for assurance:

- SPCiC/26/01/188 – BCH Staff Story – Children's Services (Flexible Working)
- SPCiC/26/01/190 - BAF and Corporate Risk Register
- SPCiC/26/01/191 – Chief People Officer Report
- SPCiC/26/01/192 - Workforce Brief on National, Regional, ICB, or Local Workforce Issues
- SPCiC/26/01/194 - Better Care Together Integration Update (Workforce and Corporate Services)
- SPCiC/26/01/195 – Due Diligence Report
- SPCiC/26/01/196 – Workforce Integrated Performance Reports
- SPCiC/26/01/197 – BCH People Strategy Bi-Annual Update
- SPCiC/26/01/200 – Exception Reporting Reforms for Resident Doctors

Chairs Logs received by the Committee:

- SPCiC/26/01/201 - WHH Workforce Review Group

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NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/26/02/153ci	Meeting	Trust Board	Date Of Meeting	4 February 2026

Date of Meeting	22 December 2025
Name of Meeting & Chair	Finance, Sustainability and Performance Committee in Common, Chaired by Tina Wilkins
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up / Review date
FSPCiC/ 25/12/15 5	**Deep Dive – Tier 1 Update (including ED Improvement)**	The Committee in Common received the presentation noting:- • Drivers for 4 and 12 hour performance include high bed occupancy, maintaining wait to be seen, ED footprint constraints and no co-located UTC. • Internal type 1 performance 51.42% in November (highest performance YTD), Widnes UTC lower performance compared to average • Interventions in place to deliver improvement by March 2026 in both 4 and 12 hour performance. • The Trust is also involved in wider System led projects such as Single Point of Access Model and NWAS alternative to conveyance pilot • When discharge target met, de-escalation takes place and close the ED corridors. • Concern around NCTR and the need to work with Local Authorities to ensure packages of care are in place to aid discharge and improve performance.	The Committee received **no** assurance for tier 1 given low performance	The Committee **noted** the report and is **assured**	**FSPCiC January 2026**
FSPCiC/ 25/12/15 5	**Deep Dive – Tier 2 Update**	The Committee in Common received the presentation noting:- • Plans in place to achieve 65% RTT by March 2026. • Forecasting a zero performance on 65 weeks by end of December 2025. • 52 week requirement to meet 1% by March 2026 is more challenging although still forecast to deliver	The Committee received **moderate** assurance for tier 2 given improved trajectory	The Committee **noted** the report and is **assured**	**FSPCiC January 2026**
FSPCiC/ 25/12/15 6	**Hot Topic – Medium Term Plan**	The Committee in Common received the report noting:- • Deficit plan limit of £16.7m accepted on the proviso that assumptions are met such as the level of income required to achieve the plan, further work required	The Committee received **no** assurance given	The Committee **noted** the	**Trust Board**

		prior to final submission in February 2026. May require negotiation over the 3 year plan to spread the deficit improvement over later years if not all achievable in 2026/27. • Concern raised around the deliverability of the deficit plan limit given the requirement for a 10% recurrent CIP and the required workforce reduction. • Meetings arranged with NHSE and ICB over the next fortnight to review assumptions.	the risk to deliverability of the plan	report received **moderate** assurance given assumptions whilst awaiting guidance	**January 2026**
FSPCiC/ 25/12/15 7	**Finance Update**	The Committee in Common received the report noting:- • Month 8 deficit position is £0.8m worse than plan at £28.9m (before deficit support funding (DSF)) due to the impact of Industrial Action (IA) in November. After DSF the deficit is £24.4m (£8.5m worse than plan). • Risk adjusted forecast excluding DSF has been submitted at a £42.2m deficit compared to a plan of £28.7m. The variance consists of £11.2m stretch target, PFR risk assessed CIP delivery of £1.7m and IA in November of £0.8m. Likely to worsen in month 9 with further IA taking place. • The Trust underlying deficit is £43.8m with the variance to plan mainly driven by the stretch target as well as non-recurrent benefits in 2025/26. • Bank not meeting 10% reduction, mainly due to IA and the impact of the pay award. • One revenue request supported by the EMT meeting. • £12.9m CIP delivered at month 8, however £5.7m delivered recurrently. FYE of non-recurrent schemes continue to mitigate, push to turn non-recurrent to recurrent. • All schemes fully developed, delivery risk reducing, £4.1m in high risk compared with £8.4m in month 4. If financial performance continues this should be mitigated in year.	The Committee received **moderate** assurance due to the risk of overall plan delivery	The Committee **noted** the report and is **assured**	**FSPCiC January 2026**
FSPCiC/ 25/12/15 7(v)	**WHH Monthly Productivity Update** **▪ Theatres** **▪ Outpatients** **▪ UEC improvemen t**	The Committee in Common received the report noting:- • Theatres – sustained above 80% on capped productivity. Average number of sessions was overinflated previously due to procedures being included in error. Late starts continue to be an issue but are improving. Average core funded sessions delivered at 76% (80% target) and majority of the unutilised sessions are on the Halton site. • Outpatients – metrics have worsened since the beginning of the financial year, some due to data quality issues which are being worked through. DNA	The Committee received **moderate** assurance given the progress that has been made	The Committee **noted** and discussed the report receiving **moderate** assurance given plans	**FSPCiC January 2026**

		improvement was dependent on the delayed PEP, data expected in January to target DNA improvement.		are not delivering	
FSPCiC/25/12/159	**Corporate Performance Report**	The Committee in Common received the report noting:- • ED 4 hour performance 69% (including Widnes UTC), (improvement from last month). • Percentage waiting over 12 hours remains a challenge. • Continued improvement in RTT performance 61%, 52 week wait is the biggest challenge, 65 week wait decreased in month, however 11 patients remain. • Strong performance in diagnostic performance nationally • Cancer performance – 97% 31 day wait consistently achieved, 86% 62 day wait is a challenge however has met the target for the first time in several years, 28 day Faster Diagnosis is 76% and is not currently meeting the target, recovery plan in place.	The Committee received **moderate** assurance given some metrics are not achieving	The Committee **noted** the report and is **assured** around level of detail reported	**FSPCiC January 2026**

Items for noting

FSPCiC/25/12/157(ii)	*Cost Pressures*
FSPCiC/25/12/157(iii)	*Cash Support Update*
FSPCiC/25/12/157(iv)	*Monthly CIP Update*
FSPCiC/25/12/157(vi)	*Capital Expenditure and Schemes over £500k – supported and approved the movement in capital contingency*
FSPCiC/25/12/161	*Integration Update*
FSPCiC/25/12/162	*Pay Assurance Report*
FSPCiC/25/12/163	*Revenue Request – Elective Recovery Q4 – supported for Trust Board approval*
FSPCiC/25/12/164	*Elective Recovery Update*
FSPCiC/25/12/165	*Delivery Unit Assurance Report*
FSPCiC/25/12/167	*EPRR Group Meeting minutes and action log*

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

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/26/02/153c(ii)	Meeting	Trust Board	Date Of Meeting	4 February 2026

Date of Meeting	26 January 2026
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/ 26/01/17 5	**Deep Dive / Hot Topic – Operational Planning**	The Committee in Common received the report noting:- • Deficit plan limit of £16.7m assumes £40.7m (10.8% of income, 9.8% in earlier version) due to reduction in funding assumptions such as CNST and drug risk share. • Negotiations still ongoing with the Commissioners around FYE of TIF, Endo and CDC as well as RTT funding. • Significant risk of delivering required CIP recurrently to achieve deficit plan level of £16.7m, including support from the Council / wider system with NCTR / ward closures. • Scenario 2 assumes a 6% CIP (£22.6m), this would be a non-compliant plan and require negotiation to reduce the deficit improvement over 3 years • CIP plans reviewed in detail by Executive team to determine what is achievable to deliver the BAU CIP highlighting the risk of delivering the remainder. • Risk of not delivering the performance metrics if the deficit control limit is not agreed. • 434 WTE reduction (offset by 120WTE for growth in activity) is a risk to deliver. • Board Assurance Statements updated from draft plan submitted in December, further Executive review to be undertaken prior to submission to Board for approval. • Capital plan noted, along with future bids.	The Committee received **no** assurance given the risk to deliverability of the plan	The Committee **noted** the report received **moderate** assurance	**Trust Board Februar y 2026**

FSPCiC/ 26/01/17 7	**Delivery Unit Assurance Report – Dashboard**	The Committee in Common received the report noting:- • Dashboards now included in the report by Care Group and Corporate area. • Bank and agency usage remain a risk as well as workforce reduction / CIP achievement. • Query raised about the level of WTE being removed and the impact on quality, a QIA is completed for every WTE that is removed to ensure that there is no impact on quality / patient safety.	The Committee received **moderate** assurance more information required on results delivered	The Committee received **moderate** assurance based on the report provided	**FSPCiC Februar y 2026**
FSPCiC/ 26/01/17 8(i)	**Finance Update**	The Committee in Common received the report noting:- • Month 9 deficit position is £0.4m worse than plan at £31.6m (before deficit support funding (DSF)) due to integration costs. • Funding for industrial action costs in November and December has been notified (£1.5m) • Risk adjusted forecast excluding DSF has been submitted at a £41.6m deficit (£40.7m excluding the CIP adjustment) compared to a plan of £28.7m. The variance consists of £11.2m stretch target and the impact of integration (£0.8m). • The Trust underlying deficit is £45.3m with the variance to plan driven by the stretch target, non-recurrent benefits in 2025/26 and some risk regarding non-recurrent CIP. • Bank not meeting 10% reduction, mainly due to IA and the impact of the pay award. • Agency on plan, however, is increasing month on month, mainly driven by nursing. • Income continues to be off plan mainly in Endoscopy, T&O and Gynae, consistent performance throughout the year. Dynamic plans in place support delivery. • One revenue request supported by the EMT meeting. • £15.1m CIP delivered at month 9, however £7.2m delivered recurrently. FYE of non-recurrent schemes continue to mitigate, push to turn non-recurrent to recurrent. • All schemes fully developed, delivery risk reducing, £3.2m in high risk compared with £8.4m in month 4. If financial performance continues this should be mitigated in year.	The Committee received **moderate** assurance due to the risk of overall plan delivery	The Committee **noted** the report and is **assured**	**FSPCiC Februar y 2026**
FSPCiC/ 26/01/17 8(v)	**WHH Monthly Productivity Update**	The Committee in Common received the report noting:- • Theatres – capped productivity on plan, however delivery of 80% of core funded theatre sessions has dropped to 68.1% following opening of additional theatre at Halton.	The Committee received **no** assurance given challenged UEC	The Committee **noted** and discussed the	**FSPCiC Februar y 2026**

	▪ **Theatres** ▪ **Outpatients** ▪ **UEC improvement**	• Outpatients – clinic utilisation better due to overbooking improving utilisation of slots. Clinic template work is ongoing with the majority now either having gone live or will do over the next few weeks. DNA improvement was dependent on the delayed PEP, further review taking place to understand why it is not improving. • UEC – Remains a challenge around flow and reducing length of stay.	performance, increased DNA's and worsening clinic utilisation	report receiving **moderate** assurance	
FSPCiC/ 26/01/18 0	**Corporate Performance Report**	The Committee in Common received the report noting:- • 200 more ambulance attends in December, highest amount in the last 4 years • ED 4 hour performance 67% (including Widnes UTC), (improvement from last month). • Percentage waiting over 12 hours remains a challenge. • Maintained RTT performance at 61%, 52 week wait is the biggest challenge, 65 week wait decreased in month, however, didn't achieve a zero position. • Cancer performance – 97% 31 day wait consistently achieved, 84% 62 day wait is a challenge with a deterioration from last month, 28 day Faster Diagnosis is 77% this is a slight improvement however is not meeting the target, recovery plan in place.	The Committee received **moderate** assurance given some metrics are not achieving	The Committee **noted** the report and is **assured** around level of detail reported	**FSPCiC February 2026**

Items for noting

FSPCiC/26/01/176	*Board Assurance Framework and Corporate Risk Register*
FSPCiC/26/01/178 (ii)	*Cost Pressures*
FSPCiC/26/01/178 (iii)	*Cash Support Update*
FSPCiC/26/01/178 (iv)	*Monthly CIP Update*
FSPCiC/26/01/178 (vi)	*Capital Expenditure and Schemes over £500k – supported and approved the movement in capital contingency*
FSPCiC/26/01/182	*Integration Update including due diligence*
FSPCiC/26/01/183	*Costing Update Q1 and Q2*
FSPCiC/26/01/185	*Elective Recovery Update*
FSPCiC/26/01/188	*EPRR Group Meeting minutes and action log*

Assurance Key:

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/26/02/154**	
SUBJECT:	**Fragile Clinical Services**	
DATE OF MEETING:	04 February 2026	
AUTHOR(S):	Paul Fitzsimmons, Executive Medical Director	
EXECUTIVE DIRECTOR SPONSOR:	Paul Fitzsimmons, Executive Medical Director	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience. SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	Y
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	**#2001** If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff , reduced patient experience and reputational damage	

LINK TO PUBLIC SECTOR EQUALITY DUTIES

Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:

	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct			***Y***
Further Information:			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not			***Y***
Further Information:			
3. Foster good relations between people who share a protected characteristic and those who do not			***Y***
Further Information:			

<table>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td colspan="3">This paper serves to provide assurance with regards to the Trust's oversight of Fragile Clinical Services.

A high-level update is provided on the services currently designated as fragile:

Orthopaedics – Fractured Neck of Femur
Urology
Cancer Services
Chronic Pain Service
Rheumatology

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

Services entering Fragile Services oversight since last report:
None</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">Trust board is asked to:
Note the current list of Fragile Services, associated clinical risk and high-level progress updates
Note significant improvements delivered in Cancer systems with a corresponding decrease in incidents
Note that following limited improvement within Planned Care Fragile Services (Fractured Neck of Femur and Chronic Pain) with associated patient safety risk – Planned Care has now been escalated into a formal Planned Care Quality Recovery Plan
Receive further Fragile Service Oversight reports</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Choose an item.</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="2"></td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED:
(if relevant)</td><td colspan="3">Choose an item.</td></tr>
</table>

REPORT TO BOARD OF DIRECTORS

SUBJECT	Fragile Services Oversight	AGENDA REF:	BM/26/02/154

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

Progress against improvement plans and trajectories for 2 Planned Care services under Fragile Service Oversight (Orthopaedics – Fractured Neck of Femur and Chronic Pain) has not been satisfactory

These services have now been escalated into a formal Planned Care Quality Recovery Plan. Which will report twice weekly to the Deputy Medical Director with an escalation report to EMT and QAC.

Orthopaedics – Fractured Neck of Femur

Summary

After improvement in Q1, National Hip Fracture Database data has demonstrated a deterioration in mortality in Q2 2025/26. Q3 mortality data is expected to be published in the coming month.

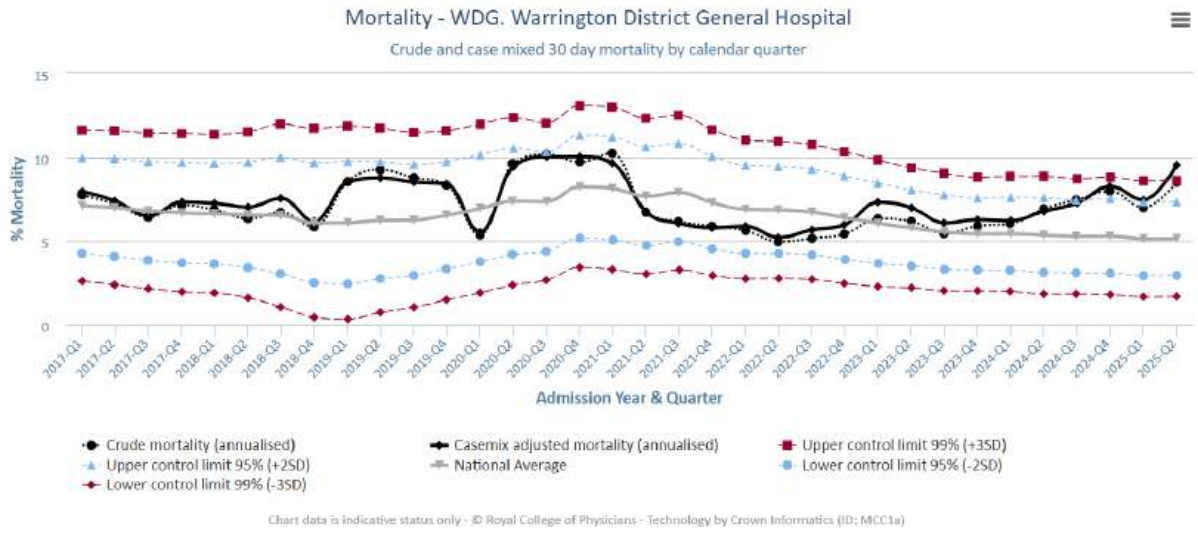
Prompt mobilisation has improved; however prompt surgery remains an unresolved quality and performance issue. Following initial progress against

directions, improvement has not been sustained leading to escalation into a formal Planned Care Quality Recovery Plan

The Trust's National Hip Fracture Database data has shown Case mix adjusted and crude mortality for fractured neck of femur moved out of predicted range in the reporting quarter Q2 2025/26 and are above the 95% control limit.

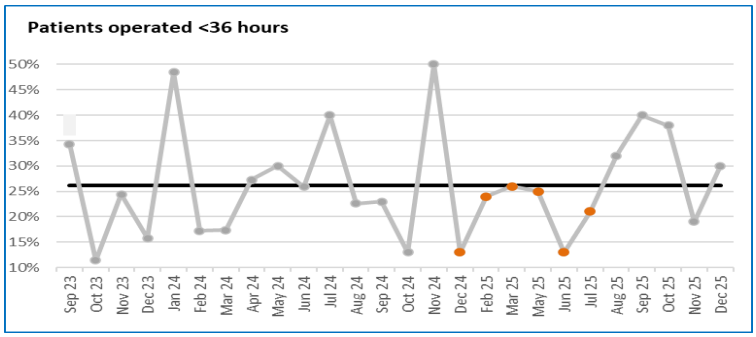
Improvement had been seen in Q1 2025/26 with data showing annualised case mix adjusted 30-day mortality as 7.5%, upper control limit 95% (2SD) 7.3%, national average 5.1%
Crude mortality for Q1 2025/26 had returned to be within expected limits

Figure 1 – Hip Fracture Crude and Case Mix Adjusted Mortality



Following November QAC and subsequent presentation to EMT the Planned Care Leadership team has been directed to complete a series of 7 and 21 day priority actions, the content of these directions have been presented to the Audit Committee.

The completion and impact of actions following on from these initial directions has been limited and have now been escalated into a formal Planned Care Quality Recovery Plan.



The service will continue to report to PSCESC and QAC monthly.

Chronic Pain Service

Summary

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

Initial Progress against initial actions was not timely, and following escalation to the MD has resulted in a change of clinical lead with additional support put in place.

Limited progress – to be included in formal Planned Care Quality Recovery Plan

Completed Actions

- Ongoing pharmacy review of all opioid recommendations
- Service Gap analysis against NICE guidelines
- No new patients have been commenced on facet joint or trigger point injections
- Review of injection activity and caseloads undertaken

Outstanding Initial Actions

- Produce opioid and gabapentoid prescribing SOP
- Standardised GP and patient letter format
- Meet with Primary Care to agree pain SOPs before implementations
- Develop plan for supporting patients on long term injection programmes to transition to less invasive care

Medium Term Actions

- Service prioritised for integration and transformation with Bridgewater Community Health needs to become community-based MDT reablement service with fewer medical and pharmaceutical interventions
- Senior leadership team site visit to East Cheshire to understand delivery model
- Development of future community integrated service model for further co-development with Commissioners and Primary Care

Urology

Summary

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

Emergent staffing risk from possible consultant staff retirements in next 12 months – mitigation now identified

Clinical risk regarding Kidney and Prostate cancer surveillance now addressed through introduction of dedicated cancer surveillance access plans and ongoing clinical validation of patient lists

- Demand and capacity mismatch – driven predominantly by workforce issues and increased demand
- Significant volume of high-risk patients on waiting lists confirmed by AI list validation
- Cluster of Urology Cancer incidents with harm – Deep Dive cluster review of cases and action plan presented at QAC April 2025

- P2 – waiting list has reduced over the last quarter and shows a reducing trend
- P3 waiting lists have reduced after increases during summer 2025
- P4 waiting lists have also shown improvement following increases over summer 2025
- 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, and continues to improve with undated waiting list now fewer than 25 patients (from a peak >200)

Completed Actions

- Increased endoscopy cystoscopy capacity by 40/week
- OP Clinic template standardisation completed
- Additional middle grades recruited
- Locum consultants commenced in post
- Successful transfer of cystoscopy into UIU - UIU have increased cystoscopy case numbers per list.
- Prostate triage nurse now in place supporting effective and timely management within the prostate pathway
- Survaillance waiting list processes for prostate and kidney cancer enhanced with dedicated surveillance access plans– validation of patients on surveillance lists underway
- CD, AMD and MD have met to discuss long term staffing sustainability plan, detailed demand and capacity and financial modelling underway

Current mitigations

- Stent register process in place – further failsafe refinements made, with process audited for assurance
- Hot stone list implemented at Warrington site with hot slots on elective lists when weekly hot stone list unavailable
- Specialist nurse delivered cystoscopy training underway with 2 nurses now practitioners undertaking an independent list each week
- WLI and outsourced sessions approved where required to support activity and safety

Ongoing improvement plan actions:

- Urology Cancer Deep Dive output – MDT and surveillance improvement underway as part of cancer improvement plan – reporting to PSCESC and QAC
- Further expansion of nurse specialist cystoscopy and training to facilitate nurse led TP biopsy
- Urology likely to be included in system work on sustainability of fragile services

Cancer Services

Summary

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

Significant improvement actions delivered with a corresponding decrease in incidents in December and January.

Completed actions

- Updated robust SOP for cancer pathway escalations implemented and audited
- Updated Consultant Upgrade process with single point of access
- ICE referral for ED Suspected Cancer/Diagnosed Cancer live August 2025
- Effective surveillance pathway tracking introduced roll-out ahead of schedule
- MDT refresh and standardisation completed across all existing cancer MDTs (With Urology to complete in February)
- Cancer Alliance Supporting Urology MDT improvement and funding consultant development time
- Trial of automated histology upgrades in Gastroenterology Feb 2026

Ongoing improvement plan actions:

- Establish Head and Neck Local MDT
- Cancer Alliance assurance of Urology MDT processes
- Complete migration of prostate surveillance patients to surveillance tracker access plan
- Roll out automating referrals/upgrades of malignancy identified via histology results across all specialities (not required to leave fragile services oversight)
- Scoping for automation of referrals/upgrades from radiology reports (not required to leave fragile service oversight)

Rheumatology

Escalated to Fragile Service Oversight following presentation at QAC November 2025 highlighted concerns raised regarding delays with prescribing and responses to patient queries. Issues driven by current workforce constraints and suboptimal processes

Key areas of risk identified for improvement include:

- Prescribing capacity and responsiveness
- Outpatient clinic waits
- Response to patient queries via email ad advice lines
- DMARD initiation and monitoring systems – to adopt GIRFT best practice
- Optimisation of shared care processes

Completed Actions

- DMARD processes amened and monitoring systems formalised
- Locum consultant in post
- Medical and Nursing job plan changes made to support demand and capacity mismatch

5. RECOMMENDATIONS

Trust Board is asked to:

- Note the current list of Fragile Services, associated clinical risk and high-level progress updates
- Note significant improvements delivered in Cancer systems with a corresponding decrease in incidents
- Note that following limited improvement within Planned Care Fragile Services (Fractured Neck of Femur and Chronic Pain) with associated patient safety risk – Planned care has now been escalated into a formal Planned Care Quality Recovery Plan
- Receive further Fragile Service Oversight reports

Appendix 1

Chronology of Fragile Service Status

	Month Escalated to Fragile Services Oversight	Month Deescalated from Fragile Services Oversight
Fractured Neck of Femur patients	June 2022	Ongoing
Histopathology Turnaround Times	July 2022	June 2023
Paediatric Ophthalmology	Feb 2023	May 2024
Diabetic Foot Clinic	April 2023	June 2023
Age-Related Macular Degeneration	May 2023	Sept 2023
Gynaecology	July 2023	Sept 2024
Urology	Jan 2024	Ongoing
ENT	Nov 2023	March 2025
Stroke Services	May 2024	Sept 2024
Theatres (procedural safety)	Jun 2024	Nov 2024
Cardiology and Cardiorespiratory	Sept 2024	Nov 2025
Cancer Services	June 2025	Ongoing
Chronic Pain Service	June 2025	Ongoing
Rheumatology Service	Nov 2025	Ongoing

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/26/01/155**			
SUBJECT:	**Maternity Incentive Scheme Year 7 Update**			
DATE OF MEETING:	**4 February 2025**			
ACTION REQUIRED:	**For information, discussion and to note**			
AUTHOR(S):	Helen Wall - Assurance and Improvement Manager (Women's and Children's)			
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**
		✓		
	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. The principles of CNST and the Maternity Incentive Scheme (MIS) is to ensure safer care for this cohort. Achieving the principles of MIS will have a positive impact on this group.			
EXECUTIVE SUMMARY:	This paper outlines the Trust's position and progress in relation to the NHS Resolution's Maternity Incentive Scheme (MIS), which aims to support the delivery of safer maternity care across NHS Trusts in England. The scheme provides financial incentives for meeting ten safety actions designed to improve clinical governance, workforce planning, and patient outcomes in maternity services. These safety actions align with the national maternity ambition to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries by the end of 2025, compared to the 2010 baseline. This paper provides an overview of current progress and incorporates feedback received from the Local Maternity and Neonatal System (LMNS) The Trust has undertaken a detailed self-assessment against all ten safety actions for the current reporting period. Progress is summarised below: • **Safety Action 1 – PMRT**: Requirements met (awaiting external verification). • **Safety Action 2 – MSDS**: Requirements met.			

<table>
<tr><td></td><td colspan="3">

Safety Action 3 – Transitional Care: Requirements met.
Safety Action 4 – Medical Workforce: Requirements met.
Safety Action 5 – Midwifery Workforce: Requirements met.
Safety Action 6 – Saving Babies' Lives: LMNS confirmed requirements met for this safety action at meeting on 20 November 2025.
Safety Action 7 – MNVP: Requirements met.
Safety Action 8 – Training: Requirements met.
Safety Action 9 – Board Oversight: Maintained through regular reporting and scrutiny.
Safety Action 10 – MNSI/EN: Requirements met; external review by Maternity and Neonatal Safety Improvement Programme and NHS Resolution is pending.

Feedback from the Local Maternity and Neonatal System (LMNS) has been incorporated into the assessment process. The Trust remains committed to continuous improvement in maternity safety and quality and anticipates full or near-full compliance across all safety actions.

The Board of Directors are asked to:
Note the current status of the MIS submission.
Endorse the Trust's declaration of compliance, subject to final validation.
Support ongoing improvement initiatives within maternity services.
</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">For members of the Trust Board of Directors to

Note the current status of the MIS submission.
Endorse the Trust's declaration of compliance, subject to final validation.
Support ongoing improvement initiatives within maternity services
Approve the submission data to date noting actions are on track for compliance against the Safety Action

</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Quality Assurance Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">QAC/26/01/229</td></tr>
<tr><td>Date of meeting</td><td colspan="2">13 January 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">noted</td></tr>
<tr><td>NEXT STEPS:</td><td colspan="3">Submit to Trust Board</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="3">None</td></tr>
</table>

REPORT TO TRUST BOARD

SUBJECT	Maternity Incentive Scheme Year 7 Update	AGENDA REF:	BM/26/01/155

1. BACKGROUND/CONTEXT

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

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

2. CURRENT POSITION

2.1 Current position against MIS Year 7

The MIS reporting period commenced on 1 December 2024 and concluded on 30 November 2025. The Trust has engaged with the Local Maternity and Neonatal Systems(LMNS) through quarterly meetings since MIS Year 7 launched in April 2025. The Trust can self-certify their compliance with safety actions 3, 4, 5, 6, 7, 8 and 9. Safety Action 2 has been externally verified through the Maternity Services Data Set (MSDS) that was submitted in July 2025. Safety actions 1 and 10 require external verification. The Trust have continued to report all applicable perinatal deaths to MBRRACE-UK within the mandated timeframe. The Trust have reported all qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme throughout the reporting period. In line with the compliance requirements, the LMNS have been invited to attend the Trust Board meeting in February. The timeline for MIS submission is outlined in Appendix 1.

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

Throughout the reporting period (1 December to 30 November 2025), the Trust has consistently met these requirements. All applicable perinatal deaths have been reported to MBRRACE-UK within the mandated timeframe, and reviews have been conducted in accordance with national standards. Reports and findings continue to be escalated to the Board of Directors via quarterly updates to the Trust Board, ensuring appropriate oversight and governance

The Trust has demonstrated full compliance with the requirements within Safety Action 1 which requires external verification.

2.3 Safety Action 2: Are you submitted data to the Maternity Services Data Set (MSDS) to the required standard?

This safety action is assessed based on data submitted in July 2025. To achieve compliance, the Trust must demonstrate that valid birthweights were recorded for at least 80% of babies born, and ethnicity was documented for at least 90% of mothers at booking.

The updated scorecard for the July dataset, published in October 2025, confirms that the Trust has met both data requirements. This reflects continued diligence in accurate data collection and reporting, supporting our commitment to improving maternity outcomes and reducing health inequalities.

The Trust is compliant with Safety Action 2.

2.4 Safety Action 3: Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?

As previously reported to Trust Board, the Trust are required to deliver a presentation to the LMNS regarding the QI project for TC and discuss the project with the safety champions. The discussion took place with the safety champions on 11 November 2025. The presentation was delivered to the LMNS by the Neonatal Matron on 26 November 2025 and received positive feedback.

Upon completion of the planned presentations to the LMNS, the Trust will be compliant with Safety Action 3.

2.5 Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Safety Action 4 addresses staffing requirements across obstetric, anaesthetic, neonatal medical, and neonatal nursing disciplines. Where staffing is not in line with requirements, as previously reported to Trust Board, action plans have been produced.

During the quarterly meeting with the LMNS, they advised they would share our staffing action plans with the Operational Delivery Network.

Upon submission of the neonatal action plan to the ODN, the Trust will be meeting the requirements of Safety Action 4.

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

This safety action requires completion of a Birthrate+ assessment within the last three years. The Trust's most recent Birthrate+ report was completed in March 2025 and as previously reported to the Trust Board, identified a shortfall of 4.87wte (1.29 WTE specialist roles and 3.58 WTE clinical roles) in the funded Midwifery establishment at WHH. In accordance with MIS guidance, where a shortfall is identified, an agreed mitigation plan must be in place. This plan was presented to QAC in August 2025 and will be shared with commissioners to demonstrate full compliance. Options for new working models are being explored to address the deficit.

The service is also required to provide 1:1 midwifery care for all women in active labour. WHH consistently meets this requirement. Additionally, the presence of a supernumerary labour ward coordinator is mandated and is reliably achieved, with assurance provided through the biannual staffing oversight report.

Finally, the Trust is required to submit a midwifery staffing oversight report to the Trust Board, covering staffing levels and safety issues. This report has been received and reviewed by the Board, confirming compliance with this element of the safety action.

The Trust is compliant with Safety Action 5.

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

The Trust Board will be aware that regular updates are provided through this paper regarding the Trust's position on the Saving Babies' Lives Care Bundle version 3 (SBLCBv3), with external oversight from the Local Maternity and Neonatal System (LMNS).

The service submitted evidence for Quarter 2 of 2025/26 and participated in a review meeting with the LMNS on 17 September 2025. For Quarter 1, the Trust achieved 99% compliance, and for Quarter 2, the LMNS has confirmed compliance at 96%.

The Maternity Incentive Scheme evidence meeting took place with the LMNS on 19 November 2025. During this meeting the LMNS confirmed they are satisfied that WHH's progress and commitment to meeting the requirements of SBL demonstrates compliance of safety action 6.

The service have submitted evidence for Q3 which was discussed with the LMNS on 17 December 2025. During this review meeting WHH were identified as 91% compliant with the requirements. Additional information will be submitted to the LMNS before the end of December which will increase our compliance. An update on our compliance will be provided at the next Trust Board meeting.

The Trust is compliant with Safety Action 6.

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

As previously reported to Trust Board, the Trust has escalated to the Integrated Care Board that the Maternity and Neonatal Voices Partnership do not meet the requirements of attending Perinatal Mortality Review Tool meetings. Due to this escalation process being followed the Trust are compliant with this safety action.

The Trust is compliant with Safety Action 7.

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

This safety action relates to mandatory training for medical, midwifery, and nursing staff. To achieve compliance, at least 90% of the identified staff groups must have completed training in fetal monitoring, multi-professional emergencies, and neonatal resuscitation.

The Trust is compliant with Safety Action 8.

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

To meet the requirements of this safety action, the Trust must demonstrate implementation of the Perinatal Surveillance Quality Model (PQSM) and progress towards embedding the revised Perinatal Quality Oversight Model (PQOM). WHH has an established cycle of business in place to ensure that all relevant information is reviewed and escalated appropriately to the Trust Board of Directors.

The Trust is also required to demonstrate that a Non-Executive Director (NED) has been appointed and is actively working with the Board Safety Champion to foster collaborative relationships. At WHH, the appointed NED also serves as the Maternity and Neonatal Safety Champion. They regularly attend Safety Champion Meetings and engage with the Quality, Assurance and Development (QUAD) Team to support relationship-building and drive service improvement. The NED also attends the Trust Board.

A further requirement is that maternity and neonatal quality and safety are reviewed by the Trust Board or an appropriate committee. This is fulfilled through monthly reports provided by the Director of Midwifery or Deputy Director of Midwifery to QAC, ensuring comprehensive oversight across each quarter.

The Trust must also demonstrate collaboration with the LMNS, including shared learning and escalation of intelligence. WHH maintains regular engagement with the LMNS through scheduled meetings to review service performance and address any identified outliers.

Ongoing staff engagement is another key requirement. At WHH, this is achieved through safety champion walkarounds, leadership drop-in sessions, and listening events led by the Retention Midwife. Feedback and progress are communicated to staff using the 'You said, we did' format to promote transparency and responsiveness.

Incident and complaint data are reviewed and shared with the Trust via QAC on a quarterly basis, in line with MIS expectations.

Finally, the Trust must demonstrate active leadership in driving the culture plan. The Board Safety Champion meets regularly with the Perinatal Leadership Team and MNVP lead to discuss quality, safety, and cultural development, ensuring alignment with national priorities and local improvement goals.

The Trust meets the requirements of Safety Action 9.

2.11 Safety Action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025?

To meet the requirements of this safety action, the Trust must:

- Report all qualifying cases to the Maternity and Neonatal Safety Investigations (MNSI) programme from 1 December 2024 to 30 November 2025.
- Report all qualifying Early Notification (EN) cases to NHS Resolution's EN Scheme within the same timeframe.
- Provide assurance that, for all qualifying cases:
    - Families have received accessible information regarding the role of MNSI and the EN Scheme.
    - The Trust has complied, where applicable, with Regulation 20 of the Health and Social Care Act (Regulated Activities) Regulations 2014 concerning duty of candour.

Through previous reports to the Trust Board, the Trust has demonstrated ongoing compliance with these requirements. This reflects a continued commitment to transparency, family engagement, and regulatory adherence in the management of serious incidents. This safety action is externally verified. The service are confident that their robust processes throughout the year have ensured compliance is maintained.

To achieve compliance with Safety Action 10, is externally reviewed by MNSI and NHSR.

3 MONITORING/REPORTING ROUTES

Progress relating to the Saving Babies' Lives Care Bundle version 3 (SBLCBv3) and Maternity Incentive Scheme (MIS) Year 7 is regularly reviewed and discussed at Clinical Business Unit (CBU) Governance Meetings. The content of this report will be formally presented at the Women's Health Governance Meeting in January 2026 to ensure continued oversight and alignment with service improvement priorities.

4 RECOMMENDATIONS

The members of the Trust Board of Directors are requested to

- Note the current status of the MIS submission.
- Endorse the Trust's declaration of compliance, subject to final validation.
- Support ongoing improvement initiatives within maternity services
- Approve the submission data to date noting actions are on track for compliance against the Safety Actions

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Maternity Incentive Scheme Year 7

Compliance report

Tina Moors – Interim Director of Midwifery

The 10 Maternity Safety Actions

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Safety Action 1: Use of the National Perinatal Mortality Review Tool
- Safety Action 2: Submitting data to the Maternity Services Data Set
- Safety Action 3: Transitional care services to minimise separation of mothers and babies
- Safety Action 4: Effective systems of clinical workforce planning
- Safety Action 5: Effective system of midwifery workforce planning
- Safety Action 6: Demonstrating compliance with Saving Babies Lives Care Bundle v3
- Safety Action 7: Listen to women, parents and families using maternity and neonatal services with users
- Safety Action 8: Multi professional maternity Core Competency Framework Version 2 training
- Safety Action 9: Board Assurance for maternity and neonatal safety and quality issues.
- Safety Action 10: Reporting of all qualifying cases to HSIB/MNSI and NHS Resolution Early Notification Scheme

Background

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- The 10 safety actions for the Year 7 MIS scheme were first published by NHS Resolution (NHSR) on 2 April 2025.
- The reporting period for MIS Year 7 is 1st December 2024 to 30th November 2025.
- NHSR reporting deadline for the Board declaration of compliance with all 10 standards is 12 noon on 3 March 2026.
- Update reports describing compliance against the standards have been shared monthly with the Quality Assurance Committee and bi-monthly to Trust Board.
- An assurance process in relation to Safety Actions 3, 4, 5, 6, 7, 8 and 9 has been undertaken by the Cheshire & Mersey Local Maternity and Neonatal System (LMNS).
- Safety Actions 1, 2 and 10 are externally validated via a cross reference of data between by MBRRACE-UK, the National Neonatal Research Database (NNRD) and NHSR.

External assurance process

Warrington and Halton Teaching Hospitals NHS Foundation Trust

▪ Cheshire & Mersey LMNS have reviewed the evidence uploaded to the NHS Futures portal for MIS year 7 Safety Actions 3 – 9.

- Safety Action 3 - Transitional Care - compliant
- Safety Action 4 - Clinical workforce - compliant
- Safety Action 5 - Midwifery Staffing - compliant
- Safety Action 6 - SBLv3 - compliant
- Safety Action 7 - Listening to women, parents and families - compliant
- Safety Action 8 - Multi professional Training - compliant
- Safety Action 9 - Board Oversight and Assurance – compliant

External assurance process

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Safety Action 1 - Use of the National Perinatal Mortality Review Tool – no external review prior to February 2026
- Safety Action 2 - Submitting data to the Maternity Services Data Set - no external review process prior to February 2026 however “Clinical Negligence Scheme for Trusts: Scorecard” evidences the criteria has been met
- Safety Action 10 - Reporting of all qualifying cases to MNSI and NHS Resolution Early Notification Scheme – no external review process prior to February 2026

Internal assurance process

Warrington and Halton Teaching Hospitals

Date	Actions
19th May to 30th November 2025	**Trust evidence submission**/LMNS offer of review checkpoints to provide support - Safety Actions 3, 4, 5, 6, 7, 8 & 9 (Safety Actions 1, 2 and 10 externally validated)
16th July 2025	Ratification of Safety Action 7 MNVP Action Plans at **LMNS Assurance Board**
15th October 2025	Final Ratification of Safety Action 7 – Updated Action Plans & Confirmation all Requirements Met at **LMNS Assurance Board**
w/c 17th November 2025	LMNS to provide **final supportive review checkpoints** prior to Trust self-declaration
30th November 2025	**MIS Year 7 Scheme Closure**
10th December 2025	**MIS Year 7 compliance position presented to LMNS Assurance Board**. LMNS to send LMNS Assurance Board Minutes to Trusts as evidence
December 2025 to February 2026	• Trusts present evidence to **Trust Quality Boards & Trust Boards** • LMNS to be invited to attend the part where MIS Year 7 evidence is being presented, and self-declaration occurs • LMNS informs the ICB of progress / evidence
11th February 2026	Confirmation of Trust self-declaration status to **LMNS Assurance Board**
17th February to 2 March 2026 12 noon.	The final MIS declaration using the Excel declaration form published on the NHSR website must be completed in full in line with the published MIS guidance. It must be signed by both the Trust Chief Executive Officer and Integrated Care Board Accountable Officer. Once complete it must be sent to nhsr.mis@nhs.net between **17 February and 2 March 2026 (12 noon).** Where relevant, an action plan must be completed for each action the Trust has not met
20th Feb 2026	Completed Trust submission form (and action plan(s) if non-compliance declared) signed by Trust CEO are to be sent to CEO of ICS for sign off. (Note: Only the Trust CEO can sign the Trust MIS submission)
23rd to 27th Feb 2026	• Integrated Care System CEO signs declaration form with Trust CEO signature on it and ICB team returns signed form to the Trusts. • Trusts must then submit the signed form (with both CEO and ICB Accountable Officers signatures) to NHSR
3rd March 2026	**Trust final submission to NHS Resolution by 12.00 noon**
April 2026	**LMNS to receive Trust Board minutes where Trust declares compliance**

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required standard	Evidence/Comments	Compliance
1a.	Notify all death: All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days.	External Validation. Internal processes demonstrate all eligible deaths have been notified within 7 days.	Compliant - awaiting external verification of compliance
1b.	Seek parents' views of care: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards.	External validation: Internal processes demonstrate that parent's views of care have been sought in all PMRT reviews conducted.	Compliant - awaiting external verification of compliance
1c.	Review the death and complete the review: For deaths of babies who were born and died in your Trust from 1st December 2024 onwards multi-disciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death, and a minimum of 75% of multi-disciplinary reviews should be completed and published within six months. For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	External validation. Internal processes demonstrate this criteria has been met.	Compliant - awaiting external verification of compliance
1d.	Report to the Trust Executive: Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2024.	Q3 24/25 PMRT QAC report Q4 24/25 PMRT QAC report Q1 25/26 PMRT QAC report Q2 25/26 PMRT QAC report April 2025 Trust Board report June 2025 Trust Board report August 2025 Trust Board report October 2025 Trust Board Report December 2025 Trust Board Report	Compliant

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required standard	Evidence/Comments	Compliance
1	July 2025 data contains valid birthweight information for at least 80% of babies born in the month. This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405)	Clinical Negligence Scheme for Trusts Scorecard	Compliant
2	July 2025 data contains valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (Relevant data tables include MSD001; MSD101).	Clinical Negligence Scheme for Trusts Scorecard	Compliant

Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required standard	Evidence/Comments	Compliance
a.	Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice Or Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and submit this to your Trust and the neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards	Transitional Care Pathway Guideline Transitional Care action plan Q4 24/25 TC report to QAC June 2025, Trust Board August 2025 via Maternity & Neonatal overview paper Q1 25/26 TC report to QAC September 2025 Q4 24/25 ATAIN report to QAC June 2025, Trust Board August 2025 via Maternity & Neonatal overview paper Q1 25/26 ATAIN report to QAC September 2025	Compliant
b.	Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation. Progress on initiatives must be shared with the Safety Champions and LMNS.	Confirmation of registration of QI project QI project LMNS presentation November 2025 safety champion meeting agenda and minutes	Compliant

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required standard	Evidence/Comments	Compliance
a.	Obstetric medical workforce 1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold a certificate of eligibility (CEL) to undertake short-term locums. Please see technical guidance for further details 2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level Safety Champions and LMNS Board. 3) Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance. 4) Trusts should ensure they are compliant with Consultant attendance in person to the clinical situations listed in the RCOG workforce document for a minimum of 80% of applicable situations: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service	Short-term locum consultant audit No long term locums in post during this reporting period Standards for Compensatory Rest for Consultants and SAS Doctors Standard Operating Procedure Compensatory rest consultant feedback Q3 24/25 Q3 consultant presence audit 24/25 Q4 consultant presence audit 25/26 Q1 consultant presence audit 25/26 Q2 consultant presence audit	Compliant

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required standard	Evidence/comments	Compliance
b.	Anaesthetic medical workforce 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. Where the Duty Anaesthetist has other 16 responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)	Labour Ward Anaesthetic Staffing Policy ACSA Accreditation Anaesthetic staffing rota	Compliant
c	Neonatal medical workforce The neonatal unit meets the relevant BAPM national standards of medical staffing or the standards are not met but there is an action plan with progress against any previously developed action plans and monitored via a risk register. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).	December Trust Board report Risk Register (Middle grade cover is not 24/7)	Compliant
d.	Neonatal nursing workforce The neonatal unit meets the BAPM neonatal nursing standards. or the standards are not met but there is an action plan with progress against any previously developed action plans and monitored via a risk register. Any action plans should be shared with the LMNS and Neonatal ODN.	December Trust Board Report July 2025 Strategic People Committee Report	Compliant

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

NHS Warrington and Halton

	Required standard	Evidence	Comments	Compliance
a	A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years. If this process has not been completed within three years due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this.	BirthRate+ Report Bi-annual midwifery staffing paper July 2025	Midwifery Summary Safe Staffing Report to Trust Board evidencing:- *midwifery coordinator in charge of labour ward must have supernumerary status to 2 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 *Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staff. *the maternity service has robust escalation processes to manage short falls in staffing level during periods of high acuity. *the midwife: birth ratio	Compliant
b	Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.	December 2025 Trust Board report		Compliant
c	The Midwifery Co-ordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Midwifery summary safe staffing report to Strategic People Committee August 2025		Compliant
d	All women in active labour receive one-to-one midwifery care.	Midwifery summary safe staffing report to Strategic People Committee August 2025		Compliant
e	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the MIS year seven reporting period	Midwifery summary safe staffing report to Strategic People Committee August 2025		Compliant

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required standard	Evidence/Comments	Compliance
1	Trusts should be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust. These discussions should include the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. • Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate.	Q1 25/26 LMNS SBL Review meeting notes – compliance 99% Q2 25/26 LMNS SBL Review meeting notes – compliance 96% Q3 25/26 LMNS SBL Review meeting notes – compliance 96% Q1 MIS report to QAC July 2025 Q2 MIS report to QAC October 2025 Q3 MIS report to QAC January 2026	Compliant Confirmation received LMNS assured by evidence

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required standard	Evidence/Comments	Compliance
1	Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting: a) Infrastructure b) Strategic influence and decision-making. c) Engagement and listening to families.	August 2025 QAC MIS report Q2 25/26 LMNS MIS review meeting notes MNVP workplan WHH CQC Maternity Survey published December 2025 Maternity and Neonatal Safety Champions meetings August and October 2025	Compliant
2	Trusts should ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of free text data, and progress monitored regularly by Safety Champions and LMNS Board.	MNVP survey action plan December 2025 Trust Board report - MIS	Compliant

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required standard	Evidence/Comments	Compliance
	90% of attendance in each relevant staff group at: 1. Fetal monitoring training 2. Multi-professional maternity emergencies training 3. Neonatal resuscitation training See technical guidance for full details of relevant staff groups. ALL staff working in maternity should attend annual training. A 90% minimum compliance is required for every staff group by the end of the MIS year 7 period (30 November 2025).	Training exception report December 2025 December 2025 Trust Board Report - MIS	Compliant

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required standard	Evidence/Comments	Compliance
A	All Trust requirements of the Perinatal Quality Surveillance Model (PQSM) must be fully embedded with evidence of Trusts working towards the revised Perinatal Quality Oversight Model (PQOM) when published in 2025.	Maternity and Neonatal Safety Overview April 2025 Maternity and Neonatal Safety Overview May 2025 Maternity and Neonatal Safety Overview June 2025 Maternity and Neonatal Safety Overview July 2025 Maternity and Neonatal Safety Overview August 2025 Maternity and Neonatal Safety Overview September 2025 Maternity and Neonatal Safety Overview October 2025 Maternity and Neonatal Safety Overview November 2025	Compliant
B	The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends, with evidence of reporting/escalation to the LMNS/ODN/ICB/ Local & Regional Learning System meetings.	Trust Board Report April 2025 Trust Board Report June 2025 Trust Board Report August 2025 Trust Board Report October 2025	Compliant
C	All Trusts must have Maternity and Neonatal Board Safety Champions(BSC) who are actively supporting the perinatal leadership team in their work to better understand and craft local cultures.	Maternity and Neonatal Safety Champion members poster Maternity and Neonatal Safety Champions meeting minutes June 2025 Maternity and Neonatal Safety Champions meeting minutes August 2025 Maternity and Neonatal Safety Champions meeting minutes October 2025	Compliant

Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required standard	Evidence/Comments	Compliance
	Required Standard (A) Reporting of all qualifying cases to MNSI from 1 December 2024 to 30 November 2025. (B) Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from 1 December 2024 until 30 November 2025. (C)For all qualifying cases which have occurred during the period 1 December 2024 to 30 November 2025, the Trust Board are assured that: i. the family have received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them1; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	MNSI position – Quality Safety Paper December 2024 MNSI position – Quality Safety Paper January 2025 MNSI position – Quality Safety Paper February 2025 MNSI position – Quality Safety Paper March 2025 MNSI position – Quality Safety Paper April 2025 MNSI position – Quality Safety Paper May 2025 MNSI position – Quality Safety Paper June 2025 MNSI position – Quality Safety Paper July 2025 MNSI position – Quality Safety Paper August 2025 MNSI position – Quality Safety Paper September 2025 MNSI position – Quality Safety Paper October 2025 MNSI position – Quality Safety Paper November 2025	Compliant

Next steps

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Date	Actions
11th February 2026	Confirmation of Trust self-declaration status to **LMNS Assurance Board**
17th February to 2 March 2026 12 noon.	The final MIS declaration using the Excel declaration form published on the NHSR website must be completed in full in line with the published MIS guidance. It must be signed by both the Trust Chief Executive Officer and Integrated Care Board Accountable Officer. Once complete it must be sent to nhsr.mis@nhs.net between **17 February and 2 March 2026 (12 noon).** Where relevant, an action plan must be completed for each action the Trust has not met
20th Feb 2026	Completed Trust submission form (and action plan(s) if non-compliance declared) signed by Trust CEO are to be sent to CEO of ICS for sign off. (Note: Only the Trust CEO can sign the Trust MIS submission)
23rd to 27th Feb 2026	• Integrated Care System CEO signs declaration form with Trust CEO signature on it and ICB team returns signed form to the Trusts. • Trusts must then submit the signed form (with both CEO and ICB Accountable Officers signatures) to NHSR
3rd March 2026	**Trust final submission to NHS Resolution by 12.00 noon**
April 2026	**LMNS to receive Trust Board minutes where Trust declares compliance**

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Thank you

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

<table>
<tr><td>AGENDA REFERENCE:</td><td colspan="4">BM/26/02/155</td></tr>
<tr><td>SUBJECT:</td><td colspan="4">Maternity & Neonatal Quality Review – November 2025</td></tr>
<tr><td>DATE OF MEETING:</td><td colspan="4">4 February 2026</td></tr>
<tr><td>ACTION REQUIRED:</td><td colspan="4">For information, discussion and to note</td></tr>
<tr><td>AUTHOR(S):</td><td colspan="4">Tina Moors -Deputy Director of Midwifery</td></tr>
<tr><td>EXECUTIVE DIRECTOR SPONSOR:</td><td colspan="4">Ali Kennah – Chief Nurse</td></tr>
<tr><td colspan="5"></td></tr>
<tr><td>LINK TO STRATEGIC OBJECTIVE</td><td colspan="4">SO1: We will ... Always put our patients first delivering safe and effective care and an excellent patient experience.</td></tr>
<tr><td rowspan="4">EQUALITY CONSIDERATIONS: (Please select as appropriate)</td><td rowspan="2">Please indicate who is impacted by the equality considerations:</td><td>Patients</td><td>Workforce</td><td>Public</td></tr>
<tr><td>√</td><td></td><td></td></tr>
<tr><td rowspan="2">Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:</td><td>Yes</td><td>No</td><td>N/A</td></tr>
<tr><td>√</td><td></td><td></td></tr>
<tr><td colspan="4">Further Information/Comments:
The paper relates to care of pregnant people/those on the pregnancy continuum and provides oversight of matters related to Maternity and Neonatal Care focussing attention on improving outcomes for this protected group.</td></tr>
<tr><td>EXECUTIVE SUMMARY:</td><td colspan="4">This paper provides an update in relation to Maternity and Neonatal quality and provides Trust Board with oversight of key matters to provide assurance to the Board of Directors on Maternity and Neonatal safety and quality issues. This information will be reported monthly to Quality Assurance Committee and then to the Trust Board of Directors on a quarterly basis.

In particular:

• Harm Incidents
• Workforce Metrics including training compliance
• Service user feedback
• Staff feedback
• Maternity & Neonatal Safety Investigations (MNSI) update
• Complaints
• Coroner Regulation 28 position

In November 2025 there were 0 fatal, 1 severe harm events in the maternity or Neonatal Services. There were 3 moderate harm events, 2 (OASI) 3rd/4th degree tear and 1 Stillbirth</td></tr>
</table>

	Themes from Maternity/Neonatology patient safety events in November 2025 are as follows: • Admission of term babies admitted to Neonatal Unit (NNU) • Postpartum Haemorrhage (PPH) 1000ml-1500ml • Postpartum Haemorrhage (PPH) >1500ml At the end of September mandatory training compliance and role specific training across maternity and child health colleagues is above 90%. Compliance with PDR completion is below Trust Target with a position of 76%. Work continues to achieve full compliance, and progress is being monitored on a weekly basis. Good compliance continues with maternity specific training standards can be noted with a continual improvement each month. Turnover for maternity and child health staff is 10.4% which is below the Trust target. The vacancy rate for maternity and child health staff remains positive and is significantly below the Trust target at 0.4% The service continues to share good practice and compliments with the team The service continues to achieve its KPIs for Maternity Triage. Work is ongoing with regard to induction of labour (IOL) particularly in reducing delays. This change highlights the need for renewed scrutiny of the IOL process An overview of the sevice's position with regard to cases being investigated by MNSI is provided for oversight. An update regarding Maternity Workstreams • Maternity Continuity of Carer (MCoC) • Homebirth • Diabetes in Pregnancy There were 3 complaints were received in the Maternity and Neonatal Services in November 2025. No Regulation 28 enquiries have been received.		
PURPOSE: (please select as appropriate)	**Approval**	**To note** √	**Decision**

RECOMMENDATION:	The Board of Directors are asked to note the contents of the report.	
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee
	Agenda Ref.	QAC/26/01/229ii
	Date of meeting	13 January 2026
	Summary of Outcome	noted
NEXT STEPS: ***State whether this report needs to be referred to at another meeting or requires additional monitoring***	***Submit to Trust Board***	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None	

SUBJECT	Maternity & Neonatal Quality	AGENDA REF:	BM/26/02/155ii

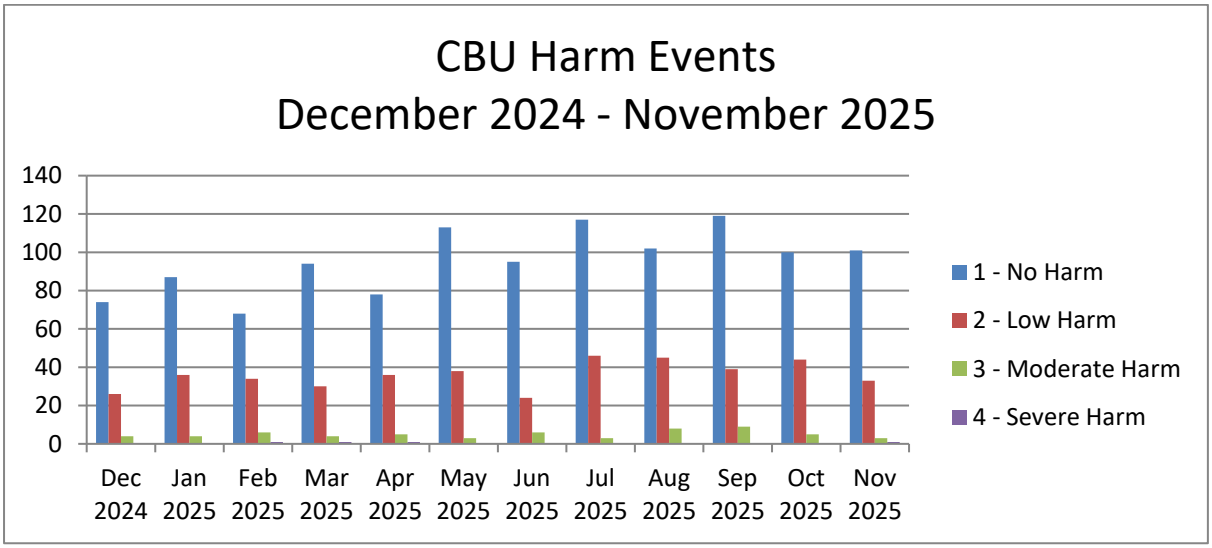
1. BACKGROUND/CONTEXT

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

The paper provides Trust 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 7 *(Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?)* alongside emerging local and regional matters.

2. HARM EVENTS

Below shows a breakdown of events reported and investigations declared across the Women's & Children's CBU for the period December 2024 – November 2025



There were 138 patient safety events reported across the CBU in November 2025.

There were 0 fatal and 1 severe harm events in November 2025 in the Maternity or Neonatal services. Severe Harm Incident (1) NNU Skin damage – longline in situ in right Antecubital Fossa (ACF)

There were 3 moderate harm events,

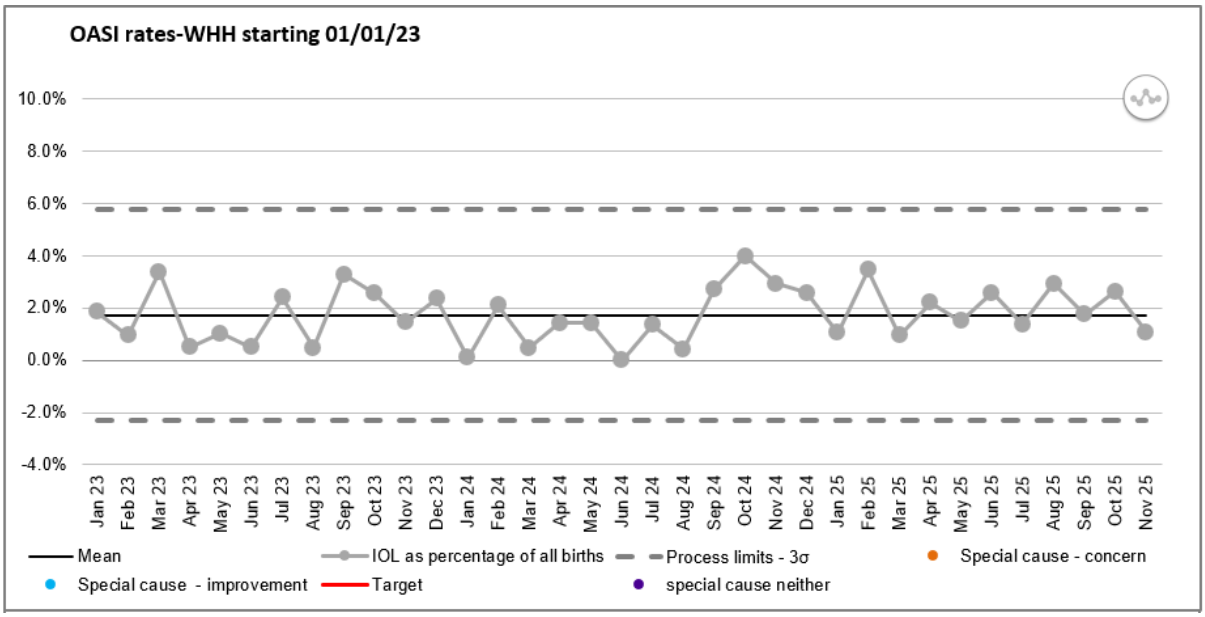
- 1 case of 3rd/4th degree tear (OASI). A decrease from October 2025. This case was reviewed by the Maternity MDT through Intrapartum Review Group (IRG).
- 2 Cases of Stillbirth - (34+3 IUD on USS, 24+6 no FH during CMW appt

<u>OASI</u>

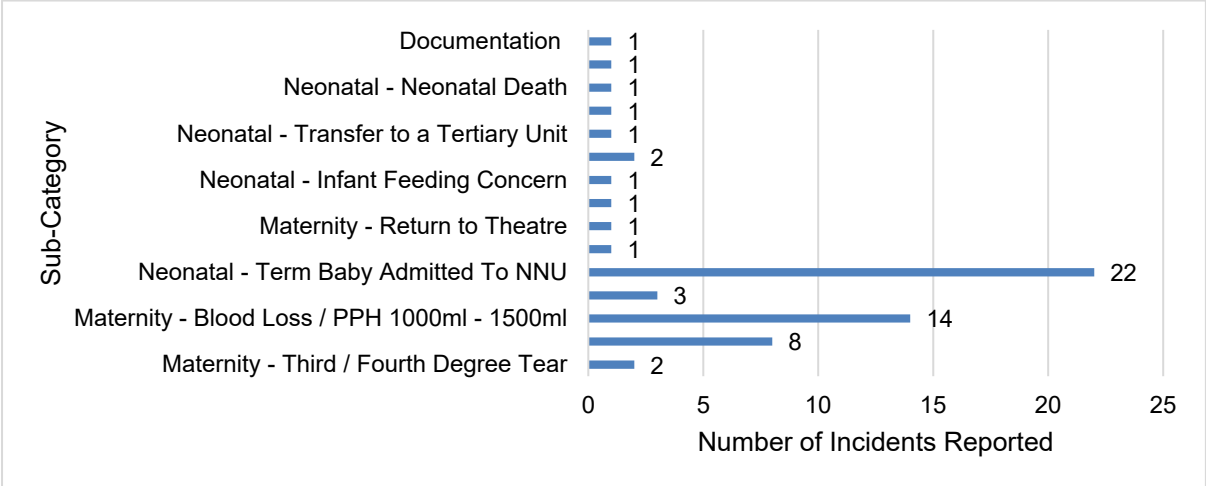
The chart continues to show common cause variation. Reduction compared to October data. One case of 3rd degree tear (3a) and one case of 4th degree tear identified.

OASI – 2 cases (1.07%)

12 month rolling mean for OASI – 1.95% (01/12/24-30/11/25)



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



2x OASI reported – 1 occurred at home with private midwives and mum was transferred into hospital for repair

1x neonatal death reported – baby born at WHH at 34+ and transferred to MFT – sadly RIP. The case is being reviewed by PMRT process.

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

- Admission of term babies admitted to Neonatal Unit (NNU)

- Postpartum Haemorrhage (PPH) 1000ml-1500ml
- Postpartum Haemorrhage (PPH) >1500ml

Admission of term babies admitted to Neonatal Unit (NNU)

Term admissions to the Neonatal Unit are reviewed each month by the ATAIN Team, consisting of colleagues from midwifery, obstetrics, neonatal and CBU management. The national target for ATAIN is 6% (Percentage of live births admitted to the neonatal unit at term.) WHH are currently an outlier for term admissions with 9.05% reported for Q2 2025/2026.The team are committed to identifying areas of improvement and driving this improvement.

Current position

In November 2025, **22** term babies were admitted to the Neonatal Unit. The admissions followed previous month's trends where the majority of admissions were due to respiratory distress. As previously presented to Quality Assurance Committee, the service completed a QI project last year and the 'PEEP for 30' pathway was implemented. This provides support for babies in respiratory distress for 30 minutes on Birth Suite or Maternity Theatre.

Action plan

The ATAIN Team have identified areas of focus for the ATAIN action plan. To help to address the main reason for admissions, a grunting baby pathway is currently being developed. This pathway would support babies to remain with their mothers while receiving regular monitoring. This should have a positive impact on the ATAIN figure as a significant proportion of babies admitted to NNU are supported for less than 6 hours as they have recovered quickly on air. The pathway should be ratified through January CBU governance.

Following the Q2 review, which was presented to Quality Assurance Committee in December, the team identified that some of the avoidable admissions may have been avoided if the decision-making was actively challenged at the time of admission to the unit. To gain a greater understanding around reasons for admission and to address if an admission is the best decision at the time of admission, a checklist is being developed by the Neonatal Matron and a Consultant Paediatrician.

The ATAIN reviews have also identified babies becoming cold. As such the team have reviewed the guidance currently available for staff and made this more readily available in the rooms. Posters have also been put on display within the postnatal ward as a reminder for staff and parents about the importance of keeping their babies warm. Refresher training will also be provided to staff.

As previously shared with the committee in December, the use of opioids has been reviewed. The impact of these changes to opioid prescribing will be reviewed throughout Q4. Staffing continues to be provided from NNU to deliver a transitional care service

Post Partum Haemorrhage

There were **13** cases of **PPH 1000ml-1500ml**. All cases of PPH 1000ml-1500ml are reviewed and learning shared.

There were **9** cases of **PPH ≥1500mls** in November.

- 4 x Caesarean Section
- 2 x Forceps
- 2 x Ventouse
- 1 x Normal Vaginal Delivery

12 month rolling mean for PPH ≥1500mls – 4.73% (01/12/24-30/11/25)

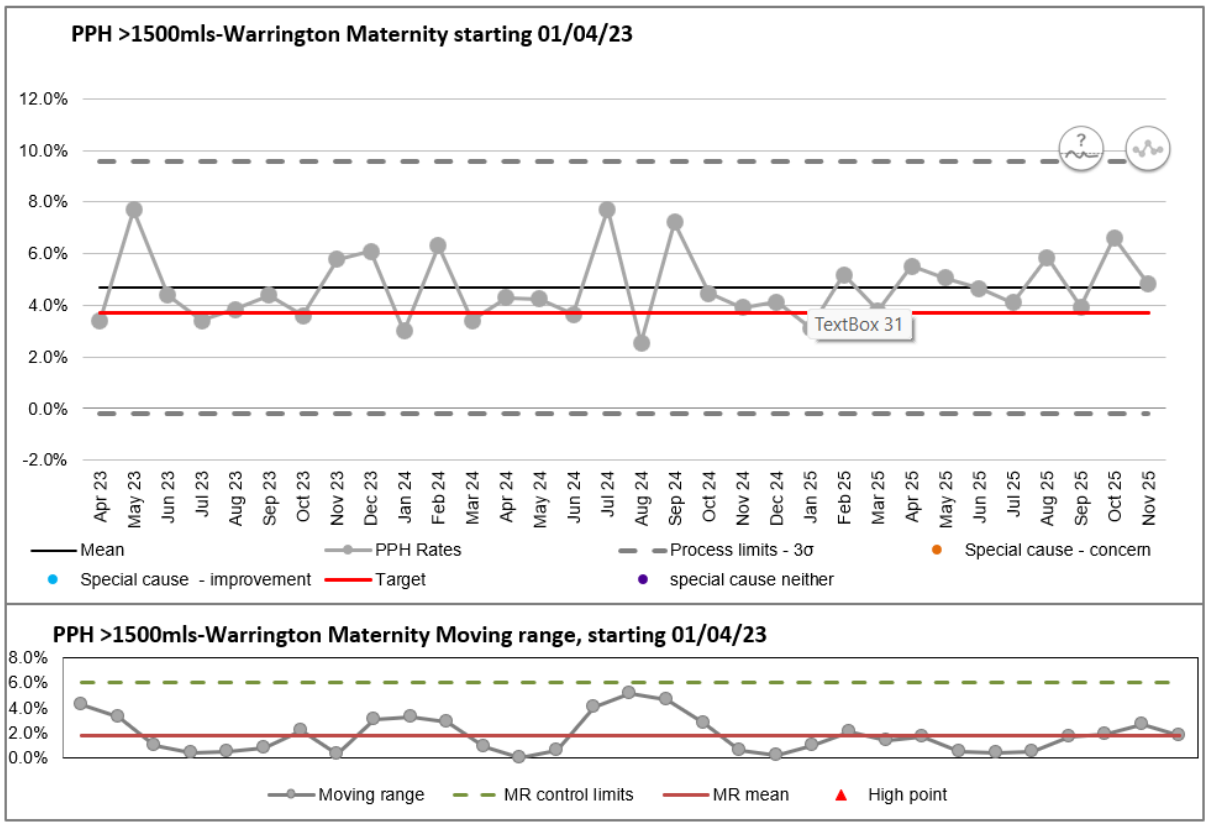
November Data Trends: Demonstrates common cause variation and a reduction compared to October 2025. Assurance can be provided that robust governance and quality improvement processes are in place. The recent implementation of the regional guideline, combined with strengthened risk assessment, quantification, and escalation measures, is expected to lead to improved outcomes over the coming months.

Regional Guideline Implementation: The Northwest Regional PPH guideline V1 was ratified in September and guidance distributed to Maternity and Obstetric Teams on 15/10/2025. It introduces revised recommendations for third stage management, which are anticipated to contribute to a reduction in postpartum haemorrhage (PPH) rates and enhance overall maternal outcomes.

Postpartum Haemorrhage (PPH) Quality Improvement: The PPH Quality Improvement Project has been reactivated and is now in a Test of Change phase, following implementation of the new Regional PPH Guideline. It introduces revised recommendations for third stage management, which are anticipated to contribute to a reduction in postpartum haemorrhage (PPH) rates and enhance overall maternal outcomes.

Case Review and Learning: Individual cases are consistently reviewed within the Intrapartum Review Group to extract learning and inform practice improvements.

Re Audit: 6-month Audit to be completed after implementation of PPH Guideline (Nov 2025 – May 2026)



3. WORKFORCE METRICS & MEASURES

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

At the end of November 2025 compliance for mandatory training across maternity and child health colleagues is 93% for Trust mandatory training (including safeguarding training) and 90% 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 remains a challenge, currently positioned at 76%. A reduction from October 2025, this is below Trust Target. Action plan to improves compliance includes allocated time for Line Managers to complete appraisals. Weekly monitoring with oversight from Matrons and escalation to CBU Senior Leadership Team where compliance is not achieved.

Good compliance with maternity specific training standards is largely being sustained.

Current position – Training compliance - maternity specific

	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)	Newborn Life Support Level 2	Maternal AIMS
Midwives	99.%	98.5%	95.4%	97.7%	91.4%
Obstetric Consultants	100%	100%	100%	n/a	n/a
Other Obstetric	100%	100%	100%	n/a	n/a
Obs Anaesthetic	93%	n/a		n/a	n/a
Maternity Support Workers	96.8%	n/a		n/a	n/a
Neonatal medical and ANNP	n/a	n/a	n/a	Awaiting Data	n/a

Turnover for maternity and child health staff (permanent staff) in November 2025 is 10.4%, below the Trust target. This is illustrated in the graph below:

The vacancy rate for maternity and child health staff remains positive and is significantly below the Trust target at 0.4%. This is illustrated in the graph below:

4. SERVICE USER AND STAFF FEEDBACK

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

5. MATERNITY TRIAGE

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

Current performance

Triage attendances November 2024-November 2025	
Month	**Attendances**
November	539
December	531
January	621
February	547
March	638
April	521
May	577
June	587
July	602
August	588
September	623
October	668
November	562

- In November 2025 562 triage attendances (389 Women) were recorded on the BadgerNet patient record system maintaining the average number of attendances per day of 21 seen since the beginning of 2025.
- 28% of attendees in November were seen immediately on arrival.
- The longest wait recorded for initial review was 59 minutes.
- 95.4% of all attenders were seen within 15 minutes of arrival (best practice guidance). This meets KPI of 90% review within 15 minutes.
- 98.7% of attenders were seen within less than 30 minutes of arrival (NICE guidance). Again, this meets KPI which stipulates 95% review within 30 minutes.
- 100% of attendees (9 women) categorised as red on arrival and seen within 15 minutes of arrival for initial triage.
- 22.8% of attendees were categorised orange on arrival, showing an upward trend to October 2025 when the proportion was 16.9%.

<u>Triage Action Plan</u>

- Categorisation of urgency, full holistic triage assessment and SBAR audits all ongoing
- Triage CISCO phone line continues to be explored to ensure best practice
- Benchmarked to C&M triage summary and recommendations to ensure triage best practice is incorporated into workstreams/action plans
- November 2025 Breaches. 25 Women Total 18 waited >15 mins and 7 Waited >30 minutes. No women categorised Red.

6. INDUCTION OF LABOUR (IOL)

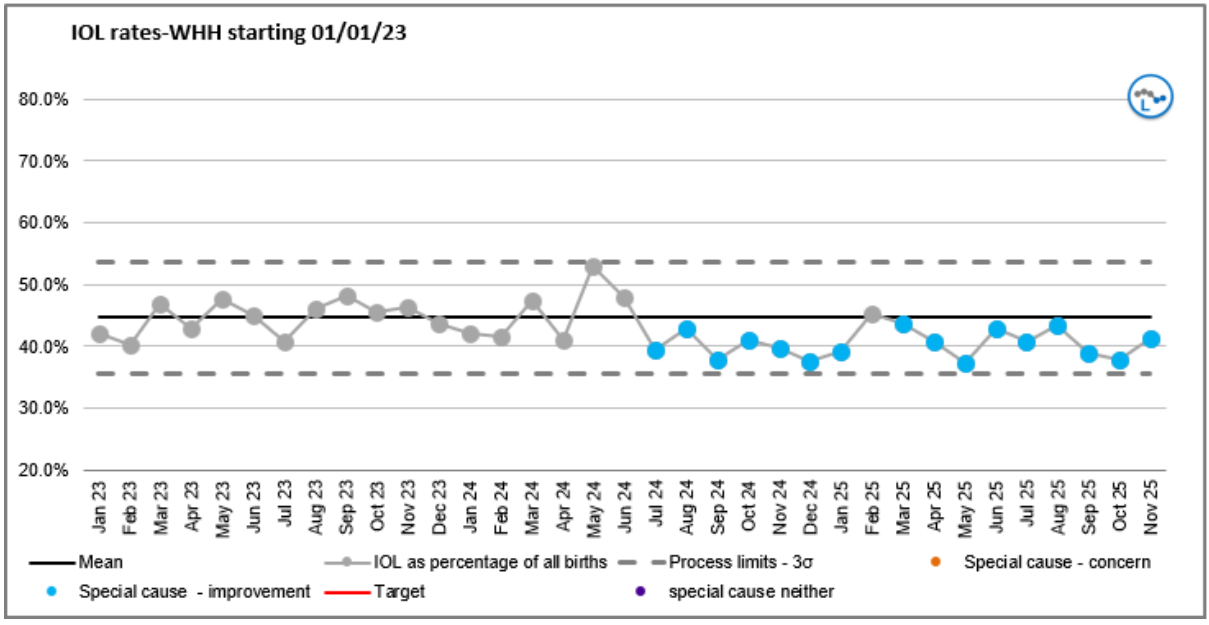
Quality Assurance Committee note the service was identified as an outlier during 2024 within the LMNS with regard to the timeliness of induction of labour (IOL) processes. As a result, a significant IOL workstream is underway.

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 November 2025, presented as a percentage of all births. The SPC chart continues to show common cause variation.

IOL data for November shows a slight increase compared to October, however the chart shows overall special cause improving variation.

IOL: 77/187 (41.18%)

12 month rolling mean for IOL rates: 40.65% (01/12/24-30/11/25)



Currently on Badgernet NHS Choices leaflet is available and leaflets specific to WHH have also been developed and will be available via BadgerNet. These are designed to inform patients about the IOL process, associated risks and benefits, declining IOL, and induction prior to 39 weeks. Filming for the new IOL information videos has been completed awaiting approval by Communication Team, this will support improved patient understanding and ensure consistency in the information provided throughout the IOL pathway.

From 1st September, dedicated outpatient IOL slots were introduced on BadgerNotes. This ensures patients are aware of their outpatient pathway from the point of booking, supporting improved planning and communication.

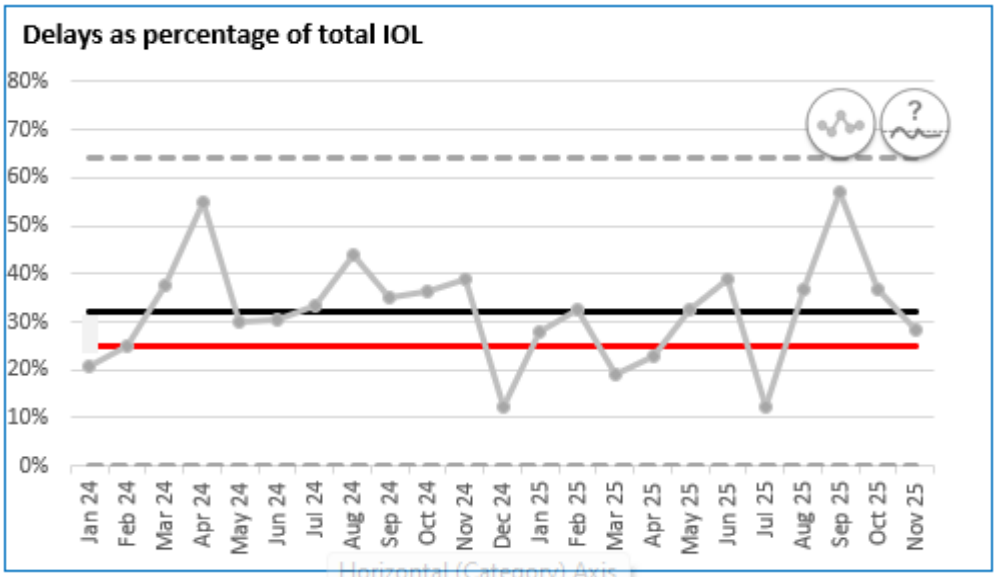
IOL Delays

The IOL data for November shows further clear improvement following the increase we observed in September.

In October, delays over 12 hours were 24% and delays over 24 hours reached 12.7%.**Total delays 36.7%**

In November, delays over 12 hours reduced to 20%, and delays over 24 hours dropped to 7.81%, bringing the overall **Total delay rate to 28.13%**

In November, the SPC chart shows IOL delays sit below the long-term mean and closer to our improvement aim, this indicates improved performance against the historical baseline and aligns with the recent changes to coordination and escalation.



Cheshire & Merseyside Inductions of Labour (IOL)

The data below reports the **total number undergoing IOL** and the **total number and percentage delayed by Provider** from **1st to 30th November 2025.**

	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total
Total number undergoing Induction of Labour	48	103	54	33	93	64	52	447
Total Delayed	44	20	2	0	22	18	3	109
% of Total	91.67%	19.42%	3.70%	0.00%	23.66%	28.13%	5.77%	24.38%

Action Plan

The updated action plan attached outlines the ongoing work supporting the induction pathway. Over the last month there has been raised awareness across all staffing groups and open, honest conversations about WHHs position as an outlier earlier in the year. This has helped ensure our position is fully understood by Band 7, Band 6 and Band 5 midwives, and that the learning is shared consistently across the service. The action tracker is now displayed within the unit so staff can clearly see what work underway, alongside up-to-date delay figures which has supported engagement.

IOL Action Tracker November 2025

Action	Owner	Update	Due Date	RAG
Visit neighbouring LMNS units to review IOL pathways, delay management and practice. To visit: • Liverpool Women's Hospital 18th December • Arrowe Park – date TBC. • Whiston – 23rd December	Kim Farrell/Amelia Crowther	LWH date confirmed, awaiting date from Arrowe Park. Aim is to benchmark delays, ARM progression, and overnight flow. Findings to be brought back.	31/12/2025	
Develop SOP for management of delays in induction of labour. To include escalation flowchart for delays of 12hrs 24hrs criteria, review responsibilities, ARMable definitions and documentation standards.	Amelia Crowther	To be presented at December guideline review group, to use learning from LWH, Arrowe Park and Whiston visits. 10/12 – As visits are now late December, SOP to be drafted and completed following visit to other LMNS sites	02/12/2025	
Introduce pathway that any woman >12h ARMable receives VE, membrane sweep and Band 7 bedside review and documented in Badgernotes.	Amelia Crowther	SOP being drafted to support implementation, change of practice slides to be circulated to staff. 10/12 – SOP in the process of being developed, to be presented at guideline review group	02/12/2025	
Women >24h ARMable to receive face-to-face obstetric review (ST3+) and further membrane sweep.	Amelia Crowther	SOP being drafted to support implementation, change of practice slides to be circulated to staff. 10/12 – SOP in the process of being developed, to be presented at guideline review group	02/12/2025	
Implement midwifery administration of second Propess (if prescribed by ST3+).	Amelia Crowther	Implemented on 1st December 2025	30/11/2025	
Present IOL and bishop score findings at Women's Health Governance To include examples of women classed as ARMable with Bishop 2–4, impact on progression and link to delays.	Amelia Crowther	Summary prepared and presented 18th November	18/11/2025	
Present floor-walking findings to Birth Suite Band 7 co-ordinators at the Band 7 meeting. Focus on cultural findings, overnight delays and BirthRate+ data	Charlotte Hampson	Summary prepared and to be present on 26th November	26/11/2025	
Day in the Life to be undertaken by Assurance and Improvement Manager to explore cultural and behavioural barriers influencing transfer decisions and escalation.	Helen Wall			
Display IOL delays, and rates for all staff to raise awareness of the challenges we face.	Amelia Crowther	IOL board now in handover room on Birth Suite, with figures of delays and comparisons to other units. This has opened discussion with staff around the delays and the barriers faced.	10/12/2025	
Introduction of colour coded magnets for IOL board, to highlight the patients that are delays for visual of delays (amber >12 and red >24)	Amelia Crowther	Magnets provided for board, and MW in the IOL bay aware of responsibility to add magnets for patient delays	18/12/2025	

Joint Oversight Support with LMNS to commence in December will further strengthen work to reduce delays in IOL

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

7. MNSI POSITION AND REPORTS RECEIVED

7.1 Background

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

7.2 Current position

Four cases in progress

Referred April 2025 (HIE/NND) in progress – Draft report delayed until COD from PM

Referred August 2025 (Shoulder Dystocia HIE) in progress

Referred September 2025 (Shoulder Dystocia HIE) in progress

Referred September 2025 (Pool birth HIE) in progress

8. UPDATE ON OTHER WORKSTREAMS

8.1 Maternity Continuity of Carer (MCoC)

Continuity of Carer (CoC) data is extrapolated from Badgernet monthly and shared with the LMNS.

Measures include:

- % of women at 29 weeks gestation on a CoC pathway
- % of Black, Asian or Mixed Ethnicity (BME) women at 29 weeks gestation on a CoC pathway
- % of women in bottom decile of deprivation at 29 weeks gestation on a CoC pathway.

The percentage of women receiving continuity at 29 weeks gestation has ranged from 45.4%-54.4% in Q3 2025, this is consistent with data since April 2023 when community services were streamlined and the number of continuity teams reduced from seven to four to support safe staffing in inpatient areas.

The other outcome measures vary dependant on the population of women at 29 weeks gestation in each given month; for BME women 64.3 -78.5% received CoC in Q3 2025. This is an increase of 14% in comparison to Q3 in 2024.

For women in the bottom decile, women allocated to a CoC team has ranged from 23.3 – 33.3% in Q3 2025 an increase of 12.4% in Q3 2024.

The effectiveness of these measures could be enhanced by including all teams and classifying them as continuity teams. The LMNS has recently emphasised a strong focus on antenatal and postnatal continuity, with the gold standard being continuity across intrapartum care where possible. A review of caseloads and care models suggests that all five teams could meet the criteria to be designated as continuity teams. This change would significantly increase the number of women allocated to a CoC team, particularly those living in areas of deprivation and those from Black, Asian, or mixed heritage backgrounds.

In addition, measures are already in place to ensure that vulnerable groups who do not formally receive CoC are fully supported throughout the pregnancy continuum. These include high-quality antenatal and postnatal team case-holding, the dedicated work of three enhanced maternity support workers, and initiatives such as the ‘baby shower’ events held in Halton. These events provide drop-in opportunities for infant feeding and smoking cessation support, as well as a chance to meet the WHH homebirth team and community midwives.

Team River operates as an enhanced continuity team, providing case-holding for women identified as particularly vulnerable. This includes women experiencing teenage pregnancy, those with mental health challenges, women subject to level three safeguarding, bereaved women, individuals affected by substance misuse, women for whom English is not their first language, and those seeking asylum.

Balancing intrapartum continuity of carer with safe inpatient staffing and retaining community staff remains a significant challenge. At present, community staff work within either a traditional model or a continuity model. Ongoing discussions are focused on how best to utilise existing intrapartum shifts to strengthen intrapartum continuity.

A comprehensive review, in collaboration with LMNS Joint Oversight and staff, is planned for 2026. Additionally, we have secured further funding from the LMNS to enhance support for continuity teams. This funding will allow us to extend contracts for current enhanced support workers and explore the recruitment of two additional team members. These measures will ensure that all women across Warrington and Halton have access to additional support, regardless of demographic factors or team model.

8.2 Northwest Regional Home Birth Programme

Following the deaths of Jennifer and Agnes Cahill and the subsequent coroner’s PFD report, the Chief Midwife for England and the Northwest Regional Chief Midwife have issued a regional directive to urgently review and strengthen home birth services. Significant concerns have been identified regarding risk assessment, staff training and experience, communication of risk (including for choices outside guidance), ambulance response times, and variation in home birth models across Trusts.

To address these risks, the Northwest region has launched a structured improvement programme:

1. Regional Home Birth Benchmarking Tool (Immediate)

All 17 maternity providers must complete the new benchmarking tool developed using national and regional learning to identify local risks and gaps.

Deadline: 22 December 2025.WHH completed this action.

2. Gap Analysis & Improvement Plans

Following submission, each Trust must produce a gap analysis and improvement plan aligned to forthcoming regional minimum standards.

Monitoring will occur through MPOP from Q1 2026/27 (August 2026).

3. Rapid Task & Finish Group (Jan–Feb 2026)

A senior midwifery representative from each Trust will join a weekly RT&F group to develop an evidence-based Northwest Homebirth Charter. WHH have allocated Sarah Nuttie Consultant Midwife as lead for this programme.

Implementation planned for 1 April 2026.

4. Implementation & Ongoing Oversight

Trusts will implement the Charter from April 2026, with continued monitoring via MPOP.

This regional approach aims to reduce unwarranted variation, strengthen safety, and ensure consistent, evidence-based home birth provision across the Northwest.

WHH will continue to align the Homebirth Service with the Northwest regional Homebirth Improvement Programme to ensure that all identified risks and learning are systematically monitored and acted upon. The outcomes of the local review, together with any improvements required, will be incorporated into the regionally agreed standards and implementation framework. This approach will enable WHH to embed consistent, evidence-based practice, strengthen safety across the pathway, and ensure that any service developments or mitigations are delivered in line with both Trust governance requirements and regional oversight.

There are no concerns with the Homebirth Service at present and no requirement to make any changes to service delivery, other than completion of the benchmarking tool and representation at the task and finish group, both of which are complete. A local Task and Finish Group has been established.

(See Appendix 1 –Homebirth Service Letter – Northwest)

8.3 Diabetes in Pregnancy

The Diabetes Working Group continues to meet on a fortnightly basis. As a Trust, we are required to demonstrate compliance with the *Saving Babies' Lives (SBL)* initiative by evidencing appropriate support for pregnant women with pre-existing diabetes. In line with SBL requirements, women should receive care through a multidisciplinary "one-stop" clinic, incorporating Obstetric and Diabetes Consultants,

a Diabetes Specialist Nurse (DSN), a Diabetes Dietitian, and a Diabetes Specialist Midwife (DSM). Additionally, the Trust must have a named DSN who is competent in pregnancy-specific hybrid closed-loop technology.

Currently, the service does not have a dietitian in place, and a revenue request is being progressed to address this gap. Due to recent vacancies and sickness within the DSN Team, the service has been supported by the Diabetes Consultant Nurse. Recruitment into the DSN role has been successful, and the new postholder is undergoing pregnancy-specific training and actively participating in the Diabetes Working Group.

The role of the Diabetes Specialist Midwife continues to develop and expand. From January 2026, the DSM will be supported by a Band 6 Midwife, ensuring specialist midwifery input throughout the week. To maintain a robust multidisciplinary approach, MDT discussions are held during each Working Group Meeting.

1. COMPLAINTS

3 complaints were received relating to care in the maternity and neonatal services in November 2025.

ID	Specialty	Description	Complaint Received in the Trust
25598	Maternity	Concerns relate to the care provided during the patients' labour and postnatally	In Progress
25662	Maternity	**HEALTHWATCH COMPLAINT** Concerns relate to the lack of appropriate action which unfortunately led to the patients' baby passing away. Patient was admitted to an inappropriate ward unequipped to deal with her pregnancy needs.	In Progress
25712	Maternity	Patients mother unhappy with care providing during birth. Patient had UTI with they believe lead to sepsis diagnosis; midwives did not recognise that baby was breech causing emergency c-section	In Progress

2. CORONER REGULATION 28 ENQUIRIES

No Regulation 28 enquiries have been received.

3. RECOMMENDATIONS

The Board of Directors are asked to receive and note the content the report.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/26/01/156**			
SUBJECT:	**Mortuary Licensed Activity Report (Including Fuller update)**			
DATE OF MEETING:	**4 February 2026**			
ACTION REQUIRED:	For Assurance			
AUTHOR(S):	Gemma Jenkins, Histopathology Manager Hilary Stennings, Associate Director for CSS			
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**
		✓	✓	✓
	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**
		N/A	N/A	N/A
	Further Information / Comments:			
EXECUTIVE SUMMARY:	This paper outlines Human Tissue Authority (HTA) related recommendations and actions, which Mortuaries must be compliant for, from the previous 2 years. The report was previously submitted in June 2025. This report is an update to include HTA inspection outcomes and new recommendations from phase 2 of the Fuller inquiry. There has been significant improvement on last report with a total of 4/116 partially compliant actions remaining. No major concerns raised. Details of compliance summary in the key elements and full details in the appendices.			
PURPOSE: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**	
RECOMMENDATION:	For the members of the Trust Board of Directors to note the contents of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee		
	Agenda Ref.	QAC/26/01/231		
	Date of meeting	13 January 2026		
	Summary of Outcome	noted		
NEXT STEPS: ***State whether this report needs to be referred***	***Submit to Trust Board***			

to at another meeting or requires additional monitoring	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None

TRUST BOARD of DIRECTORS

SUBJECT	Mortuary Licensed Activity Report (Including Fuller update)	AGENDA REF:	QAC/26/01/230

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 was reviewed in Phase 2 of the Inquiry, published in July 2025.

The phase 1 Immediate Trust-level changes (published November 2023)

The report produced 17 recommendations for Maidstone and Tunbridge Wells NHS Trust. The phase 2 report produced 75 recommendations, mostly for the government and local authorities to address, however 22 recommendations involve NHS Trusts. All recommendations are anticipated to be actioned by NHS organisations with Mortuary or body store facilities with the aim to prevent this happening again.

Phase 2 – National system changes (final report July 2025)

Phase 2 looked more widely at all settings where deceased people are cared for, including NHS hospitals, funeral services, local authorities and the private sector.

The Inquiry concluded that arrangements nationally were inconsistent and, in some cases, inadequate and made 75 recommendations to improve safety and dignity after death. (22 of which are relevant to WHH)

Key changes and expectations include:

1. Stronger governance and oversight

- Trust boards must have clear oversight of mortuary services
- Regular reporting of significant issues or concerns is expected
- Recommendation 15 specifically requires that serious or significant matters are highlighted through formal reporting routes, rather than being managed informally

2. Clear leadership and responsibility

- Named senior leads (such as a Designated Individual) with clear accountability
- Defined roles for Designated Persons involved in mortuary oversight
- Better escalation routes when concerns are identified

3. Improved access control and security

- Tighter rules about who can access mortuaries
- Use of access logs, swipe systems and monitoring
- Reduced risk from lone working wherever possible

4. Consistent standards for dignity and care after death

- Clear expectations about how deceased people are treated at all times
- Improved procedures for storage, movement and examination
- Stronger respect for families and cultural needs

5. Better recording, learning and reporting

- Accurate documentation of incidents and concerns
- Learning shared within trusts and across organisations
- Use of governance forums to review and act on issues

6. Future national regulation

- The Inquiry recommended new statutory regulation to protect people after death, including in the funeral sector
- Government has accepted many recommendations and is working towards fuller regulation by summer 2026

A regular update of WHH compliance will be presented to Trust Board of Directors via the Trust Board report biannually.

Chronology

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

Since January 2024, monthly Mortuary Meetings have been held, with the Human Tissue Authority included as a standing agenda item. Designated Persons and the Trust Designated Individual attend to report and record any findings. No significant concerns have been identified to date. Minutes and any actions arising from these meetings are shared with the 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.

10 July 2025 – HTA confirmed corrective action evidence is sufficient to close. No further outstanding actions to address.

24 July 2025 – Phase 2 of Fuller Inquiry report released with 75 recommendations, 22 considered as relevant to WHH. Gap analysis updated to reflect this report.

2. KEY ELEMENTS

On 3 October 2024, 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.

Further compliance oversight is being maintained bi-annually via this report.

Position following further review December 2025

HTA inspection May 2022, licence maintained.

- All findings now compliant and closed.

Fuller enquiry, Phase 1 recommendations WHH compliance (Appendix 1, updated

- 17/17 Now compliant and closed.

Unannounced inspections gap analysis findings (Appendix 2):

- 71/71 Compliant,

Security recommendations (Appendix 3)

- 4/4 Now compliant and closed.

HTA unannounced inspection performed 16 April 2025 (Appendix 4, updated July 2025)

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

- 2 Non-conformances found, evidence submitted, both now considered closed.

Fuller enquiry, Phase 2 recommendations WHH compliance (Appendix 5, updated Dec 2025):

22/75 recommendations considered relevant to WHH.

- 0 Non-compliance
- 18 Compliant (7 have been included within this report to meet the compliance)
- 4 Partial compliance.

- 2 require minor updates to documentation
- 1 requires additional estates/security works
- 1 requires an SLA to be completed

Recommendation 11 from **phase 2** of the Fuller inquiry, requires this report to highlight key staff with roles and responsibilities for noting.

Person	HTA relevant role	Responsibility
Warrington and Halton Teaching Hospitals NHS Foundation Trust and CEO Nikhil Khashu	Corporate Licence holder	The Licence Holder must have the prior consent of the Designated Individual to contact the HTA. The role of Licence Holder does not impose the duties that are expected of the Designated Individual; however, it is important to note that they have the right to apply to the HTA to vary the licence. This enables them to substitute another person as the Designated Individual and allows the establishment to cover circumstances where the Designated Individual is unable to oversee the licensable activities.
Dr Chenggang Li, Histopathology Department Lead.	Designated Individual (DI)	They are the person under whose supervision the licensed activity is authorised to be carried out. They have the **primary legal responsibility** under Section 18 of the Human Tissue Act to secure: that suitable practices are used in undertaking the licensed activity; that other persons working under the licence are suitable; and that the conditions of the licence are complied with.
Christopher Barlow, Mortuary Manager	Person Designated (PD), Mortuary	Support the designated individual by taking on delegated tasks like developing procedures or managing incidents but has no statutory duties themselves.
Pamela Mulligan, Senior Biomedical Scientist	Person Designated (PD), Histopathology Laboratory	
Hannah Parker, Specialist Midwife for Bereavement	Person Designated (PD), Maternity	
Gemma Jenkins, Histopathology Manager		Overall management of Histopathology and Mortuary Services, including staffing, equipment, estates, security, regulatory compliance, governance and finance.

Andrea Oxford, Principal Radiographer		Manager of radiology portering staff, who undertake transfers of deceased.
Claire Hunt, Head of Security and Car Parking		Manager of security staff, who undertake transfers of deceased out of hours.

In line with *Recommendation 15* of **Phase 2** of the Fuller Inquiry, this report is used to highlight any significant matters for information.

Reporting period 1 January – 22 December 2025:

- Staffing matters; None to note
- Security incidents;
  - 4 reported;
    - 2 involving unauthorised members of the public in the mortuary grounds. ID201592 (NC12777) and NC12781.
    - 2 involving damage to the rear gate/door which required repair. NC12677 and NC13293.
- Serious incidents;
  - ID202512 (NC12869); A bariatric deceased patient was transferred to the mortuary from the ward in a hospital bed. During the transfer the wheel of the bed broke off.
    Informed HTA, replied to state not considered a HTA reportable incident.
- Human Tissue Authority reports (where applicable);
  - Unannounced inspection undertaken in April, see appendix 4.
- Security audits, including audits of access and any access breaches.
  - 5 reported
    - Use of unauthorised access card – accessed the premises but CCTV indicated access was legitimate. ID 208192 (NC13269) and ID213986 (NC13731).
    - Attempted unauthorised access – failed NC12796 and ANC1579
    - Unauthorised personnel on the access list – no attempt to access ANC1599

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Trust Histopathology Manager and Mortuary Manager are addressing the actions as required and regularly review progress of the gap analysis.

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, as per recommendation 3 of phase 1 report.

The Committee is required to note the following recommendations from phase 2 of the Fuller inquiry:

- 16: Trust boards should assure themselves that the recommendations in this Report (Phase 2 of the Fuller inquiry) have been implemented.
- 18: Trust boards should take note of the fact that mortuary services are subject to statutory regulation and should be treated with equivalent regard to other regulated activities within trust governance arrangements.
- 19: NHS Trust boards should ensure that the security and dignity of deceased people are included in safeguarding training, policies and assurance.
- 20: The remit of the Chief Nurse in NHS trusts should explicitly include executive responsibility for safeguarding the security and dignity of deceased people in NHS mortuaries and body stores

A recommendation for NHSE which may impact the Trust:

- 21: NHS England should formally incorporate the safeguarding of deceased people into its safeguarding framework for NHS trusts.

4. RECOMMENDATIONS

- 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.

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Appendix 1 – Fuller recommendations from phase 1 report.
Complete recommendations with no update have been removed, last updated Dec 2025

Recommendation	Recommendation	Gaps/Current Position (Nov 23)	Status (Jan 25)	Actions required/Comments/Updates
3	Recommendation 3 Warrington & Halton Teaching Hospitals NHS Trust must assure itself that it is compliant with its own current policy on criminal record checks and re-checks for staff. The Trust should ensure that staff who are employed by its facilities management provider or other contractors are subject to the same requirements.	Checked Trust Recruitment & Selection Policy - currently compliant, however the policy does not mention re-checking DBS on a periodic basis & therefore needs to be considered. Regarding external contractors, they are always accompanied by Mortuary staff.	Compliant to current trust policy	Consideration of periodic review of DBS checks required.
11	Recommendation 11 z Warrington & Halton Teaching Hospitals NHS Trust must proactively share Human Tissue Authority reports with organisations that rely on Human Tissue Authority licensing for assurance of the service provided by the mortuary	Currently the latest report is not shared with external stakeholders. Details are freely available on the HTA website.	compliance	This is not currently a requirement from HTA. Currently the latest report is not shared with external stakeholders. Details are available on the HTA website. Further review and recommendations to be made in Phase 2 of the enquiry. 2/1/25 - Phase 2 recommendations and report not fully published yet. Update 12/12/25 – Phase 2 does not provide further recommendations for this. Considered compliant.
12	Recommendation 12 z Warrington Borough Council & Halton Borough Council should examine their contractual arrangements with Warrington & Halton Teaching Hospitals NHS Trust to ensure that they are effective in protecting the safety and dignity of the deceased.	No current evidence available to provide assurance this is completed.	compliance	This is not currently a requirement from HTA. No current evidence to provide assurance for this. Further review and recommendations to be made in Phase 2 of the enquiry. 2/1/25 - Phase 2 recommendations and report not fully published yet. Update 12/12/25 – Phase 2 does not provide further recommendations for this but other considerations are stated in the report, assessed for compliance in new gap analysis.

Appendix 2 – Unannounced inspections gap analysis.
Complete recommendations with no update have been removed, last reviewed 19/12/25

Requirement	Initial review	Gaps/ comments	Action required	By Whom	Target date	Update
Consent						
Perinatal/Paediatric:						
PM consent SOP	Unknown need to liaise with Butterfly team	Unknown need to liaise with Butterfly team	Liaise with Butterfly Team to request copy and upload copy to S-Drive for evidence	Chris Suku Barlow Mortuary Manager Hannah Parker Midwife	23/09/2024	Debbie Yates advised it is on intranet. Asked for help locating. 12.12.24 - Response from Hannah Parker "We are guided by the parents/family and follow the National Bereavement Care Pathway standards", no SOP. SOP is being drafted by Butterfly team. **UPDATE 19/6/25: Raised as HTA non-conformance. Being addressed by Helen Wall.** **Update 25/6/25: Flow chart of process received by Helen Wall, submitted as evidence to HTA. CAPA now closed**
PM consent policy	Unknown need to liaise with Butterfly team	Unknown need to liaise with Butterfly team	Liaise with Butterfly Team to request copy and upload copy to S-Drive for evidence	Chris Suku Barlow Mortuary Manager Hannah Parker Midwife	23/09/2024	Debbie Yates advised it is on intranet. Asked for help locating. 12.12.24 - Foetal remains policy covers PM's and consent. Policy to be published on the intranet. **UPDATE 19/6/25: Raised as same HTA non-conformance. Being addressed by Helen Wall.** **Update 25/6/25: Flow chart of process received by Helen Wall, submitted as evidence to HTA. CAPA now closed**
Governance & Quality						

SOPs:						
Viewing of the deceased (including out-of-hours and on the maternity ward if it is covered by the licence)	Need to liaise with Butterfly team regarding viewing policy?	To liaise with Butterfly team	Liaise with Butterfly Team to request copy and upload copy to S-Drive for evidence	Chris Suku Barlow Mortuary Manager	23/09/2024	Email sent 18/09/24. 12.12.24 - No SOP, chased with HP. UPDATE 19/6/25 – Gemma Jenkins and Hannah Parker have written and submitted a policy for review by all relevant CBU teams and PRG, titled 'Transfer and viewing of neonatal and paediatric deceased patients. Awaiting feedback and approval before marking compliant. **Update 22/12/25 –Approved and live on the intranet.**
Transfer of bodies internally (e.g. for PMCT, contingency storage or the return of babies/foetuses to the maternity ward for viewing)	HC-MO-2 - Police ID and Viewing procedure Appendix 2. HC-MO-36 capacity management includes transfer to Halton for storage	Available on Q-Pulse and paper copy in mortuary office	Liaise with Butterfly Team to ask if they have a policy/SOP and request copy and upload copy to S-Drive for evidence. Review/make an SOP for any internal transfers if we do not have one	Chris Suku Barlow Mortuary Manager	04/10/2024	Email sent 18/09/24 - Added appendix to HC-MO-2 for BS team to complete should the take a deceased back to the suite for viewing by parents UPDATE 19/6/25 – Gemma Jenkins and Hannah Parker have written and submitted a policy for review by all relevant CBU teams and PRG, titled Transfer and viewing of neonatal and paediatric deceased patients. Awaiting feedback and approval before marking compliant. **Update 22/12/25 –Approved and live on the intranet.**
Contingency plan	HC-MO-36 Capacity	Available on Q-Pulse and paper copy	There is a specific business continuity	Chris Suku Barlow Mortuary Manager		12.12.24 - GJ asked CS to merge continuity plans

	Managem ent	in mortuary office	plan for the mortuary			**UPDATE 19/6/25 – A contingency plan is available but is under review to merge and make more robust. Reviewed during HTA inspection, no concerns raised.**
Contingency storage arrangements	HC-MO-36 Capacity Managem ent	Available on Q-Pulse and paper copy in mortuary office	There is a specific business continuity plan for the mortuary			**Update: Capacity and contingency covered in HC-MO-36.**
Cleaning records (if these cannot be reviewed onsite):						
PM room(s)	HC-DOC-361 postmorte m cleaning log - NOT A DOCUMEN TED PROCEDUR E, Referenc d in HC-MO-6 - Post Mortem Procedure	Available on S:Drive	We need an SOP for this if we do not have one - each log can be an appendix in the SOP or recorded electronically if preferred - Cross referenced in HC-MO-53 cleaning and decontaminati on	Chris Suku Barlow Mortuary Manager	04/10/2024	Cross referenced in HC-MO-53 cleaning and decontamination. 12.12.24 - Being updated by CS. **Update 19/6/25 – Completed**

Body store(s)			We need an SOP for this if we do not have one - each log can be an appendix in the SOP or recorded electronically if preferred - Cross referenced in HC-MO-53 cleaning and decontamination	Chris Suku Barlow Mortuary Manager	04/10/2024	Cross referenced in HC-MO-53 cleaning and decontamination. 12.12.24 - Being updated by CS. **Update 19/6/25 – Completed**
Fridges/freezers			We need an SOP for this if we do not have one - each log can be an appendix in the SOP or recorded electronically if preferred - Cross referenced in HC-MO-53	Chris Suku Barlow Mortuary Manager	04/10/2024	Cross referenced in HC-MO-53 cleaning and decontamination. 12.12.24 - Being updated by CS. **Update 19/6/25 – Completed**

			cleaning and decontaminati on			
Retention of tissue/organs following a PM examination (including record keeping and traceability)	Obsolete HC-RW-7 to be implement ed as HC-MO-52, HC-MO-12 available on q-pulse and mortuary	HC-MO-12 collection of PM specimens available on Q-Pulse and mortuary	HC-MO-12 doesn't fully detail retention. Ask Pam - she completes an audit for this?	Pam Mulligan BMS	20/09/2024	HC-MO-12 collection and transport of tissue to lab SOP. Chris Suku and Pam Mulligan to implement whole organ transfer HC-MO-52. **Update 19/6/25 – Completed**
Transfer of organs and tissue (including blocks and slides) off site to other establishment s (including confirmation of receipt) and to pathologists who may review tissue	HC-MO-12 collection of PM specimens, HC-MO-39 visiting pathologist procedure, obsolete HC-RW-7 to be implement ed as HC-MO-52	HC-MO-12 collection of PM specimens available on Q-Pulse and mortuary. HC-MO-39 Visiting pathologist procedure appendix 1 available on	HC-MO-52 needs completing. None of these documents seem to fully explain this procedure - suggest a new document is written or it is all encompassed in HC-MO-52.	Chris Suku Barlow Mortuary Manager Gemma Jenkins Mortuary Manager	04/10/2024	HC-MO-12 collection and transport of tissue to lab SOP. Chris Suku to implement whole organ transfer HC-MO-52. HC-MO-39 includes record of transfer for tissue taken by visiting pathologist. **Update 19/6/25 – HC-MO-52 now completed**

slides at home		Q-Pulse and mortuary				
Access to the mortuary and supervision of non-mortuary staff, contractors and visitors	HC-DOC-279 mortuary access register, monthly requests from Security for staff with access to mortuary		As above - this is not clearly defined enough.	Chris Suku Barlow Mortuary Manager Gemma Jenkins Mortuary Manager	04/10/2014	HC-DOC-279 amended and sent to GJ for approval 6.12.24 **Update 19/6/25 – Completed**
Incident log for last 24 months for all mortuary incidents and any incidents from other areas covered by the licence e.g. in maternity	Nonconformity records on Q-Pulse	Nonconformity records on Q-Pulse	Do you complete any form of Trend analysis for this? I complete GF47 and the seniors submit HC-DOC-399 to me to include - it might be an idea to include mortuary in	Chris Suku Barlow Mortuary Manager Gemma Jenkins Mortuary Manager	04/10/2024	GJ to amend HC-DOC-399 to include "mortuary incidents" and email Chris Suku for monthly data. Chris Suku to consider error log form. **Update 19/6/25 – Completed, Trends are reviewed by Gemma Jenkins as per quarterly review.**

			this process to ensure it is covered.			
Policies covering:						
Audits						
The last 2 audit reports for traceability of tissue (including supporting information to demonstrate any non-conformances have been addressed)	Liaise with PMu (Senior BMS and PD for the lab)		PMu and CS to complete twice per year. CS/PM to meet to discuss.	Chris Suku Barlow/ Pam Mulligan Senior BMS	04/10/2024	12.12.24 - PM has started traceability audit that will be completed twice yearly. **Update 19/6/25 – Completed**
Risk Assessments						
Relating to:						
Security	RAMO29 mortuary security	Available on Q-Pulse	Change request raised to include more detail and GJ	Chris Suku Barlow/ Gemma Jenkins	04/10/2024	12.12.24 - PS provided a report, to be attached to Q-Pulse RA

			contacted PS to add further information			**Update 19/6/25 – Completed**
Lone working	RAMO15 Lone working	Available on Q-Pulse	CS to update RA and include lone worker devices and SOP mitigations as per HTA recommendations	Chris Suku Barlow Mortuary Manager	04/10/2024	11.12.24 - Security began process to connect to IT for devices to work - in progress. **Update 19/6/25 – Ongoing – being tracked through monthly meeting, now awaiting RJ security to connect devices.** **Update 19/12/25: RJ Security and IT have managed to connect devices through internal Wi-Fi. Completed.**
<u>Training records (if these cannot be reviewed onsite)</u>						
Training records for any other staff completing activities under the licence (e.g. funeral directors admitting bodies out of hours, or bereavement	Coroner's Funeral Directors require formal training for admitting deceased to the mortuary - Email sent to Bate and Holland to	No activity other than admitting deceased is undertaken by external staff	List of trained staff on S-Drive - ongoing. To ask Coroner on 6th Nov.			12/12/24 - Awaiting reply from Bate and Holland **Update 19/6/25 – Completed**

staff carrying out viewings)	request staff attend for training					
Competency records for any other staff completing activities under the licence (e.g. funeral directors admitting bodies out of hours, or bereavement staff carrying out viewings)	Coroner's Funeral Directors require formal training for admitting deceased to the mortuary - Email sent to Bate and Holland to request staff attend for training	No activity other than admitting deceased is undertaken by external staff	List of trained staff on S-Drive - ongoing. To ask Coroner on 6th Nov.			12/12/24 - Awaiting reply from Bate and Holland UPDATE 19/6/25 – Not due for 2 years. Being monitored through training log held by Chris Suku.
<u>Service records (if these cannot be reviewed onsite)</u>						
Fridges (including for any contingency	Not covered - requested mortuary	Dave Tambourini	CS/GJ Emailed for records	Chris Suku Barlow/ Gemma Jenkins	04/10/2024	12.12.24 - CS to request quote from LEEC for all equipment. **Update 19/6/25 – Completed, now hold a contract with LEEC.**

storage units)	body store to be added to estates annual service register 15/05/24					
Freezers (including for any contingency storage units)	Not covered - requested mortuary body store to be added to estates annual service register 15/05/24	Dave Tambourini	CS/GJ Emailed for records.	Chris Suku Barlow/ Gemma Jenkins	04/10/2024	12.12.24 - CS to request quote from LEEC for all equipment. **Update 19/6/25 – Completed, now hold a contract with LEEC.**
Trolleys/Hoists	Tested by Alliance and Arjo - records requested	Andrew Holland	CS/GJ Emailed for records	Chris Suku Barlow/ Gemma Jenkins	04/10/2024	12.12.24 - CS to request quote from LEEC for all equipment. **Update 19/6/25 – Completed, now hold a contract with LEEC.**
PM table	Not covered		CS email supplier for servicing	Chris Suku Barlow Mortuary Manager	04/10/2024	12.12.24 - CS to request quote from LEEC for all equipment. **Update 19/6/25 – Completed, now hold a contract with LEEC.**

Saws	Not covered		CS email supplier for servicing	Chris Suku Barlow Mortuary Manager	04/10/2024	12.12.24 - CS emailed company, no response as yet will chase. **UPDATE 19/6/25 –Unable to get serviced due to supplier wanting to package and send offsite – going to get a quote to buy a replacement if ever required. Considered compliant due to having a spare already on-site.** **27/10/25 - now risk assessed RAMO19**

Appendix 3 – Security recommendations.
Complete recommendations with no update have been removed, last reviewed 19/12/25

Requirement	Initial review	Gaps/comments/action required	By Whom	Target date	Update
Reflect all mitigations in your lone working risk assessment, such as the emergency contact number, into your lone working SOP.	Change request raised against document on Q-Pulse	CS to complete change to document	Chris Suku Barlow Mortuary Manager	04/10/2024	In progress. 2/1/25 - Awaiting lone working devices to be connected to the network. UPDATE 19/6/25 – as detailed above, being tracked through monthly meetings. **Update 19/12/25 - Lone worker devices now connected to Trust Wi-Fi__33.**
Review the level of detail in your security risk assessment to ensure all mitigations are covered (CCTV, audits, etc).	Change request raised against document on Q-Pulse	CS to complete change to document	Chris Suku Barlow Mortuary Manager	04/10/2024	In progress. 2/1/25 - Change request raised against document on Q-Pulse to be reviewed and amended. **UPDATE 19/6/25 – Document updated. Reviewed by HTA during inspection, not considered a non-conformance but they described a lot of good practice which is not detailed so recommended further update to ensure all practices are detailed.**

Appendix 4: HTA unannounced inspection report findings and outcome

Minor Shortfalls

Standard	Inspection findings	Level of shortfall
C1 Consent is obtained in accordance with the requirements of the Human Tissue Act 2004 (HT Act) and as set out in the HTA's codes of practice		
a) There is a documented policy which governs consent for post-mortem examination and the retention of tissue, and which reflects the requirements of the HT Act and the HTA's Codes of Practice	There is a documented policy which governs consent for a post mortem examination, however this does not accurately reflect the service offered or the requirements of the HT Act and the HTA's Codes of Practice. This includes: • Incorrectly stating that adult post mortems are offered by the establishment; • Reference to unavailable documents and out of date external links; and • Incorrectly using the term 'next of kin' rather than 'a person of qualifying relationship'.	**Minor**
b) There is a documented standard operating procedure (SOP) detailing the consent process	Whilst a consent SOP has been published, this has not been distributed to, or acknowledged by, staff responsible for taking post mortem consent. *This combined with an inaccurate policy increases the risk of invalid consent being taken.*	**Minor**

Actions:

C1a: Gemma Jenkins has rectified the policy to encompass the points described – now live on the intranet. Completed.

C1b: Procedural update from Helen Wall completed. Completed.

RE: CA/PA evidence

Reply | Reply All | Forward | ...

Thu 10/07/2025 15:21

SM

Shane Mongor <Shane.Mongor@hta.gov.uk>

To JENKINS, Gemma (WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST)

Cc LI, Chenggang (WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST); SUKU, Christopher (WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST); **+1 other**

You replied to this message on 10/07/2025 15:40.
Please treat this as Confidential.
Click here to download pictures. To help protect your privacy, Outlook prevented automatic download of some pictures in this message.

This message originated from outside of NHSmail. Please do not click links or open attachments unless you recognise the sender and know the content is safe.

Dear Dr Li & team,

Thank you for sending me the evidence to confirm completion of actions within your CAPA plan. I can confirm that I have reviewed the evidence provided and I am satisfied that the actions you have taken are sufficient to meet the shortfalls identified during the HTA inspection. A statement will be added to the published inspection report to confirm that the shortfalls have been addressed.

I appreciate how much work goes in gathering this information, and I wanted to thank you and your team for a smooth assessment process.

As always, please contact me anytime if I can be of help.

Kind regards

Shane

Right-click or tap and hold here to download pictures. To help protect your privacy, Outlook prevent...

Shane Mongor
Regulation Manager
Human Tissue Authority
2nd floor, 2 Redman Place, London, E20 1JQ
Direct: 020 7269 1940
General: 020 7269 1900

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Appendix 5 – Fuller recommendations from phase 2 report, filtered by relevance to Trust, updated Dec 2025.

No.	Recommendation	Responsible Organisation / Body	Current position
1	All NHS trusts with mortuaries and/or body stores should commission a specialist strategic review of the systems in place to protect deceased people, which should include a detailed risk assessment of the potential breaches of security that could occur. The review should include an assessment of the systems in place to identify any unauthorised access to the facility; the strength and effectiveness of barriers to prevent unauthorised access to the facilities; the systems in place to identify any access to deceased people for unauthorised purposes; and how CCTV is used, including its monitoring and any audits undertaken.	NHS	5/9/25 - Review SOP CCTV access MO54 to include Pamela Mulligan as independent access reviewer and need agreement with security. 19/12/25 – Now Compliant
2	All NHS trusts should install CCTV inside the mortuary, with cameras facing all doors and access points, the reception area and the doors of body fridges, while maintaining the security and dignity of deceased people by implementing the appropriate safeguards. Where double-ended fridges also open into the post-mortem room, NHS trusts should install CCTV cameras inside the post-mortem room that focus on the doors to the fridges.	NHS	5/9/25 Compliant
3	All NHS trusts should routinely audit the access data of all facilities used to store deceased people	NHS	5/9/25 - To review SOP MO54, recorded on Q-pulse 22/12/25 – Now compliant
4	The practice of using shared electronic swipe cards for specific staff groups should cease immediately.	NHS	5/9/25 - Policy states each person must swipe and covered access audit. Further action CB/GJ need to agree permission granted. 19/12/25 Emailed security. 22/12/25 – Claire Hunt agreed going forward permission for access must be approved by Gemma Jenkins or Christropher Barlow (Mortuary manager). Now compliant.

5	All NHS trusts should consider putting in place systemic operational barriers that prevent the security and dignity of deceased people being compromised. An example of this would be implementation of a rule that prevents electronic devices such as phones or cameras being taken into a mortuary, other than for approved reasons	NHS	5/9/25 - Create no mobile phone signs for around the department, except in the office. Can be monitored via CCTV. 22/12/25 – Now compliant
6	All NHS trusts should take every breach of security in a mortuary or body store extremely seriously. Each security incident should be reviewed by a security expert who is able to identify any systemic security issues associated with the incident. A detailed action plan should be developed for each security breach, no matter how minor trusts regard such breaches to be. All security breaches occurring in mortuaries should be incorporated into security reports provided to trust boards or relevant subcommittees, in line with security breaches in other vulnerable areas.	NHS	5/9/25 - No formal plan/report but breaches are raised on Q-pulse/datix where required. Include in the MO54. 22/12/25 – Now compliant
7	The NHS should ensure that the security standards required for body stores are the same as those required for facilities licensed by the Human Tissue Authority.	NHS England and the body that subsumes its functions	5/9/25 - On access spreadsheet - covered by audit - include MO54. 22/12/25 – Also added Halton, now compliant
8	All NHS trusts should consider the installation of 'swipe to exit' for mortuary facilities. This would allow trusts to monitor and audit entry and exit, as well as time spent in the mortuary.	NHS	5/9/25 – To escalate to Hilary Stennings. 22/12/25 – To obtain a quote from RJ security regarding addition of new pads on the postmortem room and exit swipe pads. Target Q1
9	All NHS trusts should monitor the number of staff with access to the mortuary or body store and keep this under routine review.	NHS	5/9/25 – Included in audit as per MO54, recorded on Q-pulse 22/12/25 – Now compliant
10	NHS trusts should ensure that Designated Individuals have enough time and resource to fulfil their responsibilities, including time for learning and development.	NHS	5/9/25 – To confirm if PA time moved into Dr Li's job plan with Dr Davison. 22/12/25 – Gemma Jenkins emailed to confirm, awaiting reply. Target Q1
11	NHS trusts should ensure that senior managers, including the Chief Executive, have a clear understanding of the role of the Designated Individual, their lines of accountability, and the individual legal responsibility associated with being a Designated Individual.	NHS	5/9/25 – To consider a policy which outlines roles and responsibilities. 19/12/25 Decision to include table in QAC report. Now compliant.

12	NHS trusts should ensure that Designated Individuals attend the correct governance forums. This would allow them to escalate issues and risks, as well as reporting upwards when required.	NHS	5/9/25 - DI attends monthly mortuary meetings, minutes escalated up through CSS meetings. In addition, bi-annual report for QAC completed by laboratory manager. Laboratory manager and DI able to escalate concerns where required via Associate Director. Compliant.
13	A professional background in the field of mortuary services should be made a prerequisite for the post of Mortuary Manager	NHS	5/9/25 - Compliant
14	NHS trusts should assure themselves that the Mortuary Manager has adequate resources and support to perform their role effectively, including meeting any reporting requirements.	NHS	5/9/25 - Discussed during annual appraisal . Compliant
15	All NHS trusts should establish a routine reporting system for matters relating to mortuaries and body stores. This reporting system should include the presentation of a formal report, by the accountable executive director, to the trust board on a routine basis. The accountable executive director should prepare and present to the trust board a formal annual report, similar to the annual safeguarding report. The report should include z staffing matters; z security incidents; z all serious incidents; z Human Tissue Authority reports (where applicable); and z all security audits, including audits of access and any access breaches.	NHS	5/9/25 – Monthly mortuary meetings cover; staffing matters; incidents; Human Tissue Authority matters. Access audits are completed monthly on Q-Pulse – laboratory QMS. Issues would be addressed by the laboratory manager. Bi-annual QAC report to include any significant; Staffing matters; Security incidents; Serious incidents; Human Tissue Authority reports (where applicable); Security audits, including audits of access and any access breaches. 22/12/25 – Included in report. Now compliant.
16	Trust boards should assure themselves that the recommendations in this Report have been implemented	NHS	22/12/25 - Included as a recommendation in this report. Compliant.
17	Trust boards should ensure that these recommendations and governance arrangements are applied to any temporary facilities used by trusts for the storage and care of deceased people	NHS	5/9/25 – Regarding temporary arrangements; Would need to consider relocation of a camera if nutwell required. 19/12/25 - If required temp storage could go in external unit - would have to be with LEEC to fit space specification. Nutwell would need to go to Halton. To be added to HC-MO-36. Q2

18	Trust boards should take note of the fact that mortuary services are subject to statutory regulation and should be treated with equivalent regard to other regulated activities within trust governance arrangements.	NHS	22/12/25 - Included as a recommendation in this report – compliant.
19	NHS trust boards should ensure that the security and dignity of deceased people are included in safeguarding training, policies and assurance.	NHS	5/9/25 – To escalate to Hiliary Stennings. 22/12/25 – To include as a recommendation in QAC report for review. Compliant,
20	The remit of the Chief Nurse in NHS trusts should explicitly include executive responsibility for safeguarding the security and dignity of deceased people in NHS mortuaries and body stores	NHS	5/9/25 – To escalate to Hiliary Stennings. 22/12/25 – To include as a recommendation in QAC report for review. Compliant
21	NHS England should formally incorporate the safeguarding of deceased people into its safeguarding framework for NHS trusts.	NHS England and the body that subsumes its functions	5/9/25 – Just to note in report, not an action for WHH. 22/12/25 – To include as a recommendation in QAC report for review.
69	Where organisations work together to care for people after death, the arrangements should be formalised through contracts or service level agreements. This should include joint Standard Operating Procedures. The parties to the contracts or service level agreements should ensure that the contracts or agreements are managed effectively, and that they seek assurance that the arrangements protect the security and dignity of people after death.	NHS trusts, local authorities, medical education providers, funeral sector	5/9/25 – Highlighted SLA required with contracts team. 22/12/25 – SLA under review for mutual aid between other network mortuaries and local funeral directors, being actioned by Gemma Jenkins. Q2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/26/02/157**	
SUBJECT:	**Communications and Engagement Update (bi monthly) November to December 2025**	
DATE OF MEETING:	4 February 2026	
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): (*Please DELETE as appropriate)*	**224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival 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. **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 **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. **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	

	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 **1757** If industrial action takes place, then there is a risk of significant workforce gaps across critical services, which may disrupt operational service delivery and compromise the Trust's ability to maintain safe, effective, and timely patient care. **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
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***

	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	✓		
Further Information:			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	✓		
Further Information:			
3. Foster good relations between people who share a protected characteristic and those who do not	✓		
Further Information:			

EXECUTIVE SUMMARY *(KEY ISSUES):*	This report updates on communications and engagement activity during November to December 2025. The report covers a two-month period to ensure alignment of communications and engagement activity reporting with the Board meeting cycle. It incorporates reporting on the Working with People and Communities Strategy and elements of the previous Communications and Engagement Dashboard into one report. Key highlights from the report include: • **Communications Activity:** The Communications and Engagement Team managed 20 job requests, issued 6 media releases and published 12 stories across various Trust websites during November and December 2025 • **Campaigns:** Key campaigns included the MaDE for Christmas campaign (17 December to 2 January)

	• **Patient and Public Participation Group (PPRG):** First meeting held on 1 December, providing an overview of integration plans and initial clinical pathways. • **Community engagement:** Carer feedback gathered around the integration at Halton's autumn Carers' Forum • **Better Care Together:** BCT programme updates shared included microsite updates and support for staff engagement sessions • **Charity:** Charity update shared included website activity, newsletter info and news overview. The report also includes details of engagement events which the Trust is hosting or planning to attend during 2026		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this update on Communications and Engagement activity during the period.		
PREVIOUSLY CONSIDERED BY:	**Committee**	EMT	
	Agenda Ref.	EMT/26/039	
	Date of meeting	27 January 2026	
	Summary of Outcome	To note	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Communications and engagement update

Bi-monthly report (November to December 2025)

Trust Board meeting

4 February 2026

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 this period the Communications and Engagement Team…

- processed and allocated **20** communications 'job requests' for design, film, photography and communications campaign support
- issued **6** Trust media releases
- published **12** stories across our main Trust website, charity website and breast screening services website
- prepared / issued **12** media statements and responses
- handled **13** enquiries from local, regional and national print and broadcast media

November / December activity and achievements overview

- Informed patients and communities of industrial action activity (17 to 22 December) via our website and social media accounts
- Supported promotion of public nominations for the People's Choice Award
- Continued to promote the annual flu vaccination campaign e.g. roaming clinics, drop-in sessions
- Informed patients and communities of the appointment of Andy Carter as new Trust chair from April 2026
- Celebrated a year of fundraising, generosity and community spirit with WHH Charity
- Raised staff and public awareness of AI application in transcribing consultation notes and patient letters c/o 'Lyrebird Health'
- Promoted free Wi-Fi access for patients / visitors across our estates
- Supported the first of our Patient Public Reference Group meetings for Better Care Together, chaired by Healthwatch

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

Media

Media releases issued during this period included:

New chair appointed at Warrington and Halton Teaching Hospitals

Read the release

Living Well Warrington highly commended at 2025 HSJ Awards

Read the release

WHH HR team highly commended at national people management awards

Read the release

Luke Littler brings cheer to hometown hospital with surprise visit

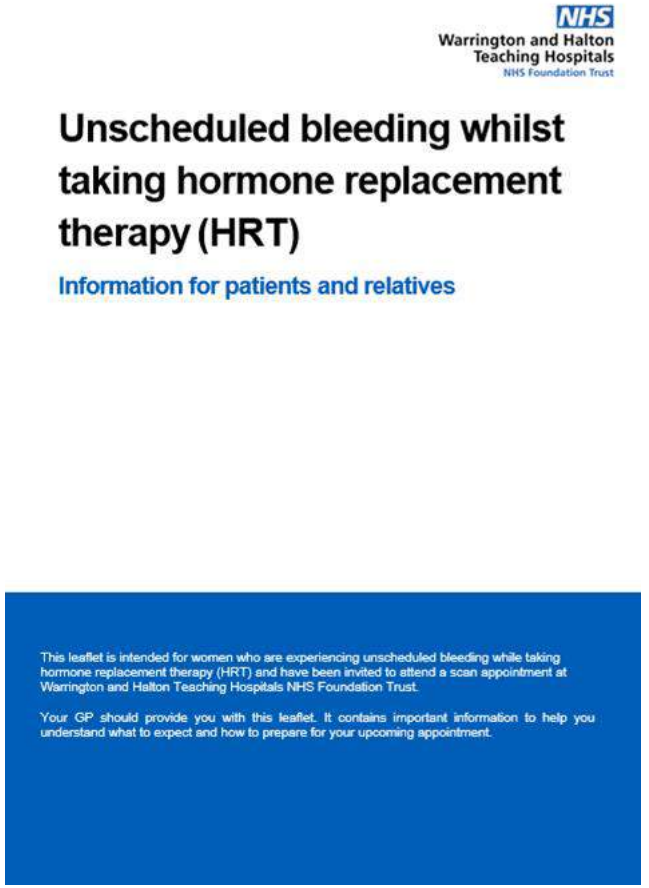
Read the release

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

Production of Patient Information (PINFO)

During this period the Communications and Engagement Team:

- supported clinical teams in putting **1** new leaflet through the PINFO process
- reviewed and edited **4** existing leaflets to ensure content remains clinically appropriate and reflects WHH style guidelines
- identified a total of **143** expired leaflets
- archived **1** leaflet
- reviewed the process and carried out a benchmarking exercise to inform how we approach integration with BCH patient information process



Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Key campaigns / highlights

MaDE for Christmas campaign

Internal communications support provided to the Multi Agency Discharge Event (MaDE) for Christmas campaign, held from Wednesday 17 December to Friday 2 January.

Communications included:

- Good Morning Message (12 December)
- inclusion in Team Brief (16 December)
- content in The Week (12 and 19 December)
- Trust desktop (8 to 19 December)
- Trust screensaver (15 December to 2 January)
- a safety hot topic (19 December) and
- a digital intranet homepage banner with MaDE for Christmas branded images

Better Care Together (BCT) – update

The BCT staff microsite continues to provide internal information on the integration programme and proposals, including regularly updated FAQs, operational activity and engagement opportunities.

Microsite activity

- November: 1,789 visits
- December: 1,659
- The most viewed pages after the homepage: Supporting teams through integration (November) and resources (December)
- Total site visits: 25,787

Site updates for this period include:

- News updates – OD support for teams through integration, joint Long Service Awards, joint corporate induction
- Resources – engagement session recording, ‘Support for you’ one pager

Monthly joint staff engagement sessions presented by the Executive Team provide regular updates on the BCT programme, as well offering a forum for staff questions / comments.

Engagement activity

- November: 241 staff comprising 59% BCH (142 staff) and 41% WHH (99 staff)
- December: 194 staff comprising 53% WHH (102 staff) and 47% BCH (92 staff)

North Cheshire and Mersey Healthcare Partnership

Public feedback

Community engagement at Halton's autumn Carers' Forum (hosted by Halton Carers Centre) on 20 November allowed us to share integration information and gather local feedback from unpaid carers.

Feedback was generally positive, with many hoping the integration will:

- improve communications between services
- enhance patient experience
- increase the use of community venues and
- improve service equity across Warrington and Halton (e.g. within neurodivergent support services for children and young people)

Patient and Public Participation Group (PPRG)

Chaired by Healthwatch Warrington and Healthwatch Halton, the PPRG will enable sharing and gathering of patient / public feedback during the Bridgewater / WHH integration, while supporting our communication and engagement across both boroughs.

Group membership includes carers services, trust governors, members of the voluntary, community, faith and social enterprise sector, Experts by Experience and other representatives.

The first meeting was held on **1 December 2025**, providing an overview of our plans to bring the two trusts together as one organisation and the intended benefits for patients and communities. There was also a focus on plans for integrating seven initial clinical pathways which are expected to have the greatest impact on patient experience.

Meeting feedback

The PPRG emphasised the need for greater awareness of the Urgent Community Response Team, clearer information on the integration plan (including benefits, end-state services and impact measures) and accessible materials.

Members highlighted the importance of keeping discussions aligned to the group's integration-focused remit rather than broader system issues.

WHH Charity

Website activity

- November: 15,413 (10,948 active)
- December: 1,284 (1,056 active)

The most viewed pages were Supporters' Club, home page and news.

Newsletters

- One newsletter published: December 2025

News

Items published in this period included:

- Luke Littler brings cheer to hometown hospital
- Celebrating 2025 and looking ahead to a milestone year

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Working with People and Communities Strategy November to December 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	• 32 Experts by Experience recruited during 2025-26 (7 during November to December). • 217 Experts by Experience (cumulatively to date). • Continuing to work with WHH and BCH colleagues to identify opportunities to involve EbyEs in partnership with the BCH's Patient Partners Network. • Delivering bi-monthly staff 'engagement, involvement and public consultation in service change' awareness sessions.	• Ongoing
2. Support EbyE recruitment and retention	• 20 EbyE projects delivered in 2025-26 (plus 4 extended projects – health literacy, site map updates, WELL Runcorn and WHH/BCH integration). • 14 EbyEs participating in November and December projects	• Ongoing
3. Enhance our programme for involvement	• Annual timetable for awareness days and events informs engagement plan (slide 18). • Ongoing involvement with estates and strategy teams to ensure substantial strategic, capital or service developments have EbyE involvement / representation.	• Ongoing
4. Undertake consultation and engagement to enable effective support for services	• Inclusion of EbyE engagement in significant projects from outset #StartWithPeople. • Ongoing EbyE participation in future Q1 projects including Better Care Together Patient Public Reference Group and clinical and operational services integration workstreams. • Communications and Engagement support provided to Better Care Together Clinical and Operational Integration workstream and training.	• 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 integration activity is supported with Bridgewater colleagues. • Establishment of the Patient and Public Reference Group (PPRG) to inform integration plans	• 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 now at the review stage.	• 2025-26
2. Ensure website compliance with Web Content Accessibility Guidelines (WCAG) standards	• Trust website accessibility recorded in the Silktide index, has achieved a rating of 'Excellent' with a 96% accessibility score and is currently 23rd place in the NHS sector rankings (December 2025).	• Ongoing
3. Accessible content creation	• New accessible policy and standard operating procedure (SOP) templates have been launched to both WHH and BCH. • The team has supported development of an Accessible Information Policy, incorporating health literacy elements.	• Ongoing
5. Patient information	• The Production of Patient Information Policy includes references to making information accessible and a new accessible Information and communication policy • This policy is being updated to support integration of WHH with BCH to ensure a robust process for creating patient information across community and hospital services.	• Ongoing
7. Signage/wayfinding	• Delivered via Wayfinding and First Impressions Task and Finish Group. Estates are progressing updated maps for Warrington and Halton.	• 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, charity, volunteers, chaplaincy, catering / estates, ward / service reps) to set / link events calendars and activities for 2026. • Planning an updated events plan and schedule 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. Community events undertaken from in this period were: ✓ Halton's autumn Carers' Forum ✓ WHH Shared Learning Forum	• Ongoing
3. Support Place Based activity and other key local events	• Content upload process for Living Well Warrington website is now co-ordinated within the Communications and Engagement Team. Ongoing promotion of Living Well Warrington continues via WHH communication 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 programmes. • Promotion of WHH volunteering opportunities with the EbyE membership, via networking and through social media.	• Ongoing
2. Promote opportunities for work, training or volunteering	• Promote WHH as a great place to work, train or volunteer to enhance the aspirations and life chances of local people. • Job of the Week highlighted every Friday via social media. • Level of engagement with social media and websites.	• Ongoing
3. To utilise local suppliers and venues	• Use local suppliers and venues to support engagement and involvement programmes, where possible.	• Ongoing
4. Support the work of the WHH Charity	• Continue work with the charity team to facilitate charity presence at public engagement and involvement events. WHH Charity activity and fundraising shared bi-monthly at the Patient Experience and Inclusion Sub-Committee. • Charity stakeholder newsletters shared monthly.	• Ongoing

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Upcoming engagement events

Upcoming engagement events: 2026

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Date	Event	Time	Venue	Event purpose
20 May 2026	International Clinical Trials Day	10am to 2pm	Main entrance, Warrington Hospital and George Lloyd Restaurant, Halton Hospital	Trust-led, annual event promoting the accomplishments of clinical research professionals in public health / medicine and their efforts in clinical trials.
13 June 2026	Warrington Pride	TBC	Warrington town centre / Golden Square	Annual partnership event celebrating the LGBTQIA+ community.
27 June 2026	Warrington Armed Forces Day	10am to 6pm	Crosfields Rugby Club, 131 Hood Lane North, Great Sankey, Warrington, WA5 1XU	Annual partnership event comprised of Armed Forces rugby league games, military vehicle displays, stands and activities.
12 July 2026	Disability Awareness Day	10pm to 4pm	Walton Hall and Gardens, Higher Walton, Warrington, WA4 6SN	Annual family fun day and pan-disability event led by Warrington Disability Partnership.
30 August 2026	Warrington Mela	11am to 4pm	Queen's Gardens, Palmyra Square, Warrington, WA1 1JN	Annual open event supporting cultural diversity and community inclusion within the town.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/26/02/158**	
SUBJECT:	**WHH Charity: Charity Commission fundraising checklist**	
DATE OF MEETING:	4 February 2026	
AUTHOR(S):	Helen Higginson, WHH Charity head of fundraising	
EXECUTIVE DIRECTOR SPONSOR:	Kate Henry, Director of Communications and 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): (*Please DELETE as appropriate)*	**224** If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival 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. **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 **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. **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	

	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 **1757** If industrial action takes place, then there is a risk of significant workforce gaps across critical services, which may disrupt operational service delivery and compromise the Trust's ability to maintain safe, effective, and timely patient care. **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
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 Charity Commission for England and Wales set out guidance on Charity fundraising: a guide to trustee duties (updated October 2022). It features six principles that trustees should follow to help meet their responsibility for their charity's fundraising. These principles are: 1. Planning effectively 2. Supervising your fundraisers 3. Protecting your charity's reputation, money and other assets 4. Identifying and ensuring compliance with the laws or regulations that apply specifically to your charity's fundraising.

	5. Identifying and following any recognised standards that apply to your charity's fundraising. 6. Being open and accountable. The guidance also includes a checklist designed to help charity trustees evaluate the charity's performance, at suitable intervals, against the legal requirements and good practice recommendations set out in the fundraising guidance. Each of the questions on the checklist links to a paragraph of the fundraising guidance. Not all of the issues listed in the checklist are appropriate for all charities. This fundraising checklist has been updated to reflect progress since the previous report. The Chairty Impact Report 2024/25 is included as Appendix 1.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Board is asked to note the updated WHH Charity progress against the checklist for trustees.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.	
	Agenda Ref.	CFC/25/12/34	
	Date of meeting	11.12.25	
	Summary of Outcome	The CFC noted the contents of the report.	
FREEDOM OF INFORMATION STATUS (FOIA):	Choose an item.		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

Charity Commission fundraising checklist for trustees

Updated December 2025

Principles and guidance	Current status	Mitigations/actions/notes
Planning effectively		
We have set out our fundraising plan		• 2022-25 Strategy approved March 2022 and KPIs are monitored at CFC. • We continue to review our strategy periodically in line with changing trends in charitable giving.
It reflects our charity's values		• WHH Charity's values are: Ethical, Transparent, Accountable, Compassionate, Creative. The charity also adopts the values of the Corporate Trustee of Working Together, Excellent, Inclusive, Kind and Embracing Change.
The resources we use and the costs we incur in our fundraising		• Our overheads are subject to scrutiny at the Charitable Funds Committee (CFC) as part of the finance report. • Work has been undertaken over recent years to reduce overheads as much as possible and we benchmark similarly to similar charities in terms of our overheads to income ratio. • Income and expenditure (actual and forecast) are scrutinised and challenged at CFC. • A reserves policy and an overheads policy are in place.
The key financial and reputational risks we may face		This has been identified in the Risk Management Statement which is approved and reviewed annually by the CFC. All WHH Charity risks are now managed through the Trust's DATIX system and reported to CFC.
We monitor progress		A fundraising activity and financial report are reviewed by the CFC at each meeting.
We manage key risks		The key risks are reviewed at each CFC meeting.
Supervising our fundraisers		
We have considered and decided which fundraising issues we will not delegate		Our fundraising team members are directly accountable to a member of the executive team.
Our fundraising staff have job descriptions		Current and in place.
Our fundraising staff are doing the job successfully		PDRs are up to date – next due October 2026. Fortnightly 1-1s with the deputy director of communications and engagement/head of

		fundraising take place, with informal catch ups in between meetings. Monthly charity leadership meetings are also held with the director of communications and engagement.
Our volunteers know who they report to and who to approach with problems or concerns		WHH volunteers assumed responsibility for all volunteers in September 2016. Those on placement with WHH Charity report to and are supervised by the charity's head of fundraising.
Our volunteers understand the boundaries within which they must work when representing the charity		They receive trust induction from WHH volunteers and local induction from the head of fundraising.
Our subsidiary trading company is monitored for effectiveness and only enters into commercial partners in the charity's best interest		
Our arrangements with commercial providers fully comply with relevant legal requirements		We undertake all procurement through the corporate trustee and ensure through contract that all legal requirements are met and maintained.
Our arrangements with commercial providers are in our charity's best interest because appropriate due diligence is undertaken		We procure using the corporate trustee's procurement team.
Our fundraising values and expectations are communicated		These are agreed upon contract.
The costs are justifiable and can be explained		All expenditure is reviewed by the budget holder and reported through the Finance Report.
Proper control is kept of the money raised		All monies are routed into the WHH Charity bank account, no other methodology is permitted. Staff training and awareness on the correct processing of charitable donations is continuous and written into the WHH Staff Handbook.
Fundraising communications used are reviewed		All communications are approved by the head of fundraising and/or the WHH deputy director of comms and engagement, and also the director of comms and engagement where appropriate.
Compliance with the agreement is monitored		Compliance is monitored following contract.
Any conflicts of interest are recognised and dealt with		The corporate trustee has a Managing Conflicts of Interest Policy which has been adopted by WHH Charity.
Protecting our charity's reputation, money and other assets		
The reputational risks our charity may face are identified, assessed, and managed		Reputational risks are addressed in our risk management statement, and any risks are recorded on our risk register.
Likely donor, supporter and public perception is considered when		Our bid application process includes this to ensure compliance of all parties via capital campaigns.

income expectations and other goals are considered		
The legal rules and recognised standards which apply to our fundraising are followed		We follow the Code of Fundraising Practice, the Chartered Institute of Fundraising and the Association of NHS Charities Together guidance. We are registered with and regulated by the Charity Commission.
Our values are communicated to the people who work on our fundraising.		All WHH staff adopt and practice the values of the corporate trustee. They and the public are further briefed on the aims and objectives of WHH Charity and are guided on how to proceed with fundraising initiatives on a personal/team/company level.
The costs of our fundraising are managed and explained.		We control our costs through a bid application process. We review our costs at CFC meetings.
Our fundraising finance is planned and monitored		We have an annual plan in place, the KPIs of which are reviewed at CFC.
Effective financial controls are in place and followed		Charitable spend is incorporated within the corporate trustee's Scheme of Reservation and Delegation. The corporate trustee's Finance Team monitor and report on expenditure
Risks of financial crime and fraud are reduced		We make use of the corporate trustee's training and arrangements in place in relation to counter fraud awareness. WHH Charity provides a letter of authorisation to every fundraiser who is requested to sign acceptance of the 'contract' between us.
Our charity is alerted to any suspicious donations		Our Finance Team review all bank statements and incoming direct funds. Provenance of all cheque and cash donations is tracked through the donor journey and recorded via Harlequin, with a receipt and thank you letter posted out to the donor.
Our charity can stop or authorise any unauthorised fundraising activity using its name		We use a letter of authorisation to authorise fundraisers to raise funds on our behalf. We would alert the relevant authorities to any suspicious activity undertaken in our name.
Serious incidents are reported to the Commission, police, and other agencies		NHS Counter Fraud Authority may also be contacted where NHS Employees or their families are involved.
Our data, name, image, logo, and IP are protected		• We do not issue our logo independently for 3rd party use. • We use letters of authorisation for 3rd party fundraisers. • We provide our own branded materials for support. • Our intellectual property is protected to the best of our ability and knowledge.
Following the law and recognised standards		

We have effective systems in place so that the Code of Fundraising Practice and other resources are used to find out about the legal rules and recognised standards which apply to our fundraising		We follow the Code of Fundraising Practice, Institute of Fundraising, and the Association of NHS Charities guidance. We are registered with the Fundraising Regulator.
These rules and standards are followed		We follow the Code of Fundraising Practice, Institute of Fundraising, and the NHS Charities Together guidance
Be open and accountable		
Any legal rules and requirements that apply to how our charity reports and accounts for its fundraising are complied with.		We are audited periodically and produce an annual report and accounts.
Our open and accessible complaints procedures are followed if concerns are raised		In the first instance complaints should be raised to the head of fundraising or director. The charity uses the resources of the corporate trustee i.e. PALS and complaints procedure.
Our fundraising aims and achievements are clearly communicated to the public and donors/supporters		Our website is maintained and updated regularly, as are our social media platforms. Increased communications activity has resulted in continued social media growth.

Warrington and Halton Teaching Hospitals Charity
An NHS Charity

Impact Report 2024-2025

How your support has helped our patients, families and staff at Warrington and Halton Teaching Hospitals

Raising more than money

Contents

Welcome

What a year it has been at Warrington and Halton Teaching Hospitals Charity!

As Chair it's a pleasure to be able to share our latest Impact Report, which gives us the opportunity to reflect on our continued progress over the past year and shine a spotlight on the fantastic efforts of our supporters, fundraisers and volunteers.

With your help we have been able to fund projects that go beyond what the NHS is able to provide, and every act of generosity has made a vital contribution – enhancing patient care, transforming spaces, funding cutting-edge equipment and supporting staff wellbeing.

This year they have ranged from our Raising Smiles and Intensive Care Unit balcony campaigns to our seasonal appeals and fundraising events, these projects vary in size and scope but they are all fantastic examples of how we can go further to support our hospitals. And as you will see over the following pages, your donations and fundraising achievements have not only made a real difference to our patients, they have also inspired others to get involved.

It's well documented that the wider economic climate continues to be challenging for households and also for charities across the UK, so we're immensely grateful to the many residents and businesses in Warrington and Halton who have remained loyal supporters, as well as those who have come on board for the first time.

We're proud to play an integral role in our communities, and were therefore delighted to receive recognition for this as the Warrington Guardian's Charity of the Year for 2024-25. As we approach our 30th anniversary in 2026 we want to see Warrington and Halton Teaching Hospitals Charity (WHH Charity) go from strength to strength – and we have big plans to make that happen.

Here's to an exciting year ahead.

Steve McGuirk

Chair, Warrington and Halton Teaching Hospitals Charity

How you helped

Facts and figures

So many of you have lent your support to WHH Charity over the past 12 months – and 'thank you' hardly feels like enough. Your time, energy and incredible commitment mean the world to us.

Here are just a few of the many wonderful ways you've made a difference.

2024-25

27

new projects made possible thanks to donations

£19,000

raised **in memory** of loved ones

850

Easter eggs were donated to support patients in hospital over Easter period

300

registered WHH Charity **members and supporters**

£36,000

in **charitable trust** and **foundation grant** fundings

£82,000

received in **legacy** donations

About us

A warm welcome to WHH Charity

As the official NHS charity for Warrington and Halton Teaching Hospitals NHS Foundation Trust we don't take our role and responsibilities lightly.

Our charity team are dedicated to supporting projects that benefit our patients, families, volunteers and staff when and where they need it most. That extends to every ward of our hospitals and every service we provide in community settings and online.

Each funding decision we make is overseen by our Charitable Funds Committee, which ensures that every pound we receive is spent responsibly.

WHH Charity has a long heritage in Warrington, Halton and the surrounding areas. Since 1996 we've been there to support people from birth through to end of life – and every day in between.

That includes:

- purchasing state of the art equipment, technology and training
- funding WHH-related research and innovation
- enhancing and transforming hospital environments
- providing additional comforts and experiences for our patients, carers and visitors while they are with us
- supporting the health and wellbeing of our staff

We can only continue doing so thanks to your generosity.

The money you fundraise, the challenges you undertake, the time you donate and the legacies you leave are truly valued and appreciated.

If you would like to lend your support in 2025 and beyond we would love to hear from you, so please do get in touch using the contact details in this report.
You can also learn more about the charity by visiting our new website.

The charity makes a significant contribution to our hospitals and communities in so many ways, but much more can be achieved when we come together.

#RaisingMoreThanMoney

Our impact

Making a difference together: Laurence's story

When Laurence Barrow, managing director of Warrington-based Barrow Electrical, was admitted to the Intensive Care Unit with Covid-19 and pneumonia, it was a frightening and isolating time.

But thanks to WHH Charity donations, Laurence received a recordable teddy bear with messages from his wife and daughters – a small but powerful source of comfort during his recovery.

"That thoughtful gift meant the world to me as I felt completely alone without my family by my bedside. After being discharged I wanted to do something more to help. Our business is rooted in the community, so giving back has always been a part of who we are."

That moment inspired Laurence to give back. Since then the company has been a strong supporter of WHH Charity. Whether it's purchasing recordable story books and colouring books for the Children's Ward, headphones for ICU patients, organising a charity football match or joining Protive Security & Surveillance Ltd at their annual charity golf day, Laurence has been there every step of the way.

Laurence said: "Supporting WHH hasn't just been a charitable act for us, it has transformed us personally and professionally.

"It's brought our team closer, inspired our clients and shows that business can be a real force for good.

"This partnership shows what happens when businesses and charities unite for a common cause. It's not just about giving it's about growing together, making a lasting impact and showing the community what true partnership can achieve."

Thank you, Laurence, for making a real difference.

Making Waves on the wards

Our patients are at the heart of everything we do.

And for the 30,000 children we treat each year, being sick and in hospital can be a particularly unsettling and emotionally challenging experience.

A comforting and engaging environment, with the right equipment and technology to help distract our young patients when they're taken away from their usual routine, is vitally important for supporting their wellbeing and making them feel at ease during their time with us.

Our Making Waves appeal was re-launched in 2023 with the aim of improving facilities within the Children's Ward at Warrington Hospital which the NHS is unable is fund.

And thanks to your generous donations and support from charity partners we have now raised more than £55,000 for this purpose.

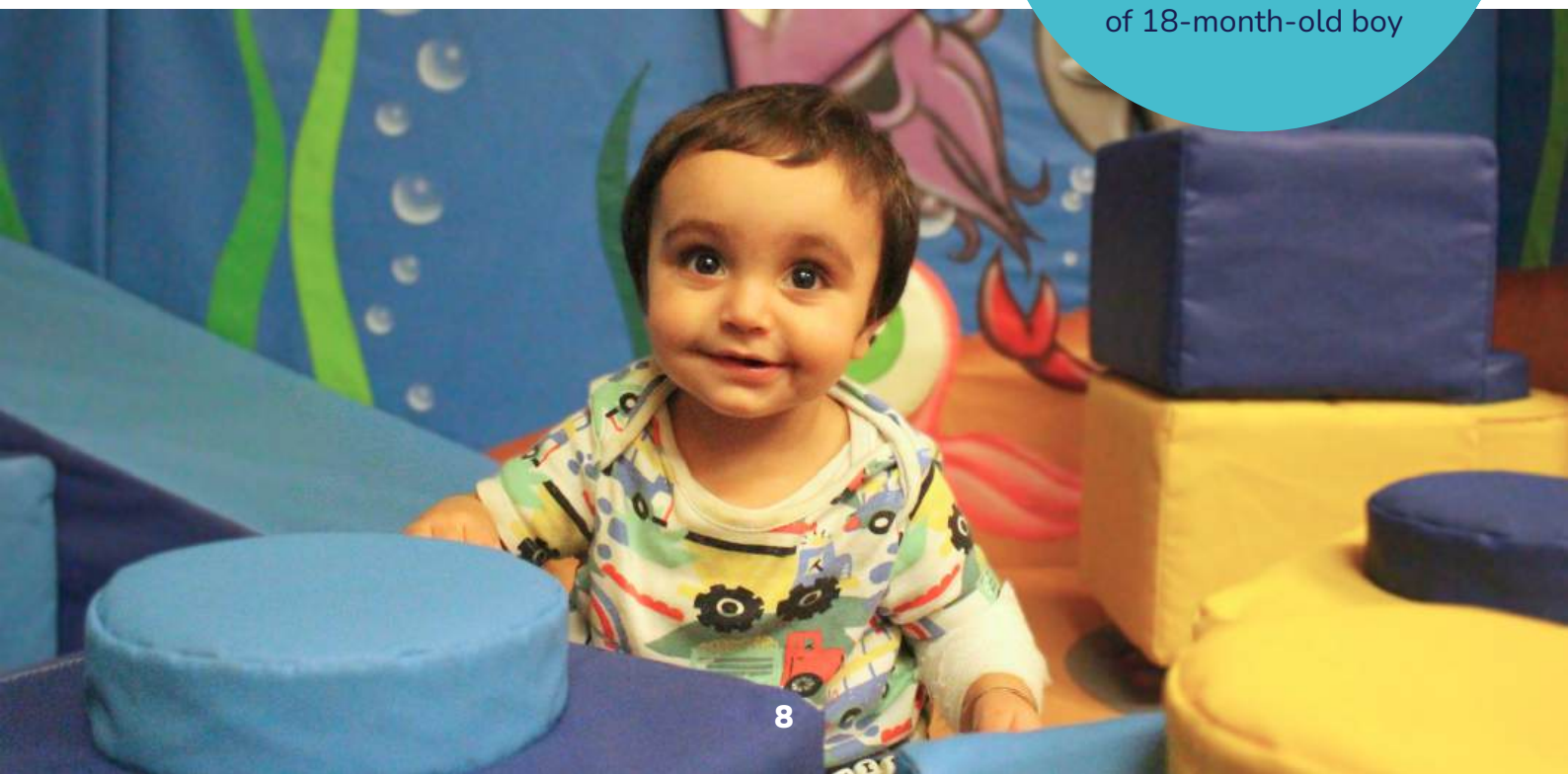
With that money we've been able to:

- transform the ward's soft play area into a bright and inviting space
- create a state-of-the-art sensory room designed for children with complex needs
- purchase interactive activity tables to encourage creativity and social interaction
- introduce gaming carts for bedsides, treatment rooms and waiting areas

We're also now able to support parents and carers of young patients, including building new accessible and inclusive shower facilities, and working with Sophie's Legacy to provide hot meals in our family room.

Thank you to everyone who supported our campaign.

"I can't believe what a difference this room has made to my child. He loved all the ceiling projectors and fibreoptic lights, and after playing he seemed much brighter in himself." – mum of 18-month-old boy



"It has been really nice to go and get a fresh hot meal and not have to worry about leaving my child or being too far away from them." – dad of two-year-old

"I became overwhelmed whilst in hospital with all the different people and doctors coming and going. The play staff offered me the opportunity to go into the sensory room for some privacy and relaxation. I really appreciated the quiet and loved the peacefulness and fidget toys available." – 14-year-old girl with mental health concerns

"The soft play area is good for non-mobile children; I felt my daughter was safe and wouldn't be able to harm herself whilst playing. She loved to crawl up the small slide. I also witnessed it being cleaned often, which reassured me it was safe for my child whilst in hospital." – mum of 15-month-old daughter

Memorial garden opens at Warrington Hospital

A peaceful memorial garden has opened at Warrington Hospital's Radiology Department, honouring much-loved colleagues Janet Guy and Trevor Wain. Janet, who worked in the NHS for 40 years, dreamed of transforming the courtyard outside her office. After her passing in 2021 and Trevor's in 2022, staff rallied to raise £1,000 before launching the Radiology Memorial Garden Appeal.

With community support, including a charity abseil and donations from local partners, £5,000 was raised. The space now features paved paths, benches and personalised plants like 'Janet' tulips and 'Trevor' thistles. Artwork from Warrington and Vale Royal College students adds a personal touch.

The garden provides a tranquil space for reflection and wellbeing, celebrating the lives and legacies of beloved team members.

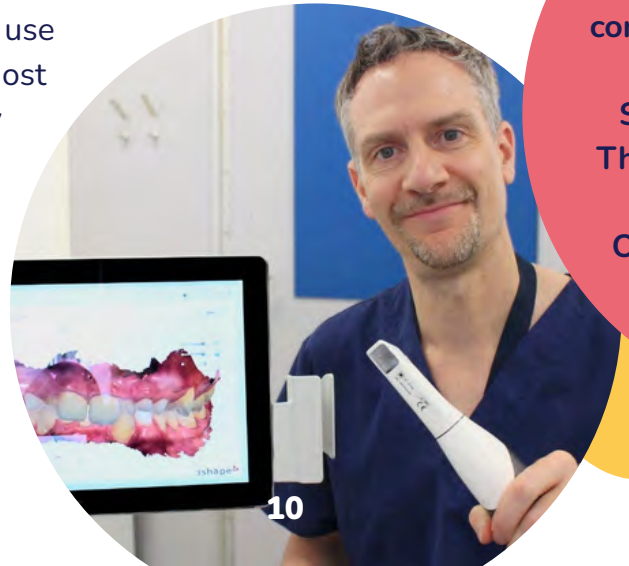
"The garden is a beautiful tribute to those we've lost and a lasting reminder of how much they meant to us. It has brought people together in such a positive way and is already making a difference to staff wellbeing. We're so grateful to everyone who helped make it a reality." – Irene Crowder, Radiology Department

Raising Smiles Appeal brings new dental tech

Thanks to amazing community support and Warrington Hospital's League of Friends, the Orthodontics Department now has two new digital intraoral scanners. These handheld devices replace uncomfortable moulds, making fast, accurate impressions that are kinder for children and anxious patients.

Ian Edwards, Consultant Orthodontist, said: "The scanners have revolutionised how we work in an instant. If we had to start going back to impressions tomorrow it would be like taking away the use of mobile phones overnight. Most importantly it is a great facility for patients."

With scanners at both Halton and Warrington, even more patients can enjoy this advanced care.



"I had an intra oral scan which was a great experience compared to having moulds of my teeth with the putty. Simple, quick and no mess. This is a great addition to the service provided by the Orthodontics Department." – Melissa, patient

Creating a ‘special space’ for intensive care patients

A new garden balcony is set to open at Warrington Hospital’s Intensive Care Unit (ICU), thanks to a generous £140,000 donation from the League of Friends. The balcony will provide critically ill patients – including those unable to leave the unit – with a secure outdoor space to enjoy fresh air and time with loved ones.

“The garden balcony on ICU will be life-changing for those being cared for on the unit. This special area will mean that we can offer patients and their families the opportunity to take time away from the busy unit and the constant noise. It has been a long-held dream for staff on the unit to create this special space for our patients and we can’t thank our hospital charity and League of Friends enough for their incredibly generous donation that will bring our dream to life.”
– Ellis Clarke, ICU Matron

The League of Friends’ donation, funded by years of public generosity, also supports refurbishment of the family room. The balcony is expected to open later in 2025.

New hub to help staff wellbeing

A new chalet-style hub has opened at Warrington Hospital, offering a calm and welcoming space for staff and volunteers to relax, reflect and recharge.

Funded by NHS Charities Together, the Cherry Tree Hub is located in one of the hospital’s courtyards and hosts wellbeing sessions including yoga, mindfulness, bereavement support, and on-site counselling.

Open daily, the hub is already proving to be a valuable space for connection, reflection and care.

“The Cherry Tree Hub has become an important part of how we support staff wellbeing. It offers a calm, green space for people to access support, join wellbeing sessions and take a break from clinical demands. We’re truly grateful for the impact it’s having.” – Adam Harrison-Moran at WHH

Gifts in kind from our communities

Every donation – big or small – makes a significant difference. We are grateful for the unwavering support from our local community, helping us bring comfort to our patients.

Teddy bears bringing comfort

Oliver Abel's Wish donated more than 400 recordable teddy bears to our Intensive Care Unit. These teddies hold the voice or heartbeat of a loved one, offering families a cherished memory during difficult moments.

Corporate sponsors raising spirits for young patients

Thanks to our corporate sponsors we created a specially designed activity book filled with engaging puzzles and activities to help put young patients at ease during hospital stays.

Heart-warming donation from Project Linus UK

Project Linus UK provided beautifully crafted duvet blankets for our youngest patients. These thoughtful donations make a significant impact on the comfort of children during their hospital stay.

Recordable audiobooks for emotional connection

Local businesses provided recordable audiobooks, helping children feel connected to their families. These audiobooks offer moments of reassurance and comfort during their stay here.

Supported by: Protive Security & Surveillance Ltd, Setfords Solicitors, Talking Wills & Trusts, Just Mortgages, DK Building, GForce Communications Ltd, The Transformer.

Clothing donation enhances patient comfort

Thanks to Shane Wrench and Touchline UK, we received essential clothing items for patients who arrive without personal belongings. This thoughtful donation ensures that patients have the basic necessities to feel comfortable during their stay.

We're also incredibly grateful to the Pyjama Fairies, who brighten up the Children's Ward at Warrington Hospital each year with their colourful pyjama donations – bringing a little extra warmth to our youngest patients.

Seasonal kindness

Our community's support during the holiday season has been outstanding.
With 850 Easter eggs and 1,150 Christmas gifts donated, local families, companies and groups made a huge difference for children and adult patients staying and visiting Warrington and Halton Teaching Hospitals.

Each donation, no matter the size, helps make a lasting impact on the lives of those we care for.

A big thank you to our supporters

Walking in memory of Erin

After the heartbreaking loss of his daughter Erin in 2022 at just 21 years old, John McSherry was inspired to give back to the Intensive Care Unit at Warrington Hospital, where she received care following multiple cardiac arrests.

To honour Erin's memory and support the team who looked after her, John organised a charity walk up Mam Tor, raising vital funds and awareness in her name.

Amount raised: £2,532
Beneficiary: Intensive Care Unit (ICU)

Snowdon sunrise walk supports hospital dental care

James Cooper and colleagues from the Orthodontics Department took on a sunrise walk up Snowdon in support of the Raising Smiles Appeal.

Despite suffering a leg and ankle fracture, James completed the challenge with the help of his team.

Amount raised: £2,930
Beneficiary: Orthodontics' Raising Smiles Appeal

A challenge to help make a difference

Mike Gittins completed the National Three Peaks Challenge, climbing Ben Nevis, Scafell Pike and Snowdon in 24 hours to support WHH Charity.

Mike covered 23 miles and more than 10,000 feet of ascent in a single day.

Amount raised: £385
Beneficiary: Making a Difference Appeal

Golf day raises £9,000 for appeal

Protive Security & Surveillance Ltd hosted its annual golf day, raising funds for WHH's Making Waves Appeal.

The event brought together golfers, sponsors and supporters for a fantastic day of fundraising.

Amount raised: £9,000
Beneficiary: Children's Ward Making Waves Appeal

Abseil challenge backs Halton's cancer and cardiac services

Staff, patients and families abseiled down Warrington Hospital's Postgraduate Centre to raise funds for cancer and cardiac care at Halton, supporting the Macmillan Delamere Centre and Cardiac Rehab services.

Amount raised: £5,105
Beneficiary: Making a Difference Appeal

Community fundraiser boosts ICU

Culcheth Village Club held a 16-hour fundraising day led by Warren Bibby, following his life-saving treatment at Warrington's Intensive Care Unit (ICU)

The event included food, live entertainment and a marathon run in Australia by Warren's son, Adam.

Amount raised: £13,000
Beneficiary: ICU and Macmillan Cancer Support

A slice of the action

We partnered with Pizza Hut Great Sankey for a 'Raising Dough' promotion, offering £2 pizzas in support of the charity.

The one-day event saw 950 pizzas sold in just six hours.

Amount raised: £1,900
Beneficiary: Making a Difference Appeal

Community volunteers dig deep to bring hospital gardens to life

Volunteers from local businesses have helped transform green spaces at Warrington and Halton Teaching Hospitals. From the Delamere Centre to the Forget Me Not Unit, their time and energy have refreshed these much-loved outdoor areas.

By planting flowers, clearing overgrowth and brightening gardens, volunteers have created calm, welcoming spaces that offer comfort to patients, families and staff all year round.

Among the businesses lending a hand was Office Bridge Group, whose team helped revitalise the Macmillan Delamere Support and Information Centre at Halton.

Mike Astbury Jnr, Director at Office Bridge Group, said: "We had a very rewarding couple of days volunteering in the garden. I hope many people utilise the outdoor space now and make use of the fantastic facilities over at the Delamere Centre which is funded by WHH Charity. Any support and donations can make a huge difference."

"Corporate volunteering has a powerful impact – not just on our hospitals, but on the people who use them. These teams give their time generously and help us create bright, comforting environments. We're so grateful for their continued support." – Helen Higginson, Head of Fundraising

The contribution of all our local business volunteers make a real difference for patients, their families and staff at Warrington and Halton Teaching Hospitals.

Our latest appeals

Raising more than money

At WHH Charity we're proud to fund projects that the NHS is unable to support – projects that make a lasting difference to the people we care for every day. From creating peaceful spaces to funding special projects, our appeals are shaped by the real needs of our patients, families and staff.

Willow Tree Hub Appeal

Transforming care for bereaved families

We're raising £200,000 to build the Willow Tree Hub – a calm, private space for families experiencing the heartbreak of baby loss. Each family's pregnancy journey is unique, but for those experiencing baby loss or recovering from a traumatic birth it can be overwhelming, particularly in a busy hospital setting.

Families may be told devastating news in rooms where they can hear women in labour and babies' newborn cries. Returning for follow-up care can also be distressing and a reminder of their past experience.

Located just outside Warrington Hospital's Maternity Department, the hub will also be home to a specialist Rainbow Clinic, offering extra care for families navigating a pregnancy after loss. The Rainbow Clinic will provide specialist monitoring and emotional support, helping families feel reassured and cared for every step of the way.

This project relies on the generosity of our community. Every donation, big or small, will go directly towards creating this space for those families needing support.

By donating, fundraising or spreading the word, you can help us make a real difference.

Visit our JustGiving page to make a donation

Ophthalmology Sensory Garden Appeal

Creating a meaningful space

The Ophthalmology Department cares for people of all ages, including patients who may find the clinical setting of a hospital overwhelming. The garden will provide a quiet and therapeutic space filled with sensory sounds, scents and textures – proven to reduce anxiety and enhance wellbeing.

Visit our JustGiving page to make a donation

This meaningful project was launched by the Orthoptic Team in memory of their colleague Tracey Parry, who sadly died in July 2023. Tracey worked for Warrington and Halton Teaching Hospitals for more than 25 years and was well known for her compassion, her sense of humour, and particularly her dedication to helping patients in need of additional support.

The sensory garden will be a lasting tribute to Tracey and will offer a peaceful environment for patients waiting for appointments, families accompanying loved ones and staff needing a moment to reflect and recharge.

Making a Difference Appeal

Help where it's needed most

This ongoing appeal ensures we can respond flexibly to emerging priorities, helping us deliver excellent care at the heart of the community.

When you donate to WHH Charity your support goes where it is really needed, funding projects that benefit both patients and staff. Whether it's providing meals for parents on the Neonatal Unit, upgrading facilities, supporting cancer patients at the Delamere Centre, or enhancing staff wellbeing, every pound makes a real difference.

Donate to help us continue making a positive impact

The incredible work we fund is only possible thanks to the generosity of our donors, the efforts of fundraisers, and the support of our local communities and corporate partners.

We can't do this without you. Every donation, event, fundraiser or gift in kind helps bring these spaces to life.

To get involved, contact our fundraising team on 01925 662666, email whh.charity@nhs.net or visit our website.


How to get involved
Warrington and Halton Teaching Hospitals Charity

There are many ways you can get involved and support WHH Charity. Whether it's taking part in a fundraiser, attending one of our events, volunteering your time or supplying much-needed items, all contributions are gratefully received and appreciated.

Leave a legacy that lasts

A gift in your will can help future generations of patients and staff at our hospitals. Legacy donations allow us to plan ahead and fund long-term projects that make a lasting impact.

No matter the size, every gift helps us continue to support care that goes above and beyond. After taking care of loved ones, including WHH Charity in your will is a powerful way to make a difference.

Speak to our fundraising team to find out how you can leave a legacy of kindness.

Donate the pennies from your payslip

The Microhive initiative lets corporate businesses support our hospital charity through simple, low-cost payroll giving.

If your company has 500 or more employees you can support WHH Charity by asking them to donate the pennies from their payslip.

Microhive allows your employees to contribute the spare change from their monthly salary, making it easier than ever to support your local NHS charity.

By donating just 1p to 99p monthly, staff can make a big difference for our patients and NHS colleagues.

Sign up with Microhive and support WHH Charity today.

Raise money your way

Take on a challenge, host your own event, or join one of ours – there's something for everyone.

From skydives to fun runs, coffee mornings to quiz nights, fundraising with WHH Charity is a great way to support your local NHS.

Our team is here to help you turn your ideas into impact, every step of the way.

Get involved and raise funds for Warrington and Halton Teaching Hospitals.

Join the WHH Supporters' Club

Be part of a network that's passionate about local healthcare.

The WHH Supporters' Club is a unique opportunity to bring together individuals, businesses and community groups who want to make a real impact.

By pledging £500 or more, you can help shape future campaigns, access exclusive events and connect with like-minded supporters, with a unique opportunity to enjoy a long-term partnership.

Your commitment supports vital projects that improve care for patients and staff across our hospitals.

Contact the fundraising team to join today.

"Supporting WHH Charity means a great deal to us at G-Force. As a business that prides itself on working closely with our local community, it's important for us to give back to a cause right here on our doorstep. Especially one we've supported for some time and seen first-hand the incredible work they do." – G-Force Communications Ltd

Financial summary

Over the past 12 months we have worked alongside our community, stakeholders and colleagues on projects to enhance the support we provide for patients and staff at Warrington and Halton Teaching Hospitals.

During 2024-25, the charity continued to support a wide range of charitable and health-related activities, including purchasing supplementary and complementary equipment or services which may not ordinarily have been provided from NHS sources.

We remain dedicated to working with our teams, partners, volunteers and supporters to ensure we use donations in the best possible way, for the benefit of our communities.

Despite an ongoing difficult fundraising climate, our dedicated supporters and fundraisers helped to raise £243k as detailed in the table below:

Total income in 2024-25

	2024-25 £000s
Legacies	£82
Donations and fundraising activities*	£331
Income from investments	£39
Total income:	**£452**

The Corporate Trustee is committed to ensuring that all funds are directed to the purposes identified in the Terms of Reference as soon as possible. Total expenditure in 2024-25 was £280k as per the table below:

Total expenditure in 2024-25

	2024-25 £000s
Expenditure on charitable funded projects	£134
Expenditure on charitable activities, including support and fundraising costs, and overheads	£146
Total expenditure:	**£280**

Funds carried forward as at the start of 2025-2026: £609k.

Our final annual report, once audited, will be published on our WHH Charity website and via the Charity Commission.

Contact us

01925 662666

whh.charity@nhs.net

whhcharity.org.uk

Make a donation, make a difference

Stay connected: Follow us on social media

whhcharity

whhhospcharity

Warrington and Halton Hospitals Charity

Sign up to our newsletter

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/26/02/159i**			
SUBJECT:	**North Cheshire and Mersey brand identity**			
DATE OF MEETING:	4 February 2026			
AUTHOR(S):	Hayley Smith, Deputy Director of Communications and Engagement			
EXECUTIVE DIRECTOR SPONSOR:	Kate Henry, Director of Communications and Engagement			
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate*)	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No** ✓	**N/A** ✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No** ✓	***N/A*** ✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes** ✓	**No** ✓	**N/A** ✓
	Further Information:			
EXECUTIVE SUMMARY ***(KEY ISSUES):***	▪ As part of the integration process a new brand identity is required that reflects who we are as North Cheshire and Mersey NHS Foundation Trust (NCM) and supports our shared vision for high-quality, joined up care. ▪ Our 'home, community, hospital' ethos is closely aligned to the national 10 Year Health Plan for England and will be central to our new brand and how we promote and market NCM to staff, patients, public and stakeholders. ▪ Branding development and engagement work has been undertaken with staff and public to gain feedback on the proposed visual identity, and the results are included within this report.			

	▪ This feedback has been used to evolve and refine the final visual designs for the new North Cheshire and Mersey brand and its associated values.		
PURPOSE: ***(please select as appropriate)***	**Approval** ✓	**To note**	**Decision**
RECOMMENDATION:	**The Board is asked to:** ▪ note the branding development and engagement work undertaken ▪ approve the new organisational brand for North Cheshire and Mersey NHS Foundation Trust from 1 April 2026 upon completion of the integration transaction, following the recommendation by the Executive Management Team ▪ support the implementation plan		
PREVIOUSLY CONSIDERED BY:	**Committee**	Executive Management Team	
	Agenda Ref.	EMT/26/031	
	Date of meeting	27/01/2026	
	Summary of Outcome	Supported	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

NHS
North Cheshire and Mersey Healthcare Partnership
Integrating Bridgewater Community Healthcare and Warrington and Halton Teaching Hospitals

NCM branding update

WHH Board: Wednesday 4 February
BCH Board: Thursday 5 February

Overview

- Integration offers a unique opportunity to build a shared brand that reflects who we are as North Cheshire and Mersey NHS Foundation Trust (NCM)
- We want a brand that is designed to support our shared vision for high-quality, joined up care
- Our ‘home, community, hospital’ ethos is closely aligned to the national 10 Year Health Plan for England, which aims to reshape the health service and provide more care on people’s doorsteps and in their own homes
- This ‘home, community, hospital’ wording will be central to our new ‘brand’ and how we promote and market NCM to staff, patients, public and stakeholders
- Our four shared values will also reflect what it means to receive care from us and they guide how our staff learn, train and work together every day. Their visual identity will help to ensure they are embedded in everything we do
- Engagement work to obtain feedback on our draft brand identity was undertaken from Monday 12 January to Friday 23 January – the results and recommendations are shared on the following slides
- This work has been undertaken in-house by the communications and engagement teams, with no external costs incurred

Brand survey distributed to:

- Leadership Forum members
- WHH Culture Champions
- BCH People Promise Champions
- Staff network members
- Council of Governors
- Experts by Experience
- Trust Boards

Number of responses:

- Staff: 137 (75.44% female / 18.42% male / 6.14% not specified)
- CoG / EbyE: 46
- In total: **183**

Our brand identity

Survey feedback

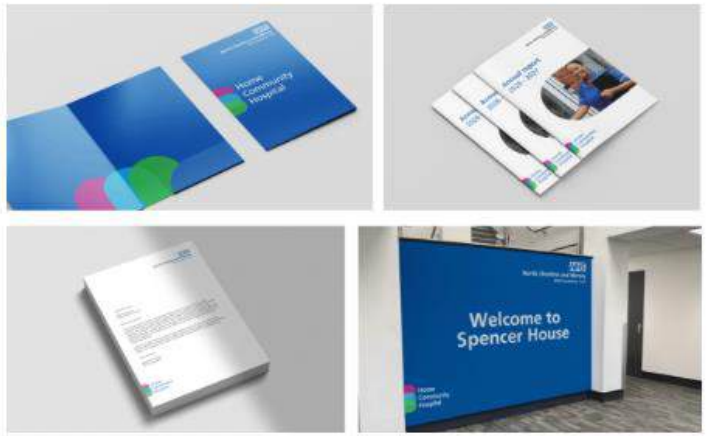
Visual Identity Staff Survey

Our visual identity

As a single organisation we will be committed to tackling health inequalities, supporting older and frail people in the community, and preventing avoidable hospital admissions.

Our 'home, community, hospital' shared vision is closely aligned to the national 10 Year Health Plan for England, which aims to reshape the health service and provide more care on people's doorsteps and in their own homes.

This 'home, community, hospital' wording is central to our new 'brand' and how we promote and market NCM to staff, patients, public and stakeholders.



1. Looking at the overall brand design, what is your first impression?

2. Do the colours, shapes and layout feel recognisably NHS while still allowing us to have our own identity as NCM? (select one option)

- ○ Yes
- ○ Mostly
- ○ Not sure
- ○ No
- ○ If the answer is no or not sure, please explain why:

Headline findings (Staff):

- Strong positive first impressions – clean, professional
- Colour palette and simplicity widely praised
- ‘Home, community, hospital’ tagline resonates with staff as aligning to clinical and strategic direction
- Staff feel the brand fits a combined trust identity
- Only minor refinements suggested for wording and clarity

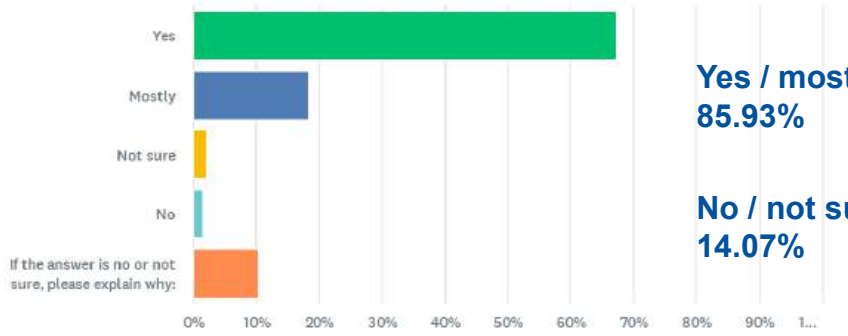
(CoG / EbyE):

- Overall identity clear, recognisable and aligned to NHS values
- Colours and simplicity attractive and easy to understand
- Appreciation given for the straightforward, modern design
- Some clarification in additional wording would strengthen confidence and understanding of the ‘home, community, hospital’ tagline

Visual identity (Staff)

Q2 Do the colours, shapes and layout feel recognisably NHS while still allowing us to have our own identity as NCM? (select one option)

Answered: 135 Skipped: 0

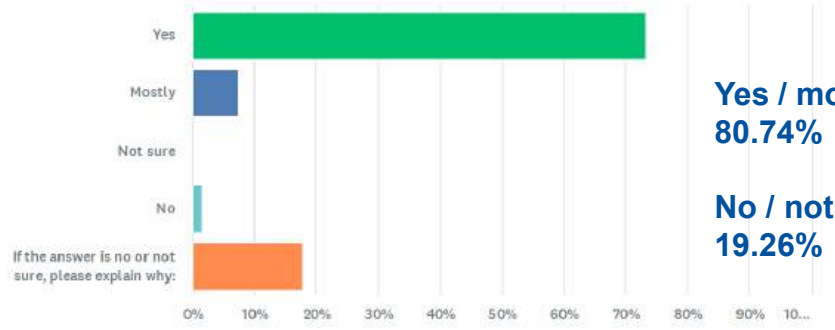


Yes / mostly: 85.93%

No / not sure: 14.07%

Q3 Does the 'home, community, hospital' tagline make sense to you? (select one option)

Answered: 135 Skipped: 0



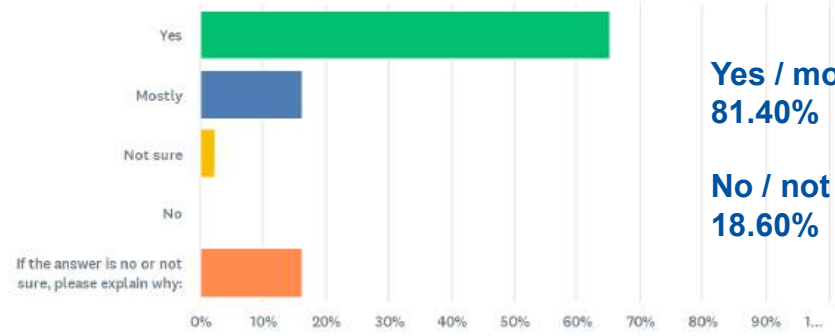
Yes / mostly: 80.74%

No / not sure: 19.26%

Visual identity (Public)

Q2 Do the colours, shapes and layout feel recognisably NHS while still allowing us to have our own identity as NCM? (select one option)

Answered: 43 Skipped: 1

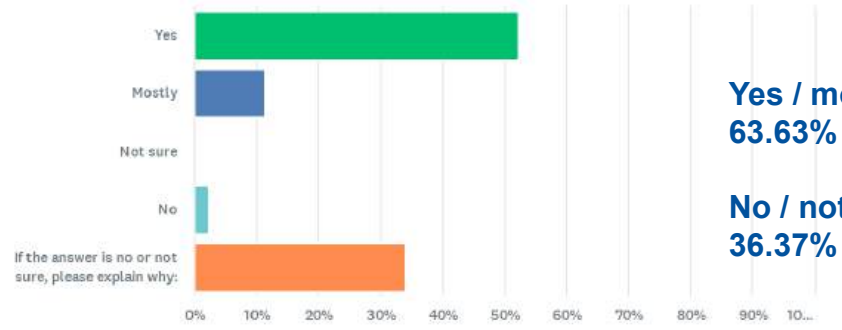


Yes / mostly: 81.40%

No / not sure: 18.60%

Q3 Does the 'home, community, hospital' tagline make sense to you? (select one option)

Answered: 44 Skipped: 0



Yes / mostly: 63.63%

No / not sure: 36.37%

Our values

Survey feedback for draft icons
(values and accompanying wording previously approved)

Headline findings (Staff)

- Icons repeatedly described as simple, friendly, approachable
- Colleagues like the harmony between shapes / styles
- Seen as clear overall, but some further refinement required to strengthen instant recognition
- Small enhancements, e.g. clearer symbolism for ‘fair’, and ‘one team’ would improve interpretation and reinforce the idea of collective working while keeping a clean design

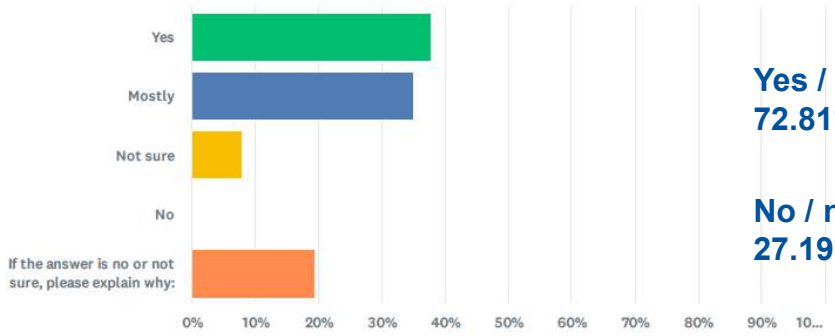
(CoG / EbyE)

- Visually appealing overall, seen as modern, cheerful and memorable
- Positive response to colours and layout
- Simple shapes easy for public to navigate and not too overwhelming
- Colour palette well received – accessibility checks required
- Not all values instantly understood without the accompanying wording – further clarity needed, predominantly for ‘fair’, and also ‘one team’

Our values (Staff)

Q8 Are they clear and easy to understand? (select one option)

Answered: 114 Skipped: 21

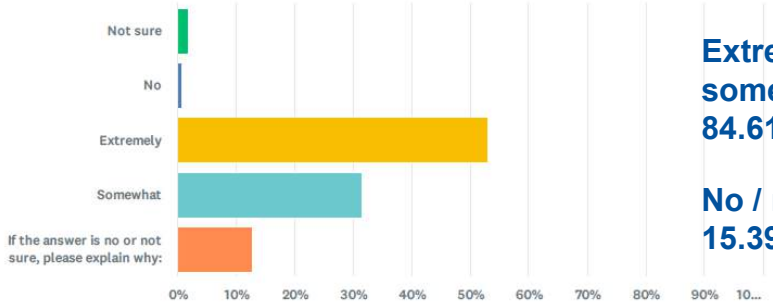


Yes / mostly: 72.81%

No / not sure: 27.19%

Q11 How well do the values kind, open, fair and one team reflect who we want to be as a single organisation? (select one option)

Answered: 117 Skipped: 18



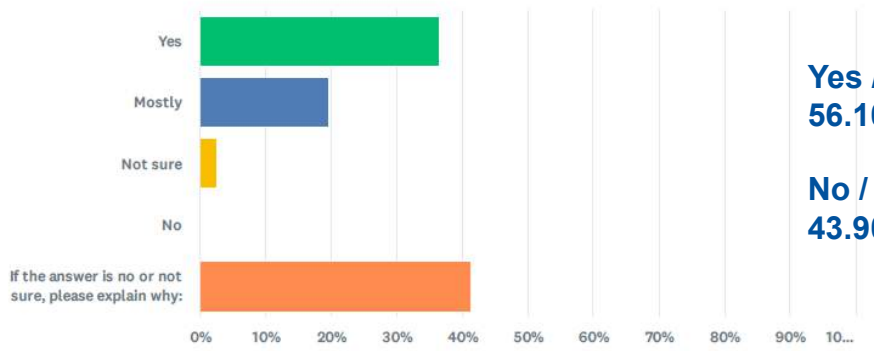
Extremely / somewhat: 84.61%

No / not sure: 15.39%

Our values (Public)

Q8 Are they clear and easy to understand? (select one option)

Answered: 41 Skipped: 3



Yes / mostly: 56.10%

No / not sure: 43.90%

(Q11 was specifically tailored to staff so not included in public survey)

Changes implemented

Changes implemented

EMT supported the overall brand design identity and ‘home, community, hospital’ tagline on 27 January 2026, with the recommendation for it to be approved at Board.

It noted the following changes that had been incorporated:

- Reordered the ‘home, community, hospital’ colour to emphasise stages of care i.e. green for home, blue for community, magenta for hospital
- Added a secondary, supporting strapline (caring for you) to emphasise that caring for patients is our priority
- Updated the ‘One team’ values icon to add a third person / hearts to make it more representative of a team
- Slightly updated the ‘Fair’ values icon to try to make it a clearer symbol
- Built upon the option for both the tagline and values to be used as a text-only version as well as a graphic / icon version
- Updated the implementation plan to incorporate feedback

Updated visual identity

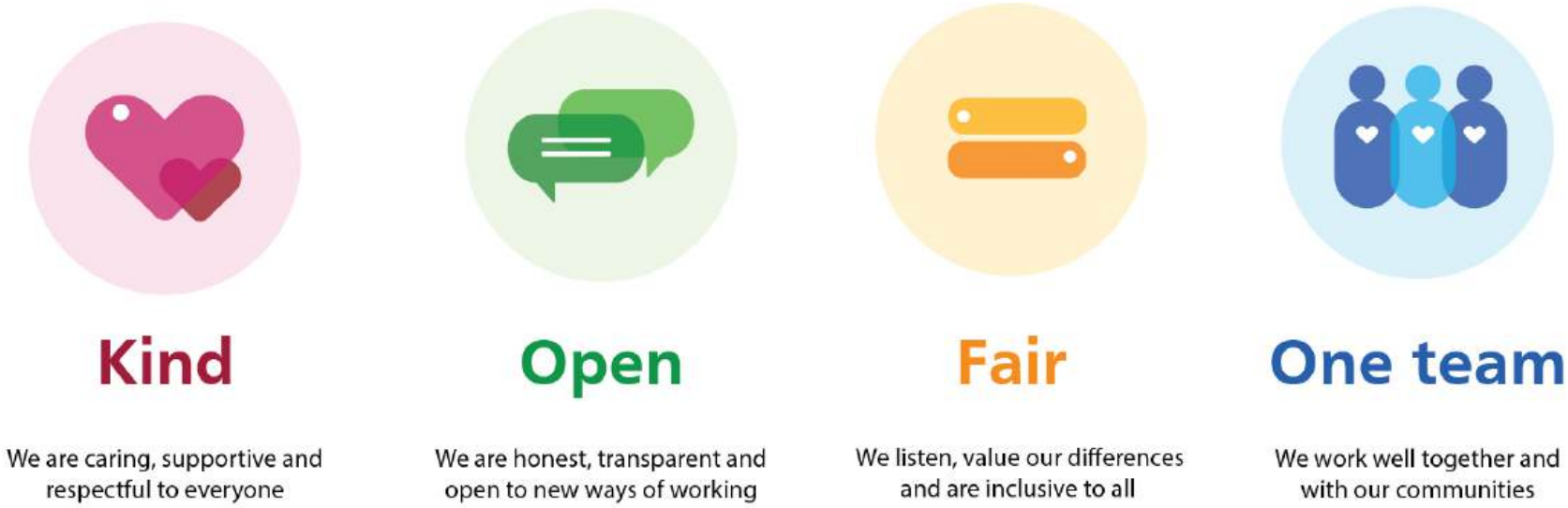
Home
Community
Hospital

Home · Community · Hospital
Caring for you

We have:

- reordered the colour of the three ‘orbs’ to highlight home first
- introduced a ‘Caring for you’ sub-strapline to emphasise care as the priority
- added coloured dots to break up the tagline wording when used horizontally

Updated values imagery (icons)

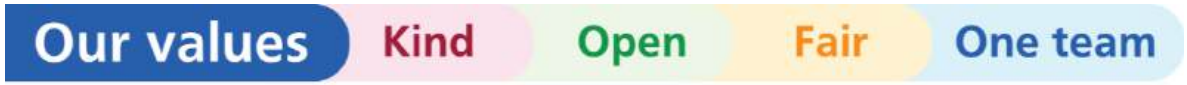


- The initial set of values icons centred around consistent paired, overlapping forms within each icon i.e. two elements per image to represent togetherness. Changing the fair and one team imagery impacts this initial design concept and overall cohesion, but does take on board survey feedback and show a willingness to listen, adapt and improve
- Fair icon – the ‘equals’ sign has now been made more prominent with increased spacing between rules and thicker lines
- One team – an additional figure and hearts have been added to represent team working / two teams joining together as one
- Alternative feedback suggestions for fair e.g. scales of justice were considered but found to be less suitable than the options progressed

Updated values imagery (no icons)

With descriptors:

Without descriptors:



Values may be used with / without icons depending on context or platform (examples to follow in brand guidelines)

Implementation

The following will be actioned as part of the implementation plan:

- Introduce a simple, consistent core narrative to highlight the ‘why’ behind the tagline i.e. providing the right care, in the right place, at the right time
- Develop a comprehensive communications plan for a successful rollout and wider implementation, using multi-channel comms to reinforce key messaging and priorities
- Consistently promote the longer-term benefits for our staff and communities – better outcomes, patient independence, faster recovery, reduced pressure on acute care etc
- Use real examples, everyday scenarios and patient / staff stories to demonstrate what this looks like in practice. e.g. virtual wards, community teams, prevention, targeted support
- Create brand guidelines, templates and accompanying style guide to provide clarity on usage and the where / when / how (ensuring all branding is used appropriately and correctly for specific environments and contexts)
- Ensure the transition to a new organisational name and brand is done as cost-effectively as possible

Recommendation

The Board are asked to:

- note the branding development and engagement work undertaken
- approve the new organisational brand for North Cheshire and Mersey NHS Foundation Trust from 1 April 2026 upon completion of the integration transaction, following the recommendation by the Executive Management Team
- support the implementation plan

Appendices

Qualitative feedback examples

Visual identity: Overall design

What staff like based on first impressions (in their words):

- *The colour scheme is effective and immediately recognisable as NHS branding, reinforcing consistency and trust*
- *The layout guides the viewer's eye naturally, making the key message and tagline easy to understand at a glance*
- *The colours feel cohesive and help reinforce a sense of warmth, care and professionalism, which aligns well with the organisation's purpose*
- *I like the cool toned colours, blue against the white and the accent colours stand out well but look harmonious too. Nice simple, easy to read font. The design successfully communicates the organisation's identity in a way that feels both reassuring and credible*
- *I like the blue colour, it looks professional, modern and fresh. The white looks more clinical*
- *The simplicity of the design is a strength. It keeps the message focused, looks clean, and feels aligned with NHS expectations around clarity and accessibility. Key strengths – subtle, thoughtful messaging. Clean and minimal visual style. Professional and appropriate for an NHS setting. Avoids over complicating the concept*
- *Visual elements e.g. colour, typography and layout work well together, making the brand appear trustworthy and intentional rather than cluttered or inconsistent*
- *It's simple but striking, a definite identity for the new trust that I think can be easily adapted for those additional services that are across a wider footprint, thereby hopefully promoting belonging while sustaining an individual identity and purpose*
- *Really does stand out! I like it more than the current branding at either of the current trusts*
- *It is nice and clean which should give a good impression to our patients who are most important*
- *It looks good. Here's hoping it does the trick!*

Visual identity: Overall design

What our governors / EbyE like based on first impressions (in their words):

- *Eye catching, colourful and simple (so effective)*
- *I like blue / white as the main colours (easily identifiable NHS colours) and having three different colours for 'home, community, hospital'*
- *It looks good and easy to read and identify with*
- *Felt a little bland on initial view until you realise each colour aligns with each strand of the trust vision. This should help users find the area they are looking for if the colour theme follows through to a particular area*
- *Crisp and clean imagery. I think it is brilliant*
- *Excellent work has gone into this branding, in my opinion there's only a few tweaks on the three words 'home, community, hospital' to read a clear message*
- *Quite like the blue background colour and the uncluttered look*
- *I like that it's a simple design and limited colour palette*
- *Looks more professional than usual NHS*
- *Fits very well with our current NHS identity*
- *The colours and text stand out really well and are easily readable and understood*
- *The design is straightforward stating what it is and where*
- *Impressive. Straight to the point. No lengthy reading required*

Home, community, hospital tagline

What staff told us:

- *It gives a clear message of the direction of travel for the future of the NHS*
- *I like the ordering with home listed first, then community and then hospital which is in line with the strategy and 10 Year Plan to keep people well, at home, in the community and hospital admission avoidance*
- *Professional, clean and NHS. With knowledge of the 10 Year Health Plan I think the message is home first then community then hospital*
- *Like the emphasis but it's almost focused on a location as opposed to outcome e.g. stay well, live well, supported well*
- *I think it looks good, unsure of hospital being in green on the bottom as green is usually associated with good – and being in hospital is not the end (good) goal*
- *I think internally it makes sense and is short and snappy. It may take time for this message and principles to gain greater awareness*
- *I can see these being really strong visual identifiers to convey different aspects of our care as we work ever closer*
- *I do like the tagline but I understand that it means home first, then community and hospital is the last resort. That would have to come through more during the promotion aimed at the community*
- *It makes sense to me, but I wonder if it will to the general public. I wonder if there should be a mention of 'care' in these locations?*
- *I like the simpler message, easier to remember and more impactful that a long slogan or summarised vision statement*

Home, community, hospital tagline

What our governors / EbyE told us:

- *Does put the message that the NHS is moving away from hospital as the first port of call*
- *Simple and communicates the key principles well*
- *Perhaps an addition to the tagline in smaller font to explain what it means in broad terms*
- *Why not include: 'Our services' before Home, Community, Hospital, to clarify the integrated and expanded scope of services provided by the new set up*
- *I think the word YOUR should be put in front of every word, otherwise it seems to read as Home Community Hospital*
- *I quite like the home, community, hospital concept since most patients are discharged to their communities early*
- *I feel the 'home' element is conflicting with the community tagline. I would suggest not using home and sticking with community only, it gives a greater sense of belonging*
- *I really like the words Home, Community, Hospital, should we add First at Home, Secondly Community or Hospital Last resort?*
- *Really like the design but it will need further explanation at roll out stage with consistent messaging to embed the vision*
- *I don't think that combination of words is fundamentally healthcare specific – I understand you're aiming for self-care, primary care, secondary care, but home and community do not individually emphasise this*
- *Impressive. Straight to the point. No lengthy reading required. Consistent message of Home, Community, Hospital*
- *I love the clarity and the goals North Cheshire and Mersey are going to achieve*

Areas for development

Collated from both surveys:

- *A recognition programme could be designed around the values embedding their use. Perhaps images could also be developed to further enhance home, community, hospital?*
- *Only minor question is the order of the three coloured 'orbs'. Should it be the opposite way round – green is home, blue is community and red is hospital to indicate that the preferred option (usually denoted by green) is home*
- *Colour alignment if intended should be green for home, blue for community and magenta for hospital*
- *One potential area for improvement is considering whether the strong corporate style could be softened slightly when viewed through a health inequalities lens, e.g. by incorporating more inclusive or accessible design elements, while still retaining clear NHS branding*
- *The 3 coloured oval things that go to the edge of the page might cause issues with creating documents / printing to the edge of paper when printing is necessary. I think circles that don't go to the edge off the page would be better, but still overlapping*
- *Just make it clearer that the three pillars are the trust's priorities*
- *The 'home community hospital' tagline needs commas or something to separate the words when used horizontally*
- *When multiple visual elements are present, simplifying or refining them slightly can help reduce visual competition and keep the focus on the core message, e.g. reducing the number of visuals or simplifying the backgrounds would help the message feel cleaner and more focused. A bit more contrast in terms of value between the accent colours and main blue would help*
- *Would be useful to see the letterhead in black and white also*

Values imagery (Staff)

What staff like based on first impressions (in their words):

- *The icon designs give a strong first impression, modern with a consistent colour scheme. They are easy to understand and the objectives they represent are clear*
- *My first impression is that the icons feel friendly, approachable and values-led. The rounded shapes, soft colour palette and simple forms make them easy to understand and emotionally warm, which suits an organisation focused on care, inclusion, and community. It seems like it is well thought out*
- *The simplicity of the values titles makes them clear and easy to understand, without feeling too corporate or formal*
- *Similar to the brand icon, the value icons are clean and simple. The colours and style jump out well*
- *I love them all apart from the 'fair' icon. They are clear and concise – simplicity is best and the colours are great*
- *The icons successfully balance clarity, warmth, and professionalism. Easy to understand*
- *'Kind' and 'open' convey the right message. I like the emphasis on all working together*
- *The colours are nice and the heart icons in 'kind' and 'one team' are nice. I feel I can buy into them*
- *Simple and colourful images are more impactful than the more traditional person avatars. Will not detract away from important narrative but will support and enhance any message*
- *The wording is good and describes values that I want our organisation to have. I feel I can buy into them*

Values imagery (Staff)

Suggested areas of improvement:

- *I like 'kind' and 'open'. Less keen on 'fair' and 'one team' as they don't necessarily create that association in my mind – but appreciate it's subjective*
- *Mostly good. The 'one team' one looks like a couple not a team. I think we could have something better for 'fair' but it's reasonable*
- *3 out of 4 made sense immediately to me. I am not sure about using a heart image in 2 of the images though*
- *The 'open' one I feel would work better for 'fair'. For the 'open' icon, I personally feel an icon depicting open arms might be better as this is what comes to mind when I think of the word 'open' – welcoming new ideas / ways of working*
- *The icons look fine at first glance, but they feel quite generic. It's unclear what the 'fair' icon is intended to represent, the meaning doesn't come across visually, so this may need clarification or redesign*
- *They align with both organisations – not sure about the fair icon – what does this represent? (I agree with the statement)*
- *Easy on the eye, the colours are good. The 'one team' graphic is a little unclear – thinking if the name and text were not present would it be understood?*
- *I like them, only one I don't feel is clear as an image is 'fair' but I am unsure how else that could be pictorial and the straplines clearly explain them all*

Values imagery (Public)

What our governors / EbyE like based on first impressions (in their words):

- *The icons are bright and draw your eyes to them*
- *Look good and need to mean what they say*
- *Easy to understand and bright colours*
- *Great. Bright, cheerful and with meaning*
- *Simple, clean and consistent imagery. Professional and friendly*
- *I like them, they look modern and are clear*
- *'Love um'*
- *Looks clear and fluent. Not too busy*
- *I like the simplicity of the images and descriptions meaning people will remember them*
- *Colourful. Like the images for 'kind', 'open' and 'one team'*
- *All should work well if people know why the changes are being made*
- *I like the simplicity of the images and descriptions meaning people will remember them*
- *They are relatable and make sense to me. The 'kind' and 'open' icons are particularly easy to understand and effective*
- *Eye catching, make people stop to read*

Values imagery (Public)

Suggested areas of improvement:

- *'Open' could be more clearly conversation. 'Fair' could be a pair of scales for balance. 'One team' needs to be a small group of people of different professions / uniforms. One paler person gives exactly the wrong impression!*
- *Having two of everything seems to accentuate difference rather than being together and united, especially when one is paler than the other*
- *The orange is a challenge for visually impaired people*
- *I like that they're simple but I'm not keen on the 'one team' icon because it reminds me of the old MSN Messenger icon*
- *Patients won't understand them. Why don't we simply use the words as opposed to symbols. If symbols have to be used replace the fairness symbol as it means nothing. Insert it with scales of justice as they are well known as symbols of fairness*
- *Not all the icons work for me as a governor and if I was a patient. Open icon means nothing to me. An open door would represent open better and more people would recognise it.*
- *Fair and open are a bit ambiguous*
- *Like the colours and short explanatory words, but other than kind the other logos don't mean anything to me. Do we actually have to have logos at all?*
- *Finding it difficult to understand the icons / symbols. Is there any way you could let the public know what they stand for? Why should 'We listen, value our differences and are inclusive to all' be just 'fair'?*
- *Didn't understand the 'fair' icon but others ok – team icon needs bigger heads*

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/26/02/160**	
SUBJECT:	**Bi-monthly Strategic Projects Highlight Report (November and December 25)**	
DATE OF MEETING:	**4th February 2026**	
AUTHOR(S):	Megan Wainwright, Strategy Project and Team Support Officer	
EXECUTIVE DIRECTOR SPONSOR:	Lucy Gardner, Chief Strategy & Partnerships Officer	
LINK TO STRATEGIC OBJECTIVE: (*Please select as appropriate)*	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	**145** If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position. **1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***	

	Yes	No	N/A
1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct			✓
Further Information:			
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not			✓
Further Information:			
3. Foster good relations between people who share a protected characteristic and those who do not			✓
Further Information:			

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

WHH and BCH continue to work towards becoming a single organisation. NHSE have completed their review of our strategic case and agreed for us to continue to develop the full business case (FBC) as the next step. The final draft of the FBC is now complete and has been approved by both WHH and BCH Trust Boards before being formally submitted to NHSE in early December. Focus of the programme now shifts to the critical actions required to complete the legal transaction and deliver a ‘safe day one’ as an integrated organisation.
The Runcorn Health and Education Hub is due to complete construction in January 2026, start to open services from June 2026.
The Living Well Warrington programme was highly commended at the prestigious 2025 national HSJ awards in November. The programme consists of three projects; Living Well Hub, Living Well in Warrington digital platform and Talking Points. Collectively, the three projects have reached over 200,000 people over the last 18 months, supporting them to live independently at home and access support in their local communities.
The Trust have commenced development of our five-year plan, in line with latest NHS England Planning Guidance. This involves formulation and submission of:

3- year plans for revenue, workforce, operational performance and activity
4-year plan for capital
5-year narrative plan

Final submission due in February 2026, with approval of the plans at February’s Trust Board.
</td></tr>
<tr><td>PURPOSE: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">The Trust Board is asked to note this report for information.</td></tr>
<tr><td>PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Choose an item.</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td></td><td>Date of meeting</td><td colspan="2"></td></tr>
<tr><td></td><td>Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="3">None</td></tr>
</table>

Strategic projects update November-December 2025

Section 1 - Key messages			
Slide 2	Summary of key developments this reporting period		
Section 2 - Stakeholder engagement			
Slide 3-4	Summary of key stakeholders engaged during the reporting period		
Section 3 - Key strategic projects			
Page	**Project**	**Strategy Lead**	**Status**
Slide 5-6	WHH/BCH Integration programme	Stephen Bennett	
Slide 7-8	Runcorn town deal	Carl Mackie/Viviane Risk	
Slide 9-10	New hospitals programme and strategic estates	Carl Mackie	
Slide 11-12	Warrington Living Well Virtual Health & Wellbeing Hub	Rachel Moran/Stephen Bennett	
Slide 13	Completed projects	Strategy team	
Section 4 - Other trust strategic updates			
Slide 14	Summary of other Trust strategy related updates		
Section 5 - Cheshire and Merseyside strategic updates			
Slide 15	Summary of strategic updates from Cheshire and Merseyside		

Key messages

- WHH and BCH continue to work towards becoming a single organisation. NHSE have completed their review of our strategic case and agreed for us to continue to develop the full business case (FBC) as the next step. The final draft of the FBC is now complete and has been approved by both WHH and BCH Trust Boards before being formally submitted to NHSE in early December. Focus of the programme now shifts to the critical actions required to complete the legal transaction and deliver a ‘safe day one’ as an integrated organisation.
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- The Trust have commenced development of our five-year plan, in line with latest NHS England Planning Guidance. This involves formulation and submission of:
    - 3- year plans for revenue, workforce, operational performance and activity
    - 4-year plan for capital
    - 5-year narrative plan

Final submission due in February 2026, with approval of the plans at February’s Trust Board.

Stakeholder and engagement overview

Key stakeholder engagement in period	Job title, organisation	Topic/Nature of engagement
Caroline Williams	Director of Adult Social Services, Warrington Borough Council	Warrington neighbourhood health plan, UEC system improvement
Alex Kirkpatrick	Deputy DoF, NHSE NW	Integration
Su Foster	Estates Delivery Lead, Cheshire and Merseyside	Halton Place Estates
Naz Ghodrati	CEO, Warrington Voluntary Action	Integration and partnerships with VCFSE sector
Dr Laura Mount Dr Ash Ahliwala Dr Golam Chowdhury	Warrington PCN Clinical Directors	Update on integration programme and clinical services workstream
Sarah Hall MP	MP	Urgent treatment centre, integration
Linda Buckley	Managing Director, CMPC	C&M blueprint
Christina Banerji Katherine Golding	Mergers and acquisitions team, NHS England	Better Care Together integration programme – advice and guidance
Team from Bradford Teaching Hospitals	Various individuals including Director of Strategy, Head of Estates, clinical and operational service leads	Site visits to Living Well Hub, Halton Health Hub and WELL Runcorn Hub to see ‘Health on the High Street’ examples
2025 HFMA Awards Judging Panel	Various individuals including the outgoing HFMA president, Lee Outhwaite	HFMA awards submission for Living Well programme
Amanda Ridge	C&M ICB	Neighbourhood health plans in Warrington, UTC, integration
Wesley Rourke	Executive Director, Environment and Regeneration	Runcorn Shopping City, Levelling up, Runcorn Town Deal, Widnes town centre strategic Board
Michael Allen	Partner, KPMG	Due diligence for production of full business case for integration
David Wilson	One Halton Clinical director	Clinical services integration
CEOs Cheshire, Warrington and Wirral Trusts	CEOs Cheshire, Warrington and Wirral Trusts	C&M blueprint

Stakeholder and engagement overview

Key stakeholder engagement in period	Job title, organisation	Topic/Nature of engagement
Tony Leo	Place Director, Halton	Place development and integration programme
Matthew Swanborough Jon Develing	Chief Strategy and Partnerships Officer, Wirral University Teaching Hospitals Director of Strategy, Countess of Chester Hospitals	Integration, C&M strategy
David Cooper	Cheshire and Merseyside ICB	Strategic estates planning, Warrington, UTC
Tim McPhee	Associate Director Integration, Transformation and Partnerships, Mersey Care	Runcorn Health and education Hub, One Halton delivery plan, Warrington neighbourhood health
Sarah Pochin MP	MP	Runcorn Town Board, Integration
Chris Nisbet	Transformation Lead, Warrington Borough Council	Development of neighbourhood health model in Warrington
Linda Edwards	Business Intelligence Lead – Warrington and Halton, Cheshire & Merseyside CSU	Development of neighbourhood health datasets within C&M B.I. portal
Richard Rout	Chief Executive, Halton Borough Council	Strategic Estates and Integration, HBC CEO interviews, integration
Sally Yeoman	CEO, Halton and St Helen's Voluntary Action	Runcorn Town Board, HBC CEO interviews
Andrew Jones	Service improvement and change manager, Mersey Care	Runcorn health and education hub
Jude Adams	Cheshire and Merseyside ICB	UTC
Derek Twigg MP	MP	Widnes development
Mary Murphy	Principal and CEO Riverside and Crompton Colleges	Runcorn health and education hub, HBC CEO interviews

Integration – part 1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Programme Overview

Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) is planning to formally acquire Bridgewater Community Healthcare NHS Foundation Trust (BCH) on 1 April 2026, bringing both partners together to create a single organisation **'North Cheshire and Mersey NHS Foundation Trust'.** The integration will support both individual Trusts with long-standing challenges around clinical and financial sustainability and create a wealth of opportunities to improve access to services, quality of care and overall patient experience.

The integration programme- entitled 'Better Care Together' is well established and consists of ten 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 a detailed delivery plan and are working with partners to deliver objectives.

What does this mean for WHH?

Over the last decade, both WHH and BCH have seen demand for services continually increasing due to a growing and ageing population locally, living longer with complex and often chronic conditions. This increasing demand has steadily led to a need to increase non-elective capacity at the acute sites, which has led to increasing financial challenges. In line with the NHS Ten-Year Plan and strategic direction regionally, the integration creates the opportunity to develop a model with greater emphasis on preventative health and community services, which together, can improve both quality and sustainability of services.

Progress:

- Completion of final draft of full business case (FBC), post-transaction integration plan (PTIP) , Board Certification and Secretary of State documents and submission to Trust Boards and NHSE.
- Meetings in place with NHSE to support review of FBC during December/early January

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
Final 'challenge' meeting with NHSE as part of review of full business case	9 February 2026
Receipt of formal outcome letter from NHS England following review of full business case	Late February 2026
Complete staff consultation around TUPE/organisational change	28 February 2026
Completion of formal transaction and establishment of new integrated organisation – North Cheshire and Mersey NHSFT	1 April 2026

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.bennett13@nhs.net

Runcorn town deal-part 1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

WHH is a key partner within Runcorn Old Town's submission to the Town Deal Investment Fund, with an overall opportunity to bring up to £25m to the town. The health and education hub project is led by WHH and is one of 7 projects within the Town Deal plan. The hub is planned to deliver services focussed on prevention, women and children and long-term conditions from a central location in Runcorn.

The project is being developed in partnership with a range of health and care providers across Runcorn, including Bridgewater and Halton Borough Council. The scheme includes a flexible education element designed in partnership with Riverside College.

What does this mean for WHH?

- Delivery of WHH services, including maternity, respiratory, and phlebotomy, from a convenient and accessible town centre location.
- Opportunity to work with local further education college to provide education and training tailored to jobs in health and care, helping to reduce our vacancies.
- Opportunities to further integrate services with other providers across health, care and wellbeing.

Progress since last report

- Internal finishes complete. Mechanical and electrical system demonstrations completed.
- Furniture installation near complete.
- Pre-handover water risk assessment completed, with scheme confirmed as suitable (pending water test results).

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	Jan 2026
Services go live	June 2026

Contact details
Viviane Risk
Strategic Project Manager
viviane.risk@nhs.net

Carl Mackie
Halton Healthy New Town and Strategy Manager
carlmackie@nhs.net

New hospitals and strategic estates planning- part 1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

- Development of new WHH hospital estate and infrastructure.
- Within Warrington, this is the development of a new hospital, either on the current site or elsewhere in the town.
- Within Halton this is the redevelopment of the Halton Hospital site, including extending Captain Sir Tom Moore to incorporate all existing services and additional services, whilst releasing land to support the Hospital and Wellbeing Campus vision.

What does this mean for WHH?

- Delivery of Trust services from modern, accessible and safe environments.
- Opportunities to develop service provision in appropriate clinical settings and expand opportunities to work with local partners or in external locations.

Progress since last report

- Continued discussion with NHS C&M around progression of case for co-located Urgent Treatment Centre
- Development of proposals for NHSE Northwest Estates Safety Fund

New hospitals and strategic estates planning- part 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality	People	Sustainability
Patient Safety ✓	**Looking after our people ✓**	**Working in partnership ✓**
Clinical effectiveness ✓	**Innovating the way we work ✓**	**Working responsibly ✓**
Patient experience ✓	**Growing our workforce for the future ✓**	**Sustainable estate and digitally enabled ✓**
Research, development and innovation ✓	Belonging in WHH	**Financial sustainability ✓**

Milestone	Date
Delivery of updated strategic estates masterplan	December 2026
Notification of UTC Bid outcome	TBC
Submission of bids to NHSE Northwest Estates Safety Fund	23 January 2026

Contact details
Carl Mackie
Halton Health New Town and Strategy Manager
carlmackie@nhs.net

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/26/02/161**			
SUBJECT:	**Strategy Bi-Annual Delivery Report**			
DATE OF MEETING:	**4 February 2026**			
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):	**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:			
	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. In February 2025 it was agreed to extend the governance and reporting arrangements through 2026/27, in order to align to the development of the strategy for the new organisation post April 2026. There are a total of 57 Key Performance Indicators (KPIs) measuring progress against delivery of the strategic priorities within the refreshed 2023-25 Trust Strategy (extended through 2026). These are broken down and monitored as below: There are 14 KPIs measuring progress across the 4 objectives within the Quality aim of the Trust strategy. These are reported twice yearly through Quality Assurance Committee. H1 KPIs were reported to 10th December 2025 as per the Quality Priorities Quarter 2 (Q2) 2025 – 2026, with additional information via the Trust's Head of Research, Development and Innovation. There are 24 KPIs measuring progress across the 4 objectives within the People aim of the Trust strategy. These are reported twice yearly through Strategic People Committee. H1 KPIs were reported to SPC on 15th October 2025 as per the WHH Bi-Annual People Strategy Update. There are 20 KPIs measuring progress across the 4 objectives within the Sustainability aim of the Trust strategy. These are reported twice yearly through Finance and Sustainability Committee. H1 KPIs were reported to FSC on 20th October 2025 as per the Sustainability Strategic Objectives Bi-Annual Report. As of this report, the Trust is on target to meet 40 priorities, 16 are behind expectations with mitigations and programmes in place to bring back in line with expectations, and 2 are behind expectations with limited or no mitigations. The two KPIs rated as Red are detailed below, with one Red indicator against our Quality Priorities and one Red indicator against our Sustainability priorities. 4.3 We will develop staff across a range of disciplines as Principle Investigators to grow research capability within our workforce: The target is for an increase of 4 Principal Investigators in year (20%), currently we have 1 additional Principal Investigator across 2025/26. 12.3 We will deliver value for money by ensuring efficient use of resources: The Trust recorded a deficit position worse than plan in 2024/25 and is in receipt of cash support from NHSE.

	Additionally, this report outlines the arrangements for governance and reporting of strategic development across 2026/27 as the new organisational strategy is produced.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	Trust Board are asked to: 1. Note progress against the delivery of the Trust Strategy 2025/26 through the Strategic Priorities across Quality, People and Sustainability aims 2. Note the arrangements in place to report on delivery of the Trust's strategic objectives across 2026/27		
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: ***(if relevant)***	Section 43 – prejudice to commercial interests		

REPORT TO TRUST BOARD

SUBJECT	Strategy Bi-Annual Delivery Report	AGENDA REF:	BM/26/02/161

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.

To support the extension of the Trust strategy through 2026, there were a number of updates agreed to the Strategic Objectives and Priorities. These are described below:

Strategic Objectives - Quality	Strategic Priorities - Quality
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 of QI training 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.
	4.4 We will grow the academic research portfolio supporting staff recruitment and retention.

Table 1: Quality Strategic Objectives and 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.

Strategic Objectives - People	Strategic Priorities - People
	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.
	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.

Strategic Objectives - People	Strategic Priorities - People
	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 2:People Strategic Objectives and 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

Strategic Objectives - Sustainability	Strategic Priorities - Sustainability
	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 though Patient Held Records (PHRs) and smartphone Apps, enabling patients to take an active role in their healthcare.
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 3: Sustainability Strategic Objectives and Priorities 2025/26

2. KEY ELEMENTS

Quality Strategic Priorities

An update on progress of the Strategic Priorities for the Quality aims was reported to QAC on 9th December 2025 as per the Quality Priorities Quarter 2 (Q2) 2025 – 2026 and additional content from the Trust's Head of Research, Development & Innovation

Strategic Objectives - Quality	Strategic Priorities - Quality	KPI	Target	Current Measure	Commentary	RAG
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.	We will use quality improvement methods to improve provision of harm free care to our patients with a focus on preventing and reducing harms from pressure ulcers, malnutrition, and sepsis.	**Objective 1**: MUST - 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. **Objective 2**: Pressure Ulcers - Reduce the number of Category 2 pressure ulcers by 20% with zero tolerance of Category 3 and Category 4 pressure ulcers.	Objective 1: Neither aim has yet been achieved, however, compliance across both measures has continued to improve in Quarter 2. Objective 2: The number of hospital acquired pressure ulcers was below the baseline average for each month of quarter 2, with the aim of a 20% reduction in category 2 HAPU (hospital acquired pressure ulcer) achieved overall during this period. However, one category 3 and one category 4 pressure ulcer were recorded during quarter 2. Objective 3: Whilst 4 of the metrics are slightly below the 85% target the lactate has been above the 85% consistently for the last 2 months. The use of the sepsis tool was between 8%-23% meaning the target has not been achieved. WHH is presently reviewing the metrics measured for sepsis and will make recommendations for amendments to the Quality Assurance Committee in the next report.	• Six wards (AMU, ED, A4, A8, B18, ICU) with the highest incidence of pressure ulcers were identified to participate in a first learning session which took place on 9 September. • Representation from 5 wards attended the learning session, along with an expert by experience. • Representatives from wards A6 and A7 also attended and shared their learning from recent improvements in pressure ulcer prevention. • Ward C21 has subsequently been invited to participate in the collaborative. • Ward visits by the QI (Quality Improvement) and TVN (Tissue Viability Nurse) Team took place following the Learning Session to support wards to complete a baseline assessment of compliance with the ASSKING (Assess, Skin, Surface, Keep, Nutrition, Giving) framework, to identify a specific focus area for improvement efforts and to plan a first test of change. Some of the changes currently being tested include: - Targeted education and training (AMU) ▪ Training sessions on correct placement of high flow Non-Invasive Ventilation (NIV) equipment (B18) ▪ Folders in all areas with educational materials on pressure ulcers and tissue viability (ED). ▪ Tissue Viability(TVN) link nurses circulating a newsletter with education (ED) - Learning from incidents ▪ Incident outcomes with photographs are hung on the pinboards in the MDT room to promote learning from incidents (B18). ▪ Reviewing Datix incidents with the nurses to garner a culture of education from incidents (ED). - Increased audit and oversight (AMU, C21) ▪ Increased SSKIN bundle audits (AMU). - Use of Siltape, a silicone-based tape designed to create a barrier between devices and the skin (B18). - HCA's performing care and comfort rounds regularly and completing SSKIN bundles (ED). - ITU specific assessment tool for level 2 patients (ICU).	

Strategic Objectives - Quality	Strategic Priorities - Quality	KPI	Target	Current Measure	Commentary	RAG
			Objective 3: Sepsis - To achieve 85% compliance with Sepsis six and the completion of the Sepsis Tool by March 2026.		• In Quarter 1, the trust wide Sepsis Improvement Group was relaunched, working collaboratively with all teams to reduce the delays in recognising sepsis, this is the most common reason for poor outcomes. The use of early warning scores (EWS), sepsis screening tools, and electronic health record (EHR) alerts significantly improves early detection.	
	1.2 We will create a culture where the safety of patients, their relatives and our staff is our foremost priority	Ensure that all patients within the Emergency Department (UEC) receive timely assessment and treatment resulting in improved patient experience and improved clinical outcomes.	**Objective 1**: Beginning – Triage: 70% of patients attending the Emergency Department, Urgent Treatment Centre and Same Day Emergency Care to have a MTS (Manchester Triage Score) triage within 15 minutes. **Objective 2:** Middle – Main Department: To develop and implement a method for all speciality response times to be measured. **Objective 3**: End – Acute Medical Unit/Discharge: To increase Hot Clinic capacity across Respiratory and Gastroenterology.	Objective 1: 69.86% Objective 2: A method for all specialty response times has been developed using the e-outcome system. Objective 3: Hot clinics within acute medicine and surgery are operational and run through the Same day Emergency Care Unit.	• The Triage Team has been established and have implemented a new triage pathway which integrates streaming to other areas of the Trust. This is based on models observed at other Trusts and aims to ensure that patients are seen in the most appropriate location for their care needs, as quickly as possible. • An intense focus on triage has resulted in sustained improvement in type 1 (ED) and type 3 (UTC) attendances. • Opportunities for discussion with the multi-disciplinary team (medical staff, nurses, ACPs, administrative colleagues, operational teams and transformation) has resulted in the identification of several opportunities for improvement in the triage pathway. • The oversight of specialty response times enables teams to flex the workforce available to reduce waiting times. • The Urgent and Emergency Care and specialty teams will need to be able to book patients directly into the Hot Clinic slots to avoid patient delays in accessing these services to support Early Supported Discharge and Admission Avoidance. • Continue to embed the Trust triage and streaming pathways across type 1 (ED), type 3 (UTC) and type 5 (SDEC) pathways. • Complete development and implementation of the Trust specialty “wait to be seen” monitoring system and dashboard. • Implement speciality hot clinic slots across Gastroenterology, Cardiology, Respiratory and Diabetes and Endocrinology to support early supported discharge and admission avoidance.	

Strategic Objectives - Quality	Strategic Priorities - Quality	KPI	Target	Current Measure	Commentary	RAG
	1.3 Design and support safety programmes that deliver effective and sustainable change	Improve access and productivity in elective care as per national operational planned guidance.	**Objective 1**: Reduce the proportion of people waiting over 2 weeks for treatment to less than 1% of the total waiting list by March 2026	**Objective 1**: The Trust is currently off trajectory for achieving the objective for reducing the proportion of patients waiting over 52 weeks to 1% of the total waiting list.	Challenges in workforce in key specialties alongside the delay to theatres being fully operational have contributed to the under performance against plan, the impact: ▪ Delay in theatre estates work being completed (1.0% RTT) ▪ Endoscopy hub, lack of referrals from C&M into the regional hub (0.6% RTT) ▪ Workforce constraints. Unplanned workforce gaps in Trauma & Orthopaedic, ENT, Rheumatology and Maxillo-facial (1.58% RTT) Recovery plans have been developed with the underperforming specialities to support delivery; this will be complemented by the technical validation programme which is estimated to remove a further 337 patients from the waiting list. • Although improvements can be seen within this quality priority, we are still currently behind schedule for the full achievement. • The following next steps will be taken to further improve compliance: - Regularly audit compliance with each element of the Sepsis Six. - Share feedback with teams promptly (e.g., dashboards showing time-to-intervention). - ED Band 3 undertaking blood culture training - Highlight successes and missed opportunities with case reviews.	
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	Delivery of the Trust wide improvement programmes across all Care Groups aligning to GIFRT recommendations to support timelier and more effective patient care.	Objective 1: Urgent and Emergency Care (UEC) Internal and System Improvement Programme Objective 2:Theatre Improvement Programme Objective 3 Outpatient Improvement Programme	Objective 1: 3/8 Measures on track • Improvements seen in walk in triage since launch - 15.33 minutes average triage time for the whole month of September 2025 (12.21 walk-ins, 25.72 ambulance). • Go live of 'push model' to all UEC areas within the Trust- SDEC, ED Ambulatory, Minors. • Reduction in Wait to be Seen time since splitting of rotas- walk-in vs trolleys. Lowest monthly average waits to be seen time all year (6.6hrs in October vs	• Older People Short Stay Unit feedback to be presented Trust wide has been completed in Q3. • Go live of 'push model' for other assessment areas including Paediatric Assessment Unit and Gynaecology Assessment Unit . 4-week validation task and finish group established. Some 'quick wins' identified with key themes being actioned i.e. - more accurate documentation and transfer of patients in real time. • Plans for SPOA to SDEC being developed for go live in October 2025. • Actions being agreed to test Frailty at the front door and better utilisation of Discharge Delivery Unit - November 2025	

Strategic Objectives - Quality	Strategic Priorities - Quality	KPI	Target	Current Measure	Commentary	RAG
				average of 7.8 hours for the preceding months). • Meetings with CBUs taken place following Board Round Audits. Current ward specific performance presented alongside benchmarking data. Action plans are in place for ward level improvements to support reduction in The Length of Stay (LoS). • Communications plan drafted to support with MaDE for winter launch. 4-week communications programme agreed with further plans being developed. • Older People Short Stay Unit impact presented to teams. K25 LoS reduced from 9.5 days prior to 4.45 days post. Geriatric Medicine specialty LoS reduced by 4 days overall too. • Reset of Criteria Led Discharge (CLD) with Associate Chief Nurses now project leads to help drive engagement and uptake. • 4-hour waterfall developed with revised trajectory. Improvement of approximately 2% in September compared to August. Objective 2: 3/7 Measures on track Theatre Utilisation • Currently above trajectory at 80.2%. On-the-Day Cancellations • Slight improvement, but still off target with 75 cancellations in September. Start on Time Performance • Remains below trajectory due to multiple contributing factors. Job Plan Delivery • Off trajectory at 59.35%. Annual leave remains high as per summer months, • Core funded sessions on track at 80.45%. Preoperative Assessment • Preoperative Tool created in Microsoft Forms and finalised by the Preoperative Team.	• Gastroenterology Hot slots to go live from mid-October (internal referrals only at current time) • Multi agency Discharge Event for winter to take place w/c 20th October. • Communications and training for both doctors and nursing in the new Criteria Led Discharge process to be rolled out. Preoperative Assessment • Digital Team expected to start building the tool in Dr Doctor by mid-November 2025. • Finalise process map and agree responsibilities for triaging forms. • Determine training/support requirements for nursing staff during the change. • Manual distribution may be required for the Test of Change if digital integration is not ready. • Schedule meeting with Preoperative Nursing Team to begin discussion on process mapping, triage decision-making, roles, and training requirements. Graphnet • Schedule meeting with Graphnet to confirm differences between Optimisation and Preoperative Triage categorisation and determine how data can be exported. (November) FDP & Reporting – Trust processes- • Need to review Theatre actions/escalation process when asking for cases to be added at list planning. HVLC Cataracts • Patient Journey Review: Meeting with ODS staff and Theatre Teams scheduled for 17 October 2025. • System Preparation: Schedule SIMS setup prior to HVLC session. • Feedback Development: Create staff and patient feedback forms. Day Case Arthroplasty • Pilot dates to be confirmed. 4 Joints Workstream • Awaiting staff feedback for 2nd and 3rd TOC. • Confirm the date for the 4th TOC. • Further discussions of how to implement 4 joints as business as usual	

Strategic Objectives - Quality	Strategic Priorities - Quality	KPI	Target	Current Measure	Commentary	RAG
				• Shared with Experts by Experience • Digital Team currently testing integration between access plan creation and automated distribution of the tool. • Preop Triage Questionnaire Clinical Exam Audit: Ongoing evaluation of the necessity for ASA I & II patient examinations. • Northwest preoperative lead site visit: Held on 19th August Graphnet • Demo with Rep complete. • Discussions with RTT, BI, and Digital Teams confirmed that integrating Graphnet Preoperative Triage categories into Lorenzo Access Plan is not feasible. Federated Data Platform(FDP) • Provides forward-looking and historical view of booked Theatre utilisation. • Background calculation issues resolved; functionality to be incorporated into the FDP upgrade in October 2025. High Volume Low Complexity (HVLC) Cataracts • 7 LA patients scheduled for the PM session; all patients identified. • Patient journey process map completed and shared with wider teams. Day Case Arthroplasty • New consultant in post; 4 Joint Workstream • 3 TOCs completed in 7.5 hours each. • Staffing: Only the first TOC had additional staff; second and third TOCs operated without extra support, impacting lunch breaks. Objective 3 Outpatient Improvement Programme: 0/5 measures on track • Progression with clinic template work. • Knowledge and Evidence Service carrying out an evidence review to inform telephone appointment SOP (findings to	• Continuation with clinic template work • Work with digital to explore re-launch of Attend Anywhere- confirmation on which specialties to be confirmed. • Progression with writing of Trust Wide policies for Telephone clinics and Inpatient as Outpatient to support reduction in DNA rate. • Drill down into specialty level OPPROC vs OP tariff to begin working up opportunities with CBUs- Therapies, general medicine, oral surgery currently flagging. • Explore use of FDP for OP as next module- demo being arranged. • Trust Wide agreement required for next steps on Advice and Guidance revenue request and Executive sponsor to be identified. Although the Trust is currently partially achieving this priority, progress is being made through several pieces of work to make further improvements with an aim to fully achieve this priority.	

Strategic Objectives - Quality	Strategic Priorities - Quality	KPI	Target	Current Measure	Commentary	RAG
				be shared next week). An audit of the timing of DNAs on e-outcomes indicated that while most clinicians try to call patients who did not answer at the end of a clinic, some consultants appeared to be outcoming a DNA after a single attempt to telephone the patient and this was associated with higher rates of DNAs. The audit findings were shared at September's consultant meeting. • Collation of information from Clinical Business Units where clinics are taking place without patients to inform next steps- will impact upon new to follow up ratio. • Information request to understand opportunity of DNAs for inpatient attending as Outpatient to inform writing of a Trust Wide policy. • Process mapping session taken place e18 for eOutcome into Lorenzo. #• Development continues with OP dashboard.		

	2.2 We will prioritise the application of QI training to empower staff and achieve measurable improvement work with identifiable learning and sustainable results.	Reduce Cancer Waiting Times Improve Theatre Safety Culture using whole quality system approach and robust governance process	Cancer: Objective 1: Improve and sustain performance against the headline 62-day cancer standard to 75% by March 2026. Objective 2: Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026. Theatre Safety Culture Objective 1: Quality Surveillance and Assurance. Standardised implementation of NATSSIPs, observational audit tool as well as documentation audit with greater than 90% compliance, across all theatre areas and appropriate escalation to PSSG and PSCESC Objective 2: Training and Awareness. Create and embed an E-learning package on 8 steps to safer surgery in line with the NATSSIPs 2 across all relevant staff groups. Objective 3: Culture. To build and embed a culture of safety and continuous improvement in theatres.	Cancer Objective 1: The standard is currently performing over the agreed trajectory to reach 75% by March 26 and the Trust is ranked 11/118 nationally. The operational standard remains at 85% and the ultimate aim of the organisation is to achieve this. Objective 2: • 28-day Faster Diagnosis Standard (FDS) remains challenging and is currently performing under trajectory. Extensive work has been done in conjunction with the services and the Cancer Alliance to develop action plans against our 3 highest priority pathways in Gynaecology, Lower Gastrointestinal and Urology with the aim of achieving an aggregate performance of 80% by March 2026. Theatre Safety Culture Objective 1: • New standardised Theatre observational audit tool fully rolled out and embedded across all theatre areas. Independent 'secret shopper' auditors completed 1 month worth of validated audits with high score (> 90%) achieved consistently. Ongoing rolling programme of independent auditors in place. • Standardised process of escalation of PSSG to PSCESC fully in place via a monthly HLBP. Furthermore, Theatre Governance Group also reports up to PSSG via a chair's report. • 1 further Never Event in September 2025 (investigated via MDT) and 1 near miss (investigated via SWARM reported to SOM). • MIAA action plan follow-up and embedding actions being presented at QAC in November 2025. Objective 2: • 8 steps to safer surgery: E-learning package is now ready and available for	Cancer • More focus on weekly Patient Tracking List (PTL) meetings with CBUs discussing patient level detail. • Implementation of updated escalation policy. • Upgrading of more patients onto a 62-day pathway. • Working with tertiary centres to ensure pathways between organisations are seamless. • Robust action plans are in place and improvement should become evident by Q3. Trajectories will be reviewed at this point and potentially increased if there is confidence to do so. Theatres Safety Culture • Key improvement and learning has been the true collaborative working of theatre senior leadership, Planned care triumvirate and the AMD procedural safety via PSSG and transparent and robust escalation via PSSG to PSCESC. • Safe surgery audit tool developed as Lorenzo form with the aim of automated data collection via power BI. However, Issues with forms usage – hence currently data being recorded on spreadsheets until IT issue resolved. • Compliance with e-learning package to be triangulated with governance data to analyse effectiveness of the training. • Issues remain with this group being as effective as it can be due to repeated quoracy and scheduling challenges. • Theatres and Planned Care have requested an external review by L&D as 'mock MIAA' inspection to pressure check theatre safety culture – awaiting response.	Theatre Safety Culture

Strategic Objectives - Quality	Strategic Priorities - Quality	KPI	Target	Current Measure	Commentary	RAG
				all staff (July 2025) on ESR. Currently discussion with Learning & development/OD to be made part of mandatory training for all relevant staff who work in or are part of The Theatres Team. Awaiting Learning and Development Governance Meeting November 2025. Objective 3: • Theatre safety culture workstream is now being managed via a Theatre culture improvement group led by Planned Care Triumvirate since January 2025. Meeting frequency is fortnightly and involved key members from the people's directorate. However, the last couple of meetings were stood down due to not being quorate. Planned Care have reviewed ToRs (terms of reference) and process of escalation of actions from the group.		
	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.	Reduce Health Inequalities in line with CORE20+5 for Children, Adults and Young People.	Objective 1: To employ a health literacy approach: 1) to improving the quality of postal and digital invitation letters for all outpatient respiratory appointments and communications to patients about 'common' respiratory diseases like COPD and asthma and 2) reviewing the quality of digital apps on the ORCHA library on respiratory conditions ahead of them being incorporated into a planned local review of respiratory services. The learning will be	Objective 1: • Appointment letters have been reviewed through a health literacy lens and improvements suggested. Any changes will be made when WHH and BCH integrate in 2026 when the letter head and logo changes. • ORCHA Digital apps for respiratory have been reviewed and six have been selected as being a useful patient facing aid. The descriptions of these apps have been reviewed using a health literacy lens. • The COPD patient information pack has been written using a health literacy lens. Objective 2: • The team leader for the Alcohol, Drug and Tobacco is ensuring a comprehensive induction will be in place. • Training of the new appointee will be arranged within the first few weeks of start date.	• When we check letters, leaflets, and digital tools to make sure they are clear and easy to understand, it makes a real difference. People are more likely to use them, trust them, and feel confident about what to do next. • Timing changes with bigger system updates (like the 2026 integration) helps everything stay consistent. When NHS organisations explain things in simple, friendly language, whether it is about an app or a health condition, we make care more equal and improve the patient experience. • To ensure a triage system is in place to select 6-8 patients per day out of the approximately 50 identified daily, who have indicated on admission they are interested in stopping smoking. • For the newly appointed Tobacco Advisor to be seeing patients and supporting their health needs by December 2025.	

Strategic Objectives - Quality	Strategic Priorities - Quality	KPI	Target	Current Measure	Commentary	RAG
			shared across the ICB footprint and beyond. Objective 2: To re-establish a Tackling Tobacco Dependency service within the Trust that will deliver brief interventions with acute inpatients.			
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.		Objective 3: To develop a pool of trainers across North Cheshire and Mersey Healthcare Partnership who can cascade the MECC for physical activity training within our respective organisations. Participants of the training will increase their knowledge, confidence and skills to be able to: 1. Identify the benefits of physical activity, and how to apply the Chief Medical Officer and NICE recommended Guidelines. 2. Define the MECC approach and explore how this can be applied to promote physical activity in health and social care services. 3. Be aware of local support services and how to effectively signpost patients to the appropriate support/referral pathways.	• All of the train the trainer sessions have been completed with a pool of 20 trainers from both WHH and Bridgewater having undertaken this. • A meeting is arranged to commence the community of practice for the trainers to develop a training schedule/roll out plan, to develop training materials and for peer support. • An evaluation review of the training outcomes is being completed by the provider which details a short- and longer-term action plan for effective embedding of a MECC (Making Every Contact Count) approach.	• A pool of trainers established, and a training schedule will follow for implementation from November 2025.	

Strategic Objectives - Quality	Strategic Priorities - Quality	KPI	Target	Current Measure	Commentary	RAG
	3.2 We will maintain our focus on patients and their families' equality, diversity and inclusion.	Improve the experience and care provided for patients with a Learning Disability and impaired Mental Health.	Objective 1: To achieve 90% (Age 16+) improved compliance in regard to the completion of the mental capacity assessment and best interest process. Objective 2: To achieve 90% of patients (Adults/Children) diagnosed with a learning disability and or autism to be offered reasonable adjustments as per the Learning Disability policy. Objective 3: Ensure 90% of patients (Adults /Children) with Learning Disability and or autism who are admitted have a Learning Disability specific discharge checklist completed.	Objective 1: Audit • A Trust Wide audit has been registered, and data collection has commenced. • This audit will examine how well WHH is adhering to the MCA's requirements when making decisions about patients who may lack capacity. This audit will ensure that patients' rights are respected and that decisions are made in their best interests, while also complying with legal obligations. • The objective of the Mental Capacity Act (MCA) audit is to ensure WHH is following the MCA's principles and procedures when working with individuals who may lack capacity. • The purpose of the audit is not just to identify areas of compliance, but also to learn from the findings and implement improvements to ensure better outcomes for individuals who lack of capacity. • The expected completion date of the audit is end December 2025. The audit forms part of the wider safeguarding audit plan for 2025/2026. MCA focussed work • From the 6 October 2025 a safeguarding adult practitioner has been moved from the duty safeguarding rota and allocated to focus on MCA/DOLS practice across the Trust. The practitioner is in the process of reviewing and updating the current training package. • The MCA Policy is being re-written and will be ratified in Q4. Objective 2 & 3: • An audit is required to measure this objective however this will not be planned until quarter 4 to enable time for the new forms/pathways to be embedded. The reasonable adjustment policy, discharge	• Improvement outcomes to be identified through pending audit and quarterly review of DATIX. Quarter 1 and 2 review of DATIX identified that MCA/DOLS knowledge continues to be a challenge for front line practitioners. Increased training opportunities have been provided Trust Wide. • A benchmarking exercise is being undertaken which will inform areas which require further review and will identify any key areas for action. Updates on improvement outcomes will feature in the Q3 update. • An audit is required to measure this objective, and this is due to take place in Quarter 4 to enable time for the new forms/pathways to be embedded.	

Strategic Objectives - Quality	Strategic Priorities - Quality	KPI	Target	Current Measure	Commentary	RAG
				checklist and a quick guide for care pathway were approved and recirculated in June 2025. • Patients who are admitted and have an identified learning disability/Autism diagnosis should be notified to the LD Nurse via the ICE notification. Each notification is reviewed by the LD Nurses and where required further support is offered. Each LD notification is inputted on to a database which will capture whether reasonable adjustments have been advised. • Learning disability awareness week was week commencing 16 June 2025. This week was used to raise awareness across the Trust of the current pathways. • Each CBU have completed a benchmarking exercise against the National Learning Disability Improvement Standards. A joint action is being developed which will support objective 2 and 3 of this quality priority.		
	3.3 The patients and the publics' voice is integral in the decision making process when making changes to services or care delivery.	Implementation of Accessible Information Standard relating to communication and reasonable adjustments to improve Patient Experience	Objective 1: Relaunch and embed 5 key steps to ensure accessibility: 1. Ask; 2. Record; 3. Alert/Flag; 4. Share; 5. Act	A Task and Finish Group has been initiated to include key colleagues in the organisation as follows: - Patient Experience and Inclusion WHH - Director of Population Health & Inequalities WHH - Communication and Engagement Team WHH - Equality and inclusion BCH - Digital Services WHH • Key milestones to achieve as per attached action plan include: - Review and update current WHH Trust Accessible Information Standard Policy to ensure fit for purpose and inclusive of recent update to the standard which sees an additional sixth stage in the process. This policy will be a joint policy with Bridgewater. - Gap Analysis to take place utilising the national self-assessment framework. An action plan will be initiated to ensure compliance following delivery of the joint policy. - Communications plan for WHH	• Accessible Information standards have been updated to include a 6th stage. As below: - Identify - Record - Flag - Share - Meet - Review • Opportunity to collaborate with Bridgewater Colleagues. • Identified key subject headers to include in the policy/programme of work to include: - Branding - How do we record communication preferences - Health literacy - Environment and signage • Aligning with other workstreams to ensure consistency of AIS approach for example: – Wayfinding and First Impressions – directional and location signage - Patient Engagement Portal - patient letters Actions: Review and update Trust policy. To include Bridgewater: • Review policies from other Trusts to assess best practice (March 2026) Based on best practice and national standards update Trust Policy:	

Strategic Objectives - Quality	Strategic Priorities - Quality	KPI	Target	Current Measure	Commentary	RAG
				and BCH to include staff training, educational materials and policy launch. - Risk review on the programme and milestones.	• Engagement with key stakeholders completed November 2025. Gap Analysis to take place utilising the national self-assessment framework. An action plan will be initiated to ensure compliance: • Utilising self-assessment tool within the AIS standard. This will be presented to Patient Experience and Inclusion Sub Committee(PEISC) in Q4. Communications plan: • Launch to include details of the policy, the standard and staff training. Q4 Risk review on the programme: • Review any risk to the programme at each stage and update action plan for onward reporting – Reports to PEISC monthly by exception.	
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.	Increase Pathway to Research participants	250	328		
		Increased awareness of research across the Trust, evidenced through annual research survey.				
		Continue to operate as part of a wider research Board, embracing commercial, non-commercial and academic opportunities				
	4.2 We will further develop and grow our research capability through the application and selection for clinical trials.	Commercial studies will achieve minimum income target (approx. £600k) to sustain Halton Clinical Research Unit infrastructure with additional funding to invest in capacity and	£600k	£715,091.95 forecast		

Strategic Objectives - Quality	Strategic Priorities - Quality	KPI	Target	Current Measure	Commentary	RAG
		capability building initiatives.				
	4.3 We will develop staff across a range of disciplines as Principle Investigators to grow research capability within our workforce.	Annual increase in 20% of Principal Investigators.	Increase of 20% (+4 Principal Investigators) to 36	33		
	4.4 We will grow the academic research portfolio supporting staff recruitment and retention.	Formal arrangement established with Higher Education Institutes e.g. Chester Medical School, Edge Hill Faculty of Health			Warrington and Halton Teaching Hospitals, NHS Trust has scoped opportunities to partner with Higher Education Institutions (HEIs), including Edge Hill, John Moore's and Chester Universities, and through the Applied Research Collaboration Northwest Coast, to develop the academic research portfolio. Collaborations of this nature will enhance opportunities for WHH staff and patients to co-produce research proposals which meet the needs of the local population and secure the necessary funding to undertake that research.	

Table 4: Quality Strategic Priorities and Measures of Success December 2025 / January 2026 (H1 2025/26 Position)

An update on progress of the Strategic Priorities for the Quality aims was reported to SPC on 15th October 2025 as per the WHH Bi-Annual People Strategy Update.

Strategic Objectives - People	Strategic Priorities - People	KPI	Target	Current Measure	Commentary	RAG
5. Looking after our people: We will prioritise the safety, health, wellbeing and experience of	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.	Sickness Absence	< 6.77%	6.1%	The Supporting Attendance Policy has undergone multiple reviews since its launch in 2022, with a current review underway to align with best practice. A new Stage 3 absence process has been piloted and approved to support compassionate exits due to ill health. The Trust is actively contributing to the regional Improving Attendance Together initiative, aiming to reduce sickness absence by 1%. WHH's Chief People Officer is leading the regional policy work, supported by the Chief Finance Officer. A project plan and data analysis are in progress.	
		Welcome Back Conversation (WBC) Compliance	> 80.5	90.4%		

Strategic Objectives - People	Strategic Priorities - People	KPI	Target	Current Measure	Commentary	RAG
our people to ensure work has a positive impact.	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.	Occupational Health DNAs	< 109	57	The People Directorate has developed a WHH Improving Attendance Plan which has been designed to foster a supportive and healthy work environment. Its objectives include: • Enhancing employee wellbeing through systematic and compassionate approaches. • Reducing absenteeism with clear oversight and compliance. • Promoting a positive work culture with Board-level accountability. Key actions include: • Health and Wellbeing Promotion: Mental health responders, wellbeing champions, physiotherapy, OH services. • Absence Management: Data analysis, reduction targets, dashboard reviews, intervention packages. • Training: Stress risk assessments, OH referrals, leadership development. • Support Mechanisms: Phased returns, redeployment, belonging culture. • Policy Review: Compassionate language, updated triggers, alternative leave options. Supporting Attendance clinics have been delivered in collaboration with HR Business Partners and Clinical Business Units (CBUs), offering guidance on policy application and paperwork. In areas with high sickness and low Welcome Back Conversation (WBC) compliance, targeted coaching, audits, and communication campaigns have been deployed to support managers and staff. Occupational Health and Wellbeing triangulation meetings with HR colleagues to review and progress individual cases under the formal stages of the Supporting Attendance Management policy have been established to ensure cases are pro-actively managed. In addition, triangulation meetings support the identification of areas with high sickness and complex sickness cases. The OH Specialist Nurses have been continuing their training sessions with managers in these areas. The Mental Health and Wellbeing team have implemented a new triage system, a Stratified Step Model, with the aim of improving staff resilience through signposting, self-help and group sessions (Rugby League Cares are supporting these), freeing capacity to support complex cases. The Trusts wellbeing initiatives are being revamped to ensure they are embedded throughout the Trust to further strengthen the organisation's commitment to staff wellbeing and ensure consistent access to support with greater emphasis on self-help/signposting. This will include resources and support for topics such as menopause, men's health, sleep and vaccinations. This approach aligns to NHS England recommendations for health and wellbeing as part of the annual diagnostic assessment.	

Strategic Objectives - People	Strategic Priorities - People	KPI	Target	Current Measure	Commentary	RAG
					As part of the annual diagnostic assessment, a review of the Mental Health First Responders (MHFR) role is currently underway, which will include the role of Culture Champions to identify opportunities to maximise the impact of both roles.	
		Recognised and Rewarded	6.1	6.1	Significant elements of this strategy are embedded into the We Are WHH Culture Plan and will be updated in the We are WHH Culture update. Exit interview data is now analysed to identify trends and inform action, with insights available to managers via the Workforce Dashboard. A review of the leavers process is underway, including a new SOP for stay conversations and an appraisal of the exit interview approach. Wellbeing initiatives continue to expand, including Rugby League Cares support, Grief and Menopause Cafés, and financial wellbeing tools like Wagestream. These efforts help staff stay well and feel supported at work. The #MYFlex campaign promotes agile working, with preference rostering launching on two wards in January 2025. A central system now tracks flexible working requests, improving visibility and responsiveness. Recruitment has been strengthened through VCP panels, enhanced events, investment in TRAC, and improved benefits. Internal mobility and collaboration with Bridgewater are also being promoted. The Widening Participation Team supports recruitment from the local community and promotes apprenticeships to aid development and retention. Social media is being used to boost attraction. Wellbeing offers are well used, and apprenticeship completion exceeds the 2.3% target. Exit interview feedback is largely positive, with flexible working identified as a key area for improvement.	
		Time to Hire	< 75.5	67		
		Turnover	< 16.5%	11.4%		
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.	Agency Reliance	<5.6%	0.9%	The KPIs linked to enabling new ways of working have all improved since 2022, highlighting success of the actions completed relating to improving this People Promise. The Trust has refined reports relating to workforce planning, which has improved the approach to the 2025/26 workforce planning national submission. The improvements have enabled greater oversight of the temporary staffing workforce, thus empowering the Care Groups and Corporate areas to review their temporary staffing usage. This has directly led to further reduction of agency usage and a reduction in vacancies through substantive recruitment and establishment reviews. The #myFLEX campaign aims to both highlight the importance of a flexible workforce and support with education for leaders. The rollout of the e-preference rostering pilot continues to progress, with two additional wards, A5 Elective and A5 Gastro, successfully going live in September 2025. Initial feedback from these launches has been extremely positive, reflecting strong engagement and satisfaction among staff. Building on earlier implementations in ACCU and B19, which went live earlier in 2025, lessons learned are being actively applied and adopted as part of	
		Vacancy Rate	<9%	6.7%		
		We Work Flexibly	>6.1	6.4		

Strategic Objectives - People	Strategic Priorities - People	KPI	Target	Current Measure	Commentary	RAG
	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.				wider rollouts. The programme is being reviewed through a quality, people and sustainability lens, with ongoing monitoring at the two-weekly steering group to ensure continuous improvement and alignment with organisational objectives. Looking ahead, further wards are being scoped for development within the pilot and work is progressing towards an NHS Charities Together bid to secure technical support for the broader rollout of preference rostering across the Trust. This initiative is particularly focused on supporting areas with more complex rostering requirements, such as the Emergency Department, and aims to deliver a more flexible and responsive approach to workforce management across all services.	
		Applicant Numbers	>11,803	26,128	The KPIs linked to empowering the workforce to change have all improved since 2022, highlighting success of the actions completed relating to improving this people promise. The Widening Participation team have successfully embedded a supported internship programme and are working directly with BCHT colleagues to maximise the use of the apprentice levy, whilst developing future plans for apprenticeships and a structured work experience placements across both organisations to engage with the future workforce. The numerous health and wellbeing offers, many which are quoted with this paper, demonstrate the importance placed on retaining a highly skilled workforce, especially during times of change. Retention rates consistently above the 85% minimum expectation highlight the success of our various offers for staff.	
		Apprentice Levy % Uptake	>3.2%	3.4%		
		Retention	>83.7%	88.1%		
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.	CSTF Compliance	>84.9%	90.5%	Two of the KPIs linked to supporting and developing our teams and individuals have improved since 2022 and the third, role specific training compliance, remains above the Trusts minimum expectations of 85% compliance, highlighting success of the actions completed relating to improving this people promise In line with the national Statutory and Mandatory Training programme, the Trust has reviewed all core skills training and ensured all the existing offers align to the national Core Skills Training Framework (CSTF) standards.	
		Role Specific Compliance	>91.3%	90.5%		
		We are a Team	>6.7	6.9		
		AfC Appraisal Compliance	>62.1%	81.6	The KPIs linked to harnessing the talents of our staff have either improved since 2022 or had no change. The two KPIs relating to appraisals remain below the Trust minimum expectation of 85%. It is acknowledged that for medics' appraisals, a separate system is utilised which has reported over 90% compliance. Differences between the two systems are understood and the Trust is working with external organisations to account appraisals for Foundation Doctors and Doctors where the Trust is not their responsible officer.	
		Medical Appraisal Compliance	>70%	78.3%		
		Engagement	6.9	6.9		

Strategic Objectives - People	Strategic Priorities - People	KPI	Target	Current Measure	Commentary	RAG
	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. 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	Employee Negative Experience	>7.8	7.9	Significant elements of this strategy are embedded into the We Are WHH Culture Plan and will be updated in the We are WHH Culture update. The Trust continues to take an informal approach to resolving workplace issues in line with the associated policy. This approach is supported by the access and investment in the Trusts internal mediation service which is available to all staff to access. On 1st April 2025, the new and improved Disciplinary Policy was launched and went live on the intranet. A fundamental change to the policy is the introduction of a 'Fact Finding' and Preliminary Investigation process into the policy. This is a decision making tool for all incidents in order to conduct a 72-hour review process which is designed for a swift yet thorough assessment of a disciplinary incident. It emphasizes integrity, fairness, transparency, accountability, and learning as outlined in Dido Harding's principles. This ensures that incidents are addressed effectively while fostering trust and confidence within the organisation. The key points of this process are: • Once an allegation has been made there is a need to gather evidence in the first instance. • This will be assessed against the Disciplinary Policy to identify what the breach/allegation is. • The process will determine if there are interim actions that need to be taken for instance suspension, action short of suspension. • To raise an OH referral for the individual.	
		Compassionate and Inclusive	>7.3	7.4		
		Have a Voice that Counts	>6.1	6.3		

Strategic Objectives - People	Strategic Priorities - People	KPI	Target	Current Measure	Commentary	RAG
	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.				• Convene a decision-making panel that will assess next steps. • The decision will then be communicated to the individual. In order to support the new process, the HR Business Partnering team will guide managers through the policy and process. Additionally, the launch of the policy will enable a test of change process therefore the policy will be reviewed post 6-month implementation to enable learning from the launch and practical application of the policy to ensure continuous improvement. All supporting documentation is available on the intranet including the policy along with processes and handbooks for those staff that are involved in part of an investigation. In order to respond to staff voice and more specifically the results of the 2024 annual Staff Survey, analysis of the results has been completed and an action plan developed for 2025/26. Updates will be reported via the We Are WHH Culture Plan update.	
		ER - Grievances	<9	8	In order to support the implementation of PSIRF, the standards identified relating to people processes have been embedded into the refresh of the disciplinary and employee relation processes to continue to ensure opportunities to learn from incidents. This has also resulted in additional commissioning of Investigating Officer and Case Manager training which took place in Q3 2024/25. The continued emphasis on Freedom to Speak Up (FTSU), resolution of workplace matters, and promoting a culture in which staff feel empowered to raise concerns has led to an increase in the number of issues being addressed through the Trust's Resolving Workplace Issues Policy (formerly the Grievance Policy). A strategic priority for 2025/26 is to enhance the use of informal resolution mechanisms within the policy framework, with the aim of addressing concerns at an early stage and reducing the need for formal grievance procedures. The Trust has also expanded the membership of the Policies and Procedures group to include OD practitioners to ensure an OD dialogic approach is embedded into policies and reflects opportunities for reflective learning aligned to the commitments outlined in the We Are WHH culture plan. Linked to OD interventions and learning opportunities, the second cohort of the Your Future, Your Way programme for ethnically diverse nursing and AHP staff has been implemented with cohort three set to expand to all staff groups from an ethnically diverse background to support the actions identified in the Workforce Race Equality Standard report for the organisation. Progress has also been made regarding the organisation's approach to zero tolerance with the implementation of a new zero tolerance campaign with executive sponsorship and imagery across the organisation, this was	
		Morale	>5.9	6.2		
		We are Always Learning	>5.1	5.8		

Strategic Objectives - People	Strategic Priorities - People	KPI	Target	Current Measure	Commentary	RAG
					further strengthened through robust supportive communications in response to the civil unrest in Q2 2024/25 across the country.	

Table 5:People Strategic Priorities and Measures of Success September 2025 (H1 2025/26 Position)

An update on progress of the Strategic Priorities for the Sustainability aims was reported to FSC on 20th October 2025 as per the Sustainability Strategic Objectives Bi-Annual Report.

Strategic Objectives	Strategic Priorities	KPI	Target	Current Measure	Previous Measure	Commentary	RAG
9. Working in partnership	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 waiting 52 weeks will be **X** by March 2026	0 (by March 2026)	1,497 (Month 5)	1,930 (Month 5 2024.25)	Improvement in position year-on-year although 52 week performance remains behind trajectory. 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.	Amber
	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	Delivery of strategic projects	Narrative	The Trust is embedded within a number of projects at place and region, including the development of neighbourhood models across both Warrington and Halton. We continue to work with system partners on a number of projects aimed at reducing health inequalities, including the NHS C&M Prevention Pledge and One Halton Wider Determinants of Health (Place) among others. Runcorn Town Deal Hub construction programme underway. Building handover expected December 2025 and service go live early 2026. CDC Phases 1, 2 and 3 now complete and operational - since Phase 1 opened in May 2023, more than 100,000 additional tests have been undertaken across the three phases. More than 30,000 people have attended the Warrington Living Well Hub since it opened in March 2024.			Green

Strategic Objectives	Strategic Priorities	KPI	Target	Current Measure	Previous Measure	Commentary	RAG
	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	Proactively review repatriation opportunities at service level.	Increase	Outpatient market share: 50.5% Elective market share: 47.4%	OP: 49.0% Elective: 45.2%	The Trust continues to work in partnership with local providers to develop opportunities for repatriation and improved patient experience through local treatment, weighed against the requirements of elective recovery. Work is ongoing with Alder Hey around paediatric repatriation via Warrington Hospital. Further opportunities to maximise the Halton elective capacity will be explored as the TIF project completes.	Amber
	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	Increased number of clinical appointments in off-site locations	Increase	38,750 (12 months to August 2024) (new OP appointments)	34,468	The Trust continues to realise opportunities across our boroughs, as evidenced through the partnership working undertaken to produce the Living Well Hub and Living Well online across Warrington and the Well Runcorn Hub in Runcorn Town Centre. The integration programme will enable further opportunities to enhance how and where the Trust delivers care, as demonstrated through the Dermatology AI project within Halton Health Hub at Runcorn Shopping City.	Green
	9.5 We will work with partners across our places to enhance the resilience of our Urgent and Emergency Care system, improving patient experience	Type 1 and Type 3 4hr Performance	78% (March 2026)	67.42% (Month 5)	69.43% (Month 5 2024.25)	Deterioration in position year-on-year, and performance continues to be negatively impacted by wait to be seen in ED, long length of stay and a overall high bed occupancy. • System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity in order to support flow. • More intensive support has been provided by the senior leadership to support a reduction in wait to be seen and time to treatment which will support the 4 hour compliance • A review of the ED staffing model to realign rota's with demand using the ECIST methodology has been completed	Amber
	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	Delivery of integration programme	Narrative	The integration programme is ongoing, with a planned transaction date of 1/4/2025.			Green

Strategic Objectives	Strategic Priorities	KPI	Target	Current Measure	Previous Measure	Commentary	RAG
10. Working responsibly	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 Warrington and Halton Places to develop maturity and deliver Core20PLUS5 objectives	Narrative	The Trust is heavily involved in workstreams internally and across One Halton and Warrington Together that specifically target the improvement of health inequalities as per the CORE20Plus 5 approach. These include: Integration joint health equity group has been established to bring together the health inequalities work of both organisations Joint health equity workshops are taking place with both organisations New EHIA tool adopted across both organisations Quality impact assessments include the EHIA tool Joint programmes of work Making Every Contact Count (MECC) Health literacy Using population health management approaches – initially on respiratory The partnership approaches around delivery of Warrington Living Well Hub and Well Runcorn Hub, both of which have been developed to specifically target and improve population health outcomes through early intervention and preventative approaches. Living Well Virtual Hub New Living Well Virtual Hub for Warrington place launched in March 2025 in partnership with stakeholders across Warrington The new virtual hub will strengthen the offer around prevention, early intervention and empowering self-care through a “community-led” approach The new platform will empower users to navigate their health and wellbeing journey more independently and become the single digital entry point for any health and wellbeing-related enquiries for the public of Warrington Phase 2 will focus on growing the network and providing tools (such as online social prescribing) for better targeting and supporting health needs of local population groups It will support improving health outcomes, reducing inequalities and help reduce future demand and pressure on statutory health and care services across the Borough To date: 300 new members to platform, 570 live activities, 6,000 active users, 35,000 page views Workforce Inequalities Mental health and wellbeing- supporting counselling placements within mental health wellbeing hub to support staff Occupational health and support- occupational health pre-employment process updated to reflect workforce needs aligned to the workforce equality and diversity and inclusion strategy Reasonable adjustments- signposting to Maximus, an access to work mental health provider to support individuals with long term mental health conditions. Implemented a passport to support staff with the resources to remain in work and thrive Prevention programmes- multiple prevention programmes and packages delivered focused on cardiovascular disease, menopause, mental wellbeing and musculoskeletal conditions			Green

Strategic Objectives	Strategic Priorities	KPI	Target	Current Measure	Previous Measure	Commentary	RAG
	10.2 We will identify opportunities to reduce the Trust's consumption of resources in order to reduce CO2 emissions.	Heat decarbonisation plan? Reduction in CO2 emissions	Narrative	Across the past 12 months the Trust has fitted over 2000 LED Smartscan lights, saving annual energy costs of circa £274k and CO2 reductions of 219,000 kg CO			Amber
	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 staff employed locally; job creation; increase footfall to town centre locations'	65.2% staff reside in Warrington or Halton (4,713 headcount) as per October 2025, against 68.0% (4,772 headcount) in November 2024. To date more than 60,000 patient at our town centre venues	The Trust has secured funding for additional community roles in Warrington as part of the Warrington Living Well Hub. The Trust continues to lead the development of the £3million Well Runcorn Hub project, and is involved in other discussions around local investment, including Widnes town centre and Hulme.			Green
	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 Assessment criteria for environmental impact included in capital project proposals	Narrative	No live opportunities for green-related projects ongoing, and funding opportunities are being assessed when available. Methodology for capturing information needed to calculate carbon/environmental impacts developed to ensure robust calculations and like-for-like comparisons. A formal request to delay a refresh to the Trust's Green Plan will be submitted to NHS C&M, with the intention to create an integrated Green Plan post-transaction April 2026. The Trust's current Green Plan would be extended through 2026 with monitoring to continue as per current practice.			Amber

Strategic Objectives	Strategic Priorities	KPI	Target	Current Measure	Previous Measure	Commentary	RAG
	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.	Narrative	The Trust is fully engaged with the NHS C&M Prevention Pledge programme as a phase 1 early adopter in 2022. The delivery plan for 2025/26 has been updated following a light-touch examination of expected outcomes and projects ongoing, with the creation of a fully integrated programme across acute and community to be produced following the integration of WHH and BCH. A core focus for Prevention Pledge across 2025/26 is MECC (Making Every Contact Count).			Green
11. Sustainable Estate and digitally enabled service models	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 communicatio ns plan. Explore alternative funding options to deliver new hospitals and estates enablers.	Narrative	The Trust have engaged with Kier Construction to refresh a Trust-wide strategic estate masterplan. This will consider community estate opportunities as made possible through the integration programme. Support for our strategic estates programme is governed through the newly-revised Acute & Community Healthcare Integration & Strategic Estates, Warrington & Halton Group which includes membership of local MPs, councillors and leaders of local public sector organisations. Potential for future funding streams and mechanisms to be described through the Autumn Budget, expected November 2025.			Green

Strategic Objectives	Strategic Priorities	KPI	Target	Current Measure	Previous Measure	Commentary	RAG
	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 Runcorn Health and Education Hub Deliver Trust Capital Programme Work with partners at Place and C&M to maximise public sector estate utilisation	Narrative	Halton Community Diagnostics Centre (CDC) A £17 million investment via DHSC to create three new diagnostics areas within Halton (Phase 1 – Nightingale Wing; Phase 2 – Halton Health Hub at Runcorn Shopping City; Phase 3 – Captain Sir Tom Moore). From phase 1 opening in May 2023, more than 100,000 additional diagnostic tests have been undertaken in these facilities. Warrington Living Well Hub A £2.7 million investment via HJM Government's Town Deal Programme to create an accessible space within Warrington Town Centre with a focus on ill-health prevention, early intervention and promoting self-care. The programme is truly multi-agency and focuses on different population cohorts on different days of the week. Attendances at the Living Well Hub have passed 30,000 since the facility opened in March 2024 6.4 Halton Elective Care Centre An investment totalling £14.2 million to upgrade the elective care provision offered at Halton General Hospital. Elements of the project include creation of a new theatre and day case unit (opened May 2024) on site at the Captain Sir Tom Moore building (CSTM), redevelopment of theatres at the Nightingale building (due 2025) and creation of a dedicated endoscopy hub (opened September 2025). An estates workstream is established within the Better Care Together programme and is developing work around best use and optimisation of estate, alongside system work led by NHS C&M at both Halton and Warrington Places.			Green
	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.	Smart Foundations 4.6	3.3	3.3	WHH DMA score shows a slight decrease compared to 2024/25. This apparent discrepancy is explained by the inclusion of several new and non-comparable items in the latest assessment. The shift in scoring reflects an expanded and more comprehensive evaluation framework, rather than any decline in performance. • 8% of the domains are entirely new additions • 8% are existing domains from last year that previously did not generate a score (e.g., DDaT workforce) • 14% are 2024 domains that have undergone significant revisions (e.g., AI, Empower Citizens)	Green

Strategic Objectives	Strategic Priorities	KPI	Target	Current Measure	Previous Measure	Commentary	RAG
	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 though Patient Held Records (PHRs) and smartphone Apps, enabling patients to take an active role in their healthcare.	Empowering Citizens	Empowering Citizens 4.1	2.9	3.4	WHH DMA score shows a slight decrease compared to 2024/25. This apparent discrepancy is explained by the inclusion of several new and non-comparable items in the latest assessment. The shift in scoring reflects an expanded and more comprehensive evaluation framework, rather than any decline in performance. • 8% of the domains are entirely new additions • 8% are existing domains from last year that previously did not generate a score (e.g., DDaT workforce) • 14% are 2024 domains that have undergone significant revisions (e.g., AI, Empower Citizens)	Green
12. Finance sustainability	12.1 We will deliver the Trust's agreed financial plan.	Achievement of CIP programme	£16.8m deficit subject to audit for the year ended 31 March 2025	Trust is on plan with a deficit of £22.1m before deficit support funding at Month 6.	£28.7m deficit (before deficit support funding)	There is significant risk to achieving the 2025/26 plan. The Trust has submitted a risk adjusted forecast of £41.8m which is £13.1m worse than plan. This is mainly driven by non-achievement of level 3 CIP schemes (£11.3m). The remainder is based on risk assumptions applied by the ICB on the Trust's CIP schemes based on delivery status (£1.8m).	Amber
		Achievement of agreed financial plan	CIP performance for 2024/25 was £18.5m against a £19.4m target (£12.6m recurrent)	CIP performance at Month 6 is on plan at £8.8m (£4m recurrent)	£21.5m	Within the £21.5m target, there is high risk of £5.4m mainly relating to productivity schemes and workforce reduction.	
	12.2 We will participate, lead and contribute to system wide procurement to drive increased efficiencies and benefits.	Actively participate and contribute to the development of procurement within the ICS.		WHH Procurement are members of the C&M Procurement Collaboration at Scale group and attend monthly meetings. The group, led by Sue Colbeck (Chief Procurement Officer) develop and deliver a C&M Procurement workplan for collaborative projects and delivery of CIP. WHH Procurement are involved in all projects and opportunities. There are also a number of sub groups – clinical consumables group (in conjunction with NHS Supply Chain), a data working group, Procurement delivery group all of which WHH Procurement leads attend and contribute to, to drive efficiencies locally and regionally.			Green

Strategic Objectives	Strategic Priorities	KPI	Target	Current Measure	Previous Measure	Commentary	RAG
	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	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 2023/24 and is in receipt of cash support from NHSE.	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 is forecasting to be £13.1m worse than plan in 2025/26 and remains in receipt of cash funding, it is expected that the rating for Financial Sustainability will be red again for 2025/26. The report will be received in June 2026.	Red
	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	Consider opportunities as they arise	New Metric	Private patients still on hold. Wholly owned subsidiary is not currently viable. Continue to increase R&D. Consider opportunities with integration	TBC	Trust focus remains on recovery, integration and performance targets. Further discussion on commercial opportunities to be taken to the Board as they arise.	Amber
	12.5 We will deliver improvements to Trust productivity	Implied productivity level as per NHS Oversight Framework	New Metric	3.15% 2024.25 vs 2023.24		New metric for 2025.26 report. As per NHSE, the Trust ranks 59th of 134 acute and specialist Trusts within England. N.B. The Trust are still working through verifying the NOF data and have queries currently outstanding.	Green

Table 6: Sustainability Strategic Priorities and Measures of Success October 2025 (H1 2025/26 Position)

3. MONITORING/REPORTING ROUTES

The monitoring and reporting route for the Trust Strategy is described in the diagram below:

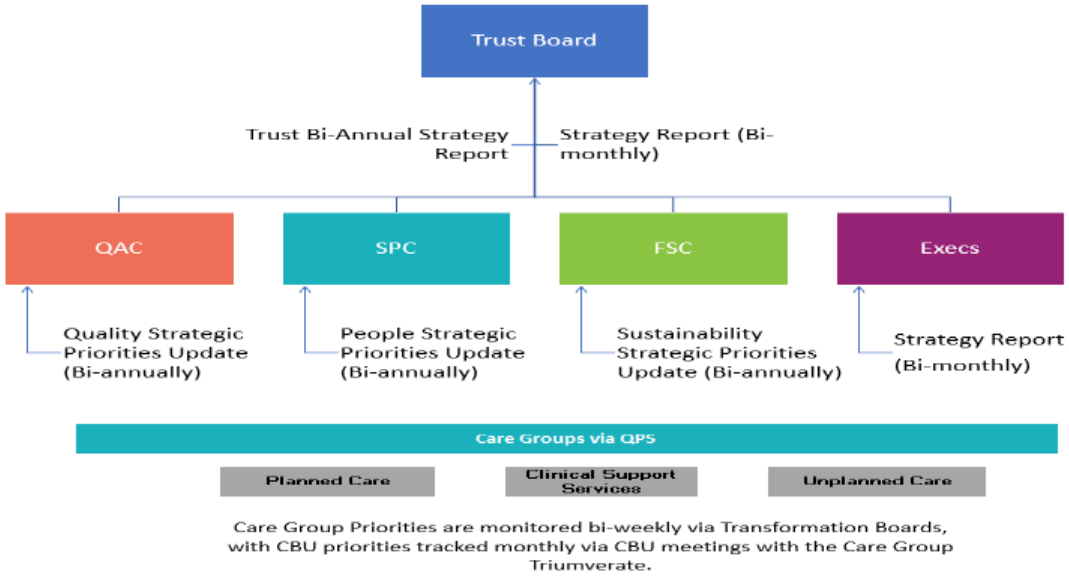

Figure 2: Monitoring and reporting arrangements for Trust Strategy 2023-25, extended through to 2026

4. TIMELINES

A joint strategy for the integrated organisation is currently in development with adoption expected at the end of 2026.

Whilst the new strategy is in development, an interim strategy will be adopted by the new organisation from the date of the acquisition for the remainder of 2026. The interim strategy is based on the existing WHH strategy, which has been formally extended and approved by both WHH and BCH Boards with some amendments to reflect the priorities of BCH and opportunities realised through the integration.

Amendments to the WHH strategy include a change to the mission statement, which now states the ambition to be exceptional, our vision statement which previously referred to a great ‘place’ to receive healthcare and now refers to a great ‘organisation providing healthcare’. Similarly, all three aims have had amendments to wording to incorporate phrases currently familiar within the BCH strategy as illustrated in figure 15.

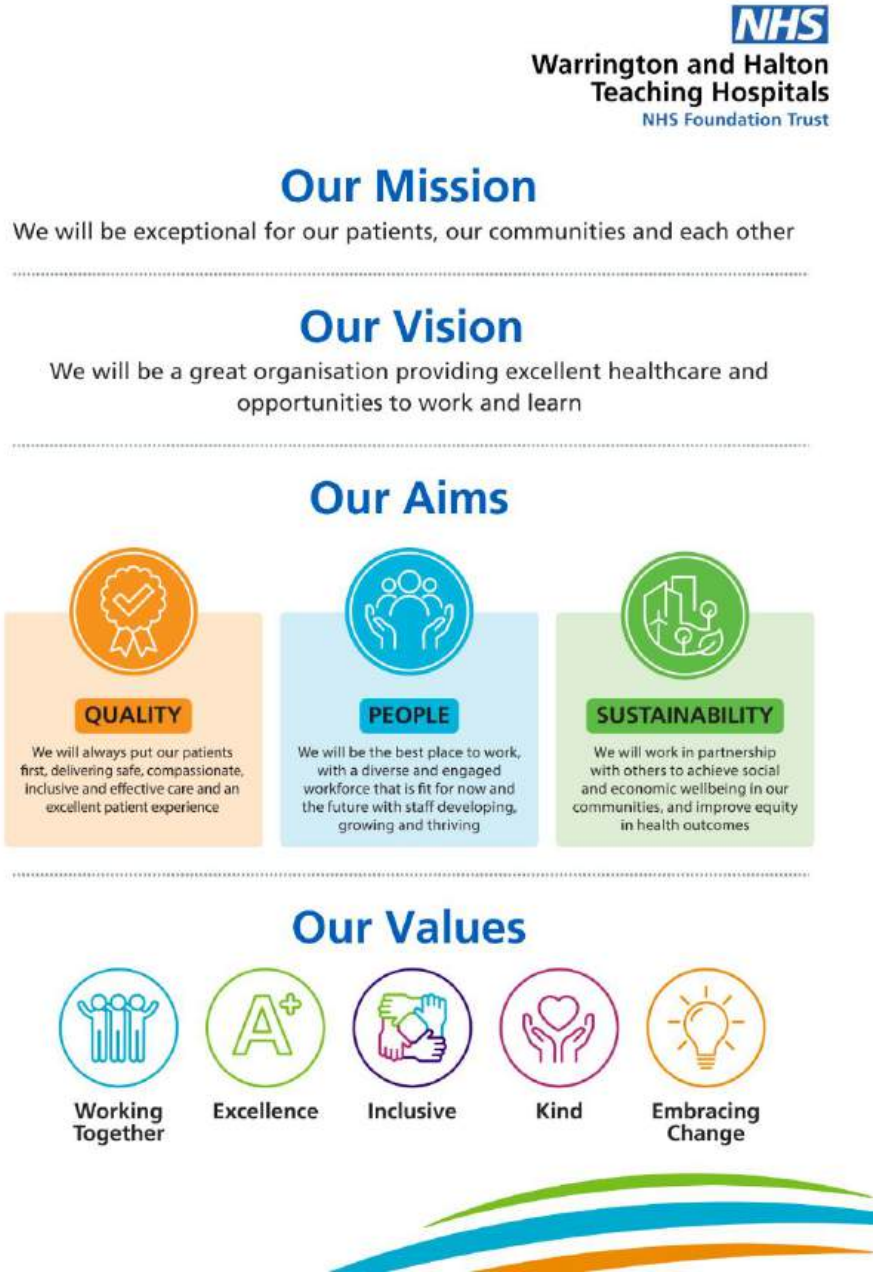

Figure 3: : Amended WHH organisational strategy

As part of the interim strategy for the integrated organisation, the current WHH strategic objectives will be adopted in the short term with one minor amendment to include belonging in 'our organisation' rather than belonging in WHH. Figure 16 below details the existing strategic objectives that are framed around the three strategic domains: quality, people and sustainability. These strategic objectives align to both WHH and BCH's existing strategies.

Figure 4: Amended interim strategic objectives

KPIs to monitor progress of delivery against the interim objectives for 2026/27 will be developed and approved via the governing committees for each domain of the strategy. Progress will be reported back to Board through the H2 update on Strategy Delivery, expected after June 2026.

5. ASSURANCE COMMITTEE

All as noted above.

6. RECOMMENDATIONS

Trust Board are asked to:

1. Note progress against the delivery of the Trust Strategy 2025/26 through the Strategic Priorities across Quality, People and Sustainability aims
2. Note the arrangements in place to report on delivery of the Trust's strategic objectives across 2026/27

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/26/02/162**			
SUBJECT:	**Quality, Safety and Assurace Committee in Common Terms of Reference and Cycle of Business**			
DATE OF MEETING:	**4 February 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):	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 services remain fragile or the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards. 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. **1757:** If industrial action takes place, then there is a risk of significant workforce gaps across critical services, which may disrupt operational service delivery and compromise the Trust's ability to maintain safe, effective, and timely patient care.			
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 Quality, Safety & Assurance Committee in Common (the "Committee"), as detailed in the attached Terms of Reference (Version 1), effective February 2026). The Committee will enhance collaboration, strategic alignment, and efficient decision-making, and support the Trusts' journey toward integration, 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 and Cycle of Business for the Quality, Safety & Assurance Committee in Common (Version 1), effective February 2026. 2. Note the Committee's review schedule			
PREVIOUSLY CONSIDERED BY:	**Committee**	Committee		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome	Supported		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None			

REPORT TO TRUST BOARD

SUBJECT	Quality, Safety and Assurace Committee in Common Terms of Reference and Cycle of Business	AGENDA REF:	BM/26/02/162

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 Quality, Safety & Assurance Committee in Common (the "Committee"), as detailed in the attached Terms of Reference (Version 1, effective February 2026). The Committee will enhance collaboration, strategic alignment, and efficient decision-making, and support the Trusts' journey toward integration, 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 Quality, Safety & Assurance Committee in Common is established to enable collaboration, shared oversight, and aligned decision-making on all aspects of quality, patient safety, clinical effectiveness, patient experience, and quality governance across Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCHT).

The Committee will provide assurance to both sovereign Trust Boards that high-quality, safe and effective care is being delivered and that quality strategies and governance arrangements support the Trusts' progression toward integration.

The CiC replaces the existing WHH Quality Assurance Committee and BCHT Quality and Safety Committee 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 two Non-Executive Directors (one serving as Chair per meeting location), Joint Chief Nurse and Joint Executive Medical Director and other joint roles such as the Joint Chief Operating Officer, Director of the Deliver Unit as well WHH and BCH roles such as but not limited to, Chief People Officer, Director of People and Organisational Development, Chief Strategy and Partnerships Officer Chief Finance Officer/Director of Finance, ensuring cross-Trust representation.

Quorum: Requires four members: two from each Trust, including one Non-Executive Director per Trust and the Joint Chief Nurse (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. maintaining flexibility for unilateral decisions if needed.

Authority: Authorised 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.

Duties: Provides strategic oversight and assurance on Quality Governance, Risk, Deep Dives & Performance Insight, Patient Safety & Investigations, Clinical Effectiveness, Patient Experience Staff Safety, Culture & Workforce-Related Quality Learning, Policy & Action Planning, Regulatory Compliance & External Requirements**,** Governance Structures & Connectivity Quality Accounts & Statutory Reporting

Benefits and Alignment

The CiC will:

- Enhance coordination, transparency, and shared scrutiny of quality governance, patient safety, clinical effectiveness and patient experience across both organisations ahead of integration.
- Provide a unified mechanism for identifying and managing quality-related risk 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 Quality, Safety and Assurance Committee in Common (Version 1), effective February 2026.

2. Note the Committee's review schedule

TERMS OF REFERENCE
QUALITY, SAFETY & ASSURANCE COMMITTEE IN COMMON

1. PURPOSE

The Quality, Safety & Assurance Committee in Common (the *Committee*) is established to enable collaboration, shared oversight, and aligned decision-making on all aspects of quality, patient safety, clinical effectiveness, patient experience, and quality governance across Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCHT).

It oversees the implementation and effectiveness of the integrated quality governance framework, ensures compliance with statutory and regulatory standards, and scrutinises risks, performance, learning and improvement activity across both organisations.

The Committee provides assurance to both sovereign Trust Boards that high-quality, safe and effective care is being delivered and that quality strategies and governance arrangements support the Trusts' progression 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)
- Joint Chief Nurse
- Joint Executive Medical Director
- Joint Chief Operating Officer and (Deputy Chief Executive WHH)
- Chief Finance Officer (WHH)
- Joint Director of Delivery Unit (Deputy Chief Executive BCHT)
- Chief People Officer
- Chief Strategy & Partnerships Officer
- Director of Communications & Engagement
- Company Secretary
- Deputy Chief Nurse & Director of Clinical Governance
- Deputy Medical Director
- Chief Pharmacist
- Director of Midwifery & Associate Chief Nurse /Midwifery Safety Champion Lead
- Associate Director of Quality

3.2 Membership of the BCHT Committee will comprise of:

- Two Non-Executive Directors (to include Committee Chair for meeting held at Bridgewater)
- Joint Chief Nurse

- Joint Executive Medical Director
- Joint Chief Operating Officer and (Deputy Chief Executive WHH)
- Joint Director of Delivery Unit (Deputy Chief Executive BCHT)
- Director of Finance (BCHT)
- Director of People and Organisational Development (BCHT)
- Deputy Chief Nurse

Attendees

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

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

Quality Governance, Strategic Oversight & Assurance

- Monitor delivery of quality objectives as set out in each Trust's Quality Strategy and associated KPIs, ensuring alignment with organisational mission, vision and strategic priorities.
- Oversee the development, implementation and impact of enabling strategies relating to quality, including Quality Strategy, Risk Management Strategy, Clinical Effectiveness, Patient Experience, and Quality Improvement.
- Provide assurance that governance arrangements across both Trusts support safe, effective, compassionate and continuously improving care.

Risk, Deep Dives & Performance Insight

- Receive and scrutinise quality dashboards, IPR/ IQPR data, and thematic performance reports to provide assurance on all aspects of care quality, patient safety, patient experience and regulatory compliance.
- Commission and receive Deep Dive Reviews into key quality risks or areas of concern, including Serious Incidents and monitor delivery of related actions.
- Initiate additional reviews where Committee-led analysis indicates emerging risks or trends.
- Ensure effective escalation of quality concerns into sRisk Register and Board Assurance Framework of each Trust.

Patient Safety & Investigations

- Ensure each Trust maintains an appropriate incident reporting and investigation framework, including Mortality Review processes consistent with the Royal College of Physician's Structured Judgement Review methodology.
- Seek assurance that incident investigations, complaints, claims and learning reviews are undertaken to a high standard and that lessons learned are embedded across both organisations.
- Monitor delivery of national patient safety actions, statutory duties and summit recommendations.

Clinical Effectiveness

- Approve and oversee the Clinical Audit and Research Programmes for both Trusts, ensuring findings are acted upon and drive improvement.
- Monitor compliance with NICE guidance, external accreditation requirements and internal audit recommendations, ensuring appropriate remedial action where gaps exist.

Patient Experience

- Receive and scrutinise patient experience intelligence including complaints, compliments, survey results, patient involvement activity and equality considerations.
- Ensure patient voice, engagement and co-production influence service improvement and strategic quality priorities.

Staff Safety, Culture & Workforce-Related Quality

- Receive assurance regarding staff safety, safeguarding, training, wellbeing and other workforce-related quality risks that may impact patient care.
- Ensure links between workforce strategies and quality outcomes are clearly established and monitored.

Learning, Policy & Action Planning

- Ensure robust frameworks exist for policy development and review, staff training and organisational development relating to quality, safety and governance.
- Provide oversight of action plans arising from internal and external reviews, regulatory inspections, investigations and risk assessments—ensuring progress, escalation and sustained improvement.
- Oversee system-wide learning processes across both organisations so that aggregated insights lead to improvements in practice and reductions in avoidable harm.

Regulatory Compliance & External Requirements

- Obtain assurance on ongoing compliance with Care Quality Commission (CQC) registration requirements and other statutory and contractual obligations.
- Oversee implementation of recommendations arising from national inquiries, regulatory reviews, external inspections and significant audit findings.

Governance Structures & Connectivity

- Receive assurance that all reporting sub-committees across both Trusts have effective reporting lines, business cycles and escalation mechanisms.

Quality Accounts & Statutory Reporting

- Monitor processes for producing each Trust's annual Quality Account and provide assurance before submission to Audit Committees and Trust Boards.
- Review Committee assurance reports and support both Boards in fulfilling their responsibilities for quality.

Board Escalation

- Alert each Trust Board to emerging or significant concerns regarding standards of care, patient safety or quality governance, and advise on required actions.

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:

- 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
- Quality Compliance Oversight Group
- Research & Oversight Suc-Committee

BCHT:

Groups reporting to this Committee

- Quality Council
- Risk Management Council

Groups reporting to the Quality Council

- Corporate & Clinical Policy Group
- Education Governance
- Infection Prevention & Control
- Medical Devices
- Medicines Management
- Patient Safety Incident Review Group
- Research & Clinical Audit
- Resus Advisory Group
- Safeguarding & Risk Assurance – by exception and the Annual Report
- Serious Incident Review Panel
- Time to Shine

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 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.

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.

TERMS OF REFERENCE
REVISION TRACKER

Name of Committee:	Quality, Safety & Assurance Committee in Common
Version:	V1
Implementation Date:	January 2026
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:**

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

QUALITY ASSURANCE COMMMITTEE
CYCLE OF BUSINESS 2025-2026

CALENDAR YEAR (APRIL 2025 - MARCH 2026)				2025										2026			
Item	**Reporting Frequency**	**Process**	**Lead**	**08-Apr**	**13-May**	**10-Jun**	**08-Jul**	**Extra 31-Jul**	**12-Aug**	**09-Sep**	**14-Oct**	**11-Nov**	**09-Dec**	**13-Jan**		**10/02/2025 CiC**	**10/03/2026 CiC**
STANDING AGENDA ITEMS																	
Welcome, apologies, declarations, cycle business, rolling attendance log	Monthly	**Noting**	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Review Minutes and Action Log	Monthly	**Approval**	Chair	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
OPENING AGENDA ITEMS																	
Patient Story	Bi-Monthly	**Noting**	Dep Chief Nurse		✓		✓			✓			✓ defer Nov	✓ defer Dec			✓
Deep Dive	Monthly	**Assurance**	Chief Nurse	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
Compliance Update (WHH)	Quarterly	**Assurance**	Chief Nurse/Dep Dir Gov		✓Q4 deferred	✓Q4			✓Q1			✓Q2				✓ Q3	
Hot Topics	Monthly	**Assurance**	Chief Nurse	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
COMPLIANCE & OVERSIGHT																	
Quality IPR Metrics (WHH)	Bi-Monthly	**Discuss & Assurance**	Chief Nurse	✓		✓			✓		✓		✓		Committee in Common	✓	
IQPR (BCH)	Bi-Monthly	**Discuss & Assurance**	Joint Chief Nurse/ Joint Chief Operating Officer													✓	
UEC Update	Monthly	**Assurance**	Chief Strategy & Partnerships Officer									✓	✓	✓		✓	✓
Review and Refresh of Trust KPIs	Annually	**Discuss & Assurance**	Chief Nurse							`							✓
MATERNITY UPDATE																	
Cheshire & Merseyside Perinatal Mortality Report (PMRT)	Quarterly	**Assurance**	Director of Midwifery		✓Q4				✓Q1			✓Q2			Committee in Common	✓ Q3	
Avoiding Term Admission into Neonatal Unit (ATAIN)	Quarterly	**Assurance**	Director of Midwifery			✓Q4				✓Q1			✓Q2				✓ Q3
Perinatal Mortality Report	Annually	**Assurance**	Director of Midwifery	✓													
Maternity Incentive Scheme (MIS) to include Saving Babies Lives Care Bundle (SBLCB)	Monthly	**Assurance**	Director of Midwifery	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
Maternity Self Assessment Tool	Bi-Annually	**Assurance**	Director of Midwifery		✓							✓					
Maternity & Neonatal Quality Review Report	Monthly	**Assurance**	Director of Midwifery	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
Review of Harm Events	Bi-Annually	**Assurance**	Director of Midwifery	✓							✓						
Transitional Care Audit (limited time)	Quarterly	**Assurance**	Director of Midwifery			✓Q4				✓Q1			✓Q2				✓ Q3
Post Partum Haemorrhage (Audit)	Bi-Annually	**Assurance**	Obstetric Governance Lead							✓						✓	
CQC Maternity Survey	Annually	**Assurance**	Director of Midwifery														✓
MNVP biannual report	Bi-Annually	**Assurance**	Director of Midwifery				deferred Aug		✓					deferred Feb		✓	
Birth Trauma position (limited time)	Annually	**Assurance**	Director of Midwifery				deferred 31 Jul	✓									
SAFETY																	
Mental Health Update	Quarterly	**Assurance**	Chief Nurse		deferred	✓ deferred	✓			✓			✓		Committee in Common		✓
Safeguarding Update Report (inc Annual Report)	Bi-Annually	**Assurance**	Dep Chief Nurse			✓ deferred	✓						✓ deferred	✓			
Medicines Management Report	Annually	**Assurance**	Exec Med Director		✓ deferred	✓											
Controlled Drugs Report	Annually	**Assurance**	Exec Med Director		✓ deferred	✓											
CIP/GIRFT Quality Impact Assessment Compliance QIA High Level Briefing	Bi-Annually	**Assurance**	Exec Med Director / Chief Finance Officer & Deputy CEO		✓							✓					
QIA Report (BCH)	Bi-Monthyl	**Assurance**	Chief Nurse														✓
Learning from Experience Report	Quarterly	**Assurance**	Deputy Chief Nurse & Director of Clinical Governance Governance & Quality		Q4 deferred	✓Q4			✓Q1			✓Q2				✓Q3	
Serious Incident Oversight (BCH)			TBC													✓	
Staffing report - Safe Nurse Staffing	Bi-Annually	**Assurance**	Chief Nurse			✓ deferred	✓ deferred	✓					✓				
Director of Infection Prevention & Control (DIPC) Report	Quarterly	**Assurance**	Associate Director Infection Prevention and Control		✓Q4				✓Q1			✓Q2				✓Q3	
DIPC Report	Annually	**Assurance**	Associate Director Infection Prevention and Control				✓ deferred	✓									
Infection Prevention and Control BAF	Bi-Annually	**Assurance**	Associate Director Infection Prevention and Control				✓						Def Jan	✓			
PSIRF Bi-Annual Report	Bi-Annually	**Assurance**	Director of Deputy Chief Nurse & Director of Clinical Governance Governance & Quality		✓ deferred	✓						✓					
Mortuary Licensed Activity Report (Including Fuller update)	Bi-Annually	**Assurance**	Chief Nurse				✓							✓			
Violence Reduction Strategy Update	Bi-Annually	**Assurance**	Chief Nurse			✓ deferred		✓						✓			
Health and Safety Report	Annually	**Approval**	Deputy Chief Nurse & Director of Clinical Governance & Quality				✓ deferred	✓						✓			
Sepsis High Level Update	Quarterly	**Assurance**	Dep Chief Nurse		✓Q4				✓Q1			✓Q2				✓ Q3	

~NOF	Monthly	**Assurance**	Assoc Director of Planned Care						✓	✓	✓	✓	✓	✓	Common	✓	✓
MIAA Theatre Safety Audit	Monthly (until assurance received)Bi-monthly from June 2025	**Assurance**	Exec Med Director	✓	✓	✓			✓		✓		✓ defer as deep dive I November	✓ - can be included as part of Dec deep dive		✓	
Cardiopulmonary Resuscitation (CPR) Decisions and Discussions (Adults) Position Report	Bi-Annually	**Assurance**	Exec MD / Dep Chief Nurse	✓							✓						
CLINICAL EFFECTIVENESS																	
Learning From Deaths Review	Quarterly	**Assurance**	Exec Med Director			✓Q4				✓Q1			✓Q2				✓Q3
Clinical Audit Forward Plan	Annually	**Assurance**	Deputy Chief Nurse & Director of Clinical Governance Governance & Quality	✓													✓
Clinical Audit Report	Bi-Annually	**Assurance**	Associate Director of Quality						✓					✓			
PATIENT EXPERIENCE																	
Dementia Strategy Report and Annual Report	Bi-Annually	**Assurance**	Dep Chief Nurse			✓ deferred		✓				✓					
Patient Experience & Inclusion Sub Committee Bi-annual Report	Bi-Annually	**Assurance**	Dep Chief Nurse	✓							✓						
PALS & Complaints Report (BCH)	Annually	**Approval**	Chief Nurse														✓
Complaints Report	Annually	**Approval**	Director of Deputy Chief Nurse & Director of Clinical Governance Governance & Quality		✓												
COMPLIANCE & OVERSIGHT																	
Board Assurance Framework ▪ WHH (inc Corporate Performance Report) ▪ BCH (Inc Risk Management Council Report)	Bi-Monthly	**Approval**	Company Secretary		✓		✓			✓		✓		✓			✓
Annual Review of BAF risks (now included within the Committee Chair's Annual Report)	Annual	**Approval**	Company Secretary				✓										
Review and Refresh of Trust KPIs	Annually	**Discuss & Assurance**	CFO & Deputy CEO														✓
Quality Priorities Report	Quarterly	**Assurance**	Deputy Chief Nurse			✓Q4				✓Q1			✓Q2				✓Q3
Quality Priorities 2023-24	Annually	**Approval**	Chief Nurse														✓
Quality Account	Annually	**Approval**			✓ DRAFT	✓ FINAL											
Quality Strategy Update	Annually	**Assurance**								✓							✓
Quality Strategy Refresh 2024-27	3-yearly	**Assurance**															✓
Risk Management Strategy Report	Annually	**Assurance**				✓ deferred		✓									
Nursing & Midwifery Strategy Update	Annually	**Approval**	Dep Chief Nurse			✓ deferred		✓									
ED Improvement Programme Update	Monthly	**For assurance**	COO/EDM/CN& Dep CEO	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
Quality Improvement Progress Report	Bi-Annually	**Assurance**	Associate Director of Quality						✓					✓			✓
Trust improvement Plan (BCH)	Bi-Monthly	**Assurance**	TBC														
Enabling Strategy Alignment Progress report	Bi-Annually	**Assurance**	Chief Strategy & Partnerships Officer			✓							✓ deferred	✓			
Patient Safety & Clinical Effectiveness Sub Committee Exception Report	Monthly	**Assurance**	Exec Medical Director	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
Quality Council Report (Inc Effectiveness & Safety Group & NICE Guidelines Compliance **(BCH)**	Monthly	**Assurance**	Joint Chief Nurse													✓	
Palliative and End of Life Care Report (strategy updates)	Bi-Annually	**Assurance**	Cons Palliat Med	✓												✓	
Quality Impact Assessment high-level briefing paper (from July 25)	Bi-Monthly	**For assurance**	Chief Nurse, Executive Medical Director				✓			✓		✓		✓			✓
Information Governance + Corporate Records Group	Quarterly	**Assurance**	Chief Information Officer		✓					Q1				✓Q2			✓Q3
Quality Management System (paused awaiting **Impact**)	Annually	**Assurance**	Deputy Chief Nurse & Director of Clinical Governance Governance and Quality														
In-Patient Survey in the Patient Safety & Clinical Effectiveness Sub Committee Exception Report (October Report)	Annually	**Assurance**	Chief Nurse								✓						
Ward Accreditation Report	Bi-Annually	**Assurance**	Dep Chief Nurse	✓							✓						
Due Diligence update (from Jan 2026)	Monthly	**Assurance**	Chief Strategy and Partnerships Officer											✓		✓	✓
Review of MIAA Audits (as required) **BCH**																	✓
Claims Report	Bi-Annually	**Assurance**	Chief Nurse	✓							✓						
GOVERNANCE																	
Terms of Reference	Annually	**Approval**	Chair/Co Secretary														✓
Cycle of Business	Annually	**Approval**	Chair/Co Secretary														✓
Committee Effectiveness Annual Review	Annually	**Assurance**	Chair/Co Secretary	✓													
Committee Chair's Annual Report	Annually	**Assurance**	Chair/Co Secretary				✓										
Committee Annual Report (BCH)	Annually	**Assurance**	Director of Corporate Governance														✓
Committee Effectiveness Action Update	Annually	**Assurance**	Chair/Co Secretary								✓						
High Level Enquires & External Assessment / Inspections (when notified)	Monthly	**Assurance**	Director of Deputy Chief Nurse & Director of Clinical Governance Governance & Quality	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
MATTERS TO NOTE FOR ASSURANCE																	
Minutes from the Quality Academy Sub-Committee	Bi-Monthly	**Assurance**	Med Director/Chief Nurse			✓			✓				✓				
minutes from the Research Oversight Sub committee			Chief Nurse	✓		✓			✓		✓		✓			✓	
CLOSING MEETING																	
Items for Escalation to the Trust Board	Monthly	**Assurance**	Chair	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓
Review of Meeting	Monthly	**Assurance**	Chair	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓

Common Committee in Common