North Cheshire and Mersey
NHS Foundation Trust

Trust Board Part 1 - Public

Date and time:	Wednesday 01 April 2026, 2pm to 4:30pm
Location:	Trust Conference Room, Warrington and via MS Teams

Agenda item	Time	Agenda item	Objective/ desired outcome	Process	Lead
BM/26/04/001	**2:00**	Engagement Story – PALS & Complaints	***To note***	***Presentation***	Nicky Edmondson, Associate Director of Governance
BM/26/04/002	**2:15**	Welcome, Apologies and Declarations of Interest	***To note***	***Verbal***	Chair
BM/26/04/003	**2:17**	Minutes and Action Log of the previous WHH Trust Board meeting held on: I. 4 February 2026 II. 12 March 2026	***For approval***	***Minutes***	Chair
BM/26/04/004	**2:20**	Matters Arising	***To note for assurance***	***Verbal***	Chair
BM/26/04/005	**2:25**	Chief Executive's Report	***For assurance***	***Report***	Chief Executive
BM/26/04/006	**2:35**	Chairs's Report	***For info/update***	***Verbal***	Chair
BM/26/04/007	**2:40**	Board Assurance Framework • Approval of NCM Risk Appetite Statement 2026/27	***For approval***	***Report***	Company Secretary
Trust Board Matters					
BM/26/04/008	**2:50**	Integration Update	***For info/update***	***Verbal***	Chief Executive and Chief Strategy and Partnerships Officer
BM/26/04/009	**3:00**	i. Integrated Performance Report Refresh ii. Performance Assurance Framework (PAF) Refresh	**For approval**	**Report**	Chief Finance Officer
BM/26/04/010	**3:10**	Integrated Performance Reports (IPR) and Assurance Committee Reports IPR Dashboard – **WHH (Feb)** IQPR Dashboard **– BCH (Feb)**	***For assurance***	***Report***	All Executive Directors
a)		**Quality Dashboard Including**	***For assurance***	***Report***	Chief Nurse, Cliff Richards,

		Assurance Reports Quality Safety and Assurance Committee in Common 10.02.2026, 10.03.2026			Committee Chair
b)		**People Dashboard** **Including** Assurance Reports Strategic People Committee in Common 18.02.2026, 18.03.2026	***For assurance***	***Report***	Chief People Officer, Julie Jarman, Committee Chair
c)		**Sustainability Dashboard - *including Cash Support*** **Including** Assurance Reports Finance, Sustainability and Performance Committee in Common 23.02.2026, 23.03.2026	***For assurance***	***Report & Presentation***	Chief Finance Officer John Somers, Committee Chair
d)		**WHH Audit Committee** **Including** Assurance Reports 26.02.2026	***For assurance***	***Report & Presentation***	Senior Independent Director Mike O'Connor Committee Chair
e)		Charitable Funds Committee **Including** Assurance Report 05.03.2026	***For assurance***	***Report & Presentation***	Director of Communications and Engagement Chair
		Quality			
BM/26/04/011	**3:35**	Fragile Clinical Services Update	***To note for assurance***	***Report***	Executive Medical Director
BM/26/04/012	**3:45**	**Maternity Update** i. Quarter 3 Avoiding Term Admission into Neonatal Unit (ATAIN) Report ii. Maternity Incentive Scheme (MIS) to include Saving Babies Lives Care Bundle (SBLCB) iii. Maternity and Neonatal Quality Review Report iv. Transitional Care Audit Q3 v. CQC Maternity Survey	***To note for assurance***	***Report***	Interim Director of Midwifery
		People			
BM/26/04/013	**4:00**	NHS National Staff Opinion Survey	***For info/update***	***Presentation***	Chief People Officer

Sustainability					
BM/26/04/014	**4:10**	Strategy Bimonthly Highlight Report	***For info/update***	***Report***	Chief Strategy and Partnerships Officer
BM/26/04/015	**4:15**	Communications and Engagement Report	***For info/update***	***Report***	Director of Comms and Engagement
Governance					
BM/26/04/016	**4:25**	Terms of Reference • Quality and Safety Assurance Committee • Strategic People Committee • Finance, Sustainability and Performance Committee	***For approval***	***Report***	Chair
Closing					
BM/26/04/017	**4:30**	Review of Meeting	***To note for assurance***	***Verbal***	Chair
BM/26/04/018		Any Other Business	***For info/update***	***Verbal***	Chair

Supplementary Papers for Noting

Agenda item	Report Title	Assurance Committee	Objective/ desired outcome	Process	Lead
BM/26/04/019	Learning From Experience Q3 Report	Ref: QSACiC/26/03/40 Date:10.02.2026 Outcome: noted	For info/update	Report	Chief Nurse
BM/26/04/020	Learning from Deaths Q3	Ref: QSACiC/26/03/40 Date: 10.03.2026 Outcome: noted	For info/update	Report	Exec Medical Director
BM/26/04/021	Infection Prevention & Control Update Q3	Ref: QSACiC/26/02/17 Date: 10.03.2026 Outcome: noted	For info/update	Report	Chief Nurse
BM/26/04/022	BCH Intersource PO uplift – Dermatology	Ref: BCH Trust Board Date: 24.03.2026 Outcome: approved	For info/update	Report	Chief Operating Officer

Date and time of next meeting:

6 May 2026, starting at 10am. Trust Conference Room, Warrington Hospital

North Cheshire and Mersey
NHS Foundation Trust

Patient Advice and Liaison Service (PALS)

Supporting patients, families and carers

01 April 2026

Home
Community
Hospital

Purpose of the presentation

- Respond to Board concerns about PALS response delays.
- Provide assurance on performance, governance, risk and quality
- Outline actions taken and planned improvements
- Confirm current level of organisational assurance

Role and Function of PALS

- Statutory NHS service offering advice, support and early resolution
- Aim: resolve concerns locally within 3 working days, where possible
- Provides information, signposting and coordination (does not replace formal complaints process)
- Access via email, phone or walk-in via PALS Office (10:00-12:00 and 14:00-16:00, Monday-Friday-temporarily closed)
- Demand rising in both volume and complexity
- Small team managing inbox, calls, ward engagement and case coordination

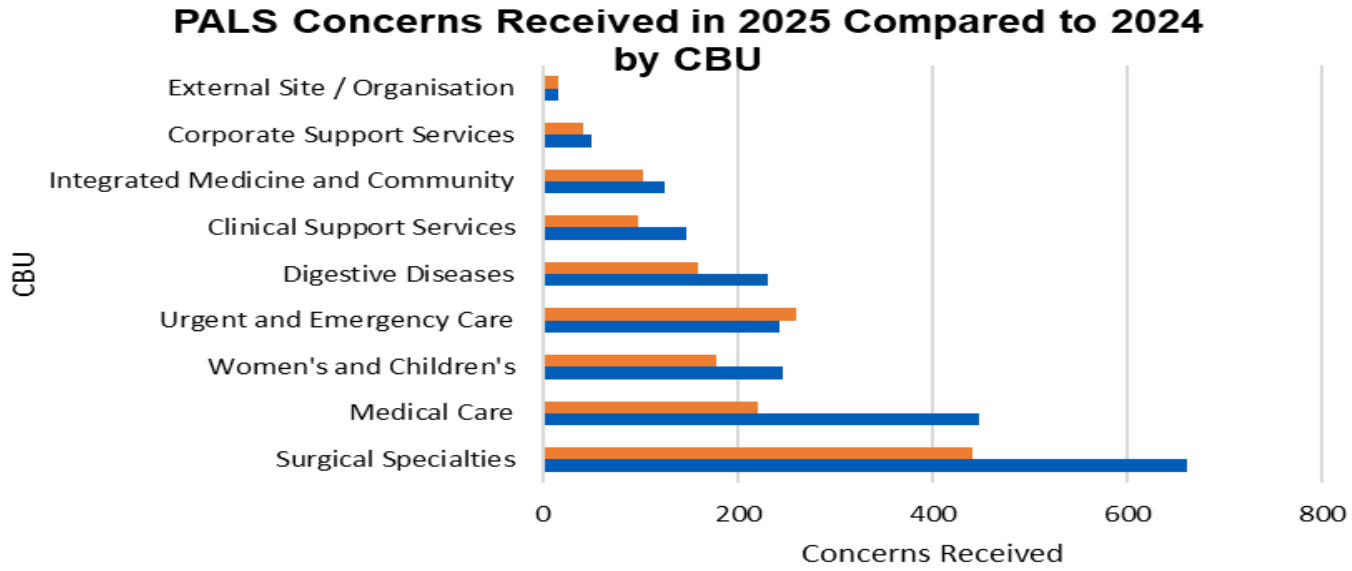
Concerns raised regarding PALS Service

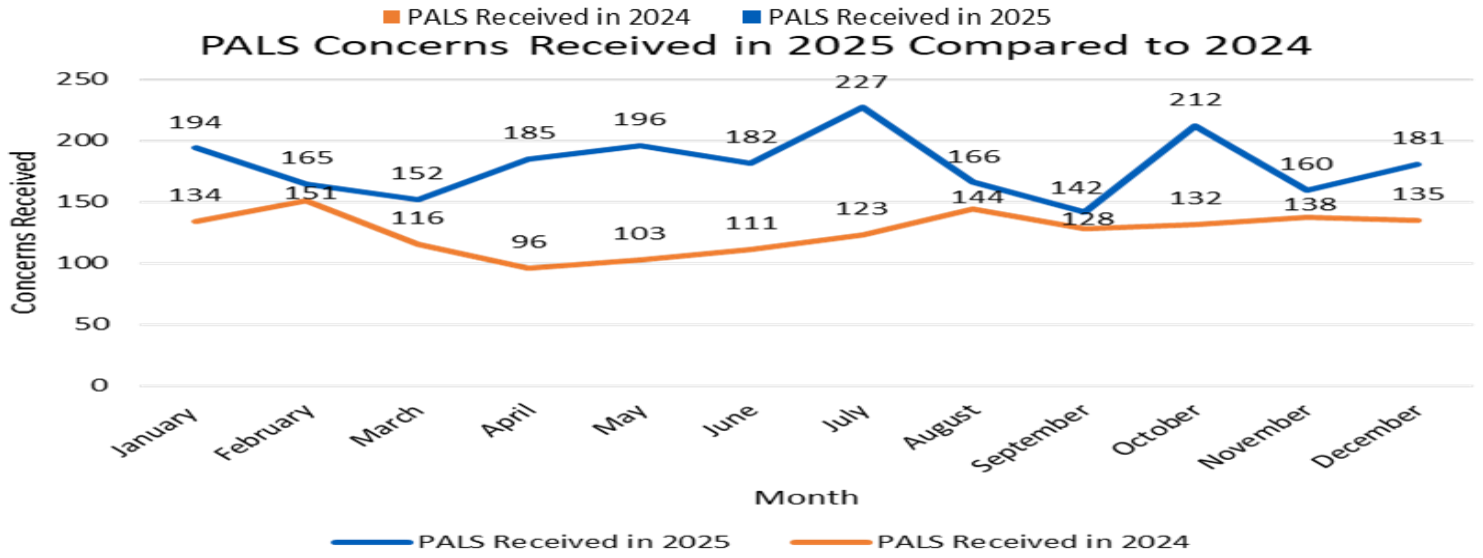
- Limited walk-in access to the PALS Office
- Delayed responses
- Missed or delayed call backs after voicemails

Learning identified from review (Q3 2025)

- PALS Office environment not welcoming or suitable for sensitive conversations.
- Demand now significantly exceeds 2 WTE capacity, affecting responsiveness, and office cover
- Concerns not being formally closed when handed to clinical teams
- Escalation strengthened from April 2026 (Safety Oversight Meeting tracking, Director oversight)
- Front of house queries frequently redirected to PALS, reducing capacity.

Current Activity and Demand

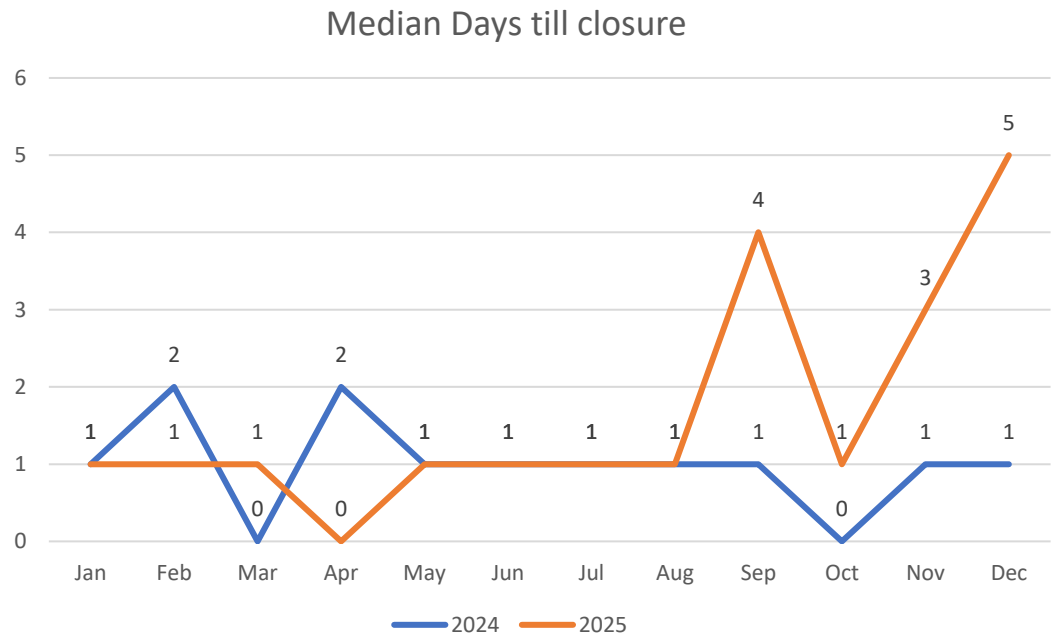




- 2024: 1,511 concerns → 2025: 2,162 concerns (**43% increase**).
- Peaks in July and October 2025.
- Highest rises in Surgical and Medical specialties

Performance and Case Complexity

- Closure times increased due to greater complexity and multi-issue cases.
- Delays most evident during Sep–Dec 2025 staffing shortages.
- Walk-in office temporarily closed



Governance, Risk and Quality Assurance

- Clear escalation routes
- Shared inbox / voicemail monitoring
- Daily workload reviews with senior oversight
- Revised PALS policy with new timeframes for complex cases (20 working days)
- Patient Safety and Clinical Effectiveness Sub-Committee ensure effective system of clinical governance is embedded within the Trust and that it is under constant review and improvement.
- Weekly Safety Oversight Meeting monitoring to commence in April 2026.
- Weekly operational review with Director of Governance.

Impact on Patient Experience

Some real words from a patient who has been supported through PALS for a number of years:

“These words are not about me asking for your help. No. I just wanted to take this time to say thank you from deep within me for all of your patience, support and understanding whenever I reach out to you for help. You have always graced me with kindness and a persistent effort to be supportive, with an abundance of respect for my circumstances. This will never be something I can repay, but I hope my words can go a little way to helping you realise how special and important you are. Reaching out to you allows me to communicate my fears and concerns before any hospital appointment and has been the reason certain elements of my health have been able to be addressed. Thank you may only be a word, but from me Cassie it comes with a genuine appreciation. Thank you so much for being here.”

Current vs Planned PALS Establishment following integration

- Recruitment of additional PALS staff to improve resilience and capacity
- Planned establishment increase from 2.0 WTE to 5.0 WTE

Role / Post Title	Band	Planned PALS Establishment (WTE)	Current PALS Establishment (WTE)
PALS Officer	Band 4	3.0	2.0
PALS Officer	Band 3	1.0	0
PALS Manager	Band 6	0.5	0
PALS Administrator	Band 2	0.5	0
Total		**5.0**	**2.0**

Benefits of integrated team

- Faster, more consistent responses
- Greater visibility and engagement
- Better tracking and closure of concerns
- Strengthened organisational learning
- Enables PALS to undertake appropriate duties while front of house signposting remains with the welcome desk
- Reduced pressure on individual team members

Assurance to the Board

Identified risks are understood, controlled and actively mitigated. Improvements are completed or underway to strengthen resilience and sustainability:

- **Revised Policy:** response times extended up to 20 working days, based on case complexity
- **Front-Desk Presence:** volunteers improving accessibility and provision of immediate support for patients and families
- **Environment Improvements:** Exploring charity funding to refurbish the PALS Office, to enhance confidentiality and comfort
- **Co-Production:** Ongoing work with Governors and Experts by Experience to strengthen patient involvement. This will report to Patient Experience and Inclusion Sub Committee attended by the Governors
- **Strengthened processes and IT improvements:** Voicemail-email linkage
- **Improved communication and signposting:** Ensuring patients and families know how and when to access PALS
- **Monitoring:** Improved tracking of open cases to ensure timely and responsive handling. Weekly Safety Oversight Meeting monitoring to commence in April 2026
- **Induction and training:** for the new PALS team to deliver a high-quality service

Questions and Discussion

Any questions?

North Cheshire and Mersey
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

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 4 February 2026 Trust Conference Room, Warrington Hospital/Via MS Teams	
Present	
Steve McGuirk (SMcG)	Chair
Nikhil Khashu (NK)	Chief Executive
Cliff Richards (CR)	Non-Executive Director & Deputy Chair
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
Andy Carter (AC)	Associate Non-Executive Director/Chair Designate
Paul Fitzsimmons (PF)	Executive Medical Director
Jane Hurst (JH)	Chief Finance Officer
Ali Kennah (AK)	Chief Nurse
Lynne Carter (LC)	Director of Delivery Unit
Apologies	
Dan Moore (DM)	Chief Operating Officer and Deputy Chief Executive
In Attendance	
Lucy Gardner (LG)	Chief Strategy and Partnerships Officer
Kate Henry (KH)	Director of Communications & Engagement
Michelle Cloney (MC)	Chief People Officer
Zoe Harris (ZH)	Deputy Chief Operating Officer
Tina Moors (TM)	Deputy Director of Midwifery
Michelle Catterall (MC)	UEC Matron (**BM/26/02/146**)
Olivia Leech SN)	Patient (**BM/26/02/146**)
John Culshaw (JC)	Company Secretary
Emily Kelso	Corporate Governance and Membership Manager **(minutes)**
Catherine McLennan (CM)	LMNS (**BM/26/02/155)**
Debby Gould (DG)	LMNS (**BM/26/02/155)**
Observing	
Sue Fitzpatrick	Lead Governor – Public Governor, Warrington and Halton
Margaret Bamforth	Public Governor, Warrington and Halton
Catherine Ardern	Public Governor, Warrington and Halton

Agenda Ref	Agenda Item
BM/26/02/146	**Engagement Story - Urgent Emergency Care Experience** SMcG introduced OL (patient) and thanked maternity and urgent/emergency care teams for facilitating the learning opportunity. SD set the scene, explaining that OL's journey had traversed maternity, ED and Same Day Emergency Care (SDEC) and that ED Matron MC was available to support the reflection on communication and pathway learning. OL described the uncomplicated and positive hospital experience during her sons birth on 4 August, along with a series of severe pain episodes beginning two weeks pre-delivery and recurring post-delivery, initially triaged in maternity (possible kidney infection excluded) and subsequently presenting via A&E on an August bank holiday with severe back/epigastric pain. After overnight assessment, a clinician first raised gallbladder disease; OL returned the next day for ultrasound, attended SDEC for results and was told gallstones were present and a waiting list referral would follow. Pain recurred the following day; on re-attendance for bloods and SDEC review, OL expected discharge with analgesia but was commenced on IV analgesia and without prior medical explanation, IV antibiotics were briefly started. A doctor then explained blood results indicated infection and cholecystitis and admitted OL for urgent care with plan for MRCP/MRI and surgery. OL reported clear, compassionate communication from the admitting doctor, including reassurance and next steps. OL had MRI Thursday AM, transferred late to Gynaecology overnight for bed availability, then underwent laparoscopic cholecystectomy Friday morning with an uncomplicated course, overnight stay and Saturday discharge. The post-op follow-up was not required clinically; however, a later letter caused confusion as it appeared to be the original specialist outpatient appointment that was superseded by surgery. OL suggested three improvements: earlier consideration of gallstones in late pregnancy triage, clearer communication about antibiotics/diagnosis in SDEC/ED, and more explicit discharge information (including what to expect, when to re-attend, diet/analgesia, and GP notification) In discussion, SMcG asked what could have been done better; OL felt antenatal triage might have flagged gallstone risk in pregnancy and that communication around initiating antibiotics before medical explanation could be improved, as could the clarity of follow-up letters and GP notifications. PF acknowledged the pathway gap at the "front end" and committed to speak with clinicians about anticipatory guidance in antenatal settings, while noting the Trust's top-decile performance for gallbladder surgery once patients enter the surgical pathway. AK thanked OL and, with the ED Matron, recognised communication handovers between ED/SDEC/wards and discharge information as the key improvement areas. AC asked about post-op follow-up and GP notification; OL was unsure if information had reached the GP and had expected some check-in, highlighting a need for clearer discharge expectations for first-time surgical patients.

	The Board agreed that the story blended positive peri-operative care with clear learning on anticipatory advice, consistent explanations before treatments, discharge information (including "when to return" guidance), and GP communication. **The Trust Board noted the content of the patient story and thanked the patent for sharing her story.**
BM/26/02/147	**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/26/02/148	**Minutes and Action Log of the previous meeting held on 3 December October 2025** The minutes were taken as read and were approved with no amendments The action log items were either closed, on-going, or scheduled on the day's agenda. **The Trust Board approved the minutes of the meeting held on 3 December 2025 and noted the Action Log**
BM/26/02/149	**Matters Arising** No other matters were raised. **The Trust Board noted that there were no matters arising.**
BM/26/02/150	**Chief Executives Report** NK began with the coroner's conclusion into the death of baby Pippa Gillibrand, noting the finding of avoidable delay and the Trust's full and unreserved apology. He confirmed that a full independent Maternity and Newborn Safety Investigation had been undertaken and all recommendations implemented; he emphasised compassion and support for families and staff, encouraged colleagues to seek support from line managers and the Trust's wellbeing offers, and stressed that while governance processes had been followed at the time, the organisation must continue to learn at pace. SMcG reflected that a tragedy requiring learning can coexist with the absence of wrongdoing; he reiterated the apology should be recorded and that governance alone was not a sufficient response. He asked JD (NED, Maternity Champion) and MOC (SID) to step back

and consider assurance beyond technical compliance, reporting how the Board can ensure that learning translates to improved patient and family experience rather than merely evidence of process. It was agreed a reflective assurance paper would be bought through the Quality Committee on learning "beyond governance."

The following key highlights were taken from the report:

- Recognition of three board members: SMcG on his final public Board as Chair after service since April 2015 including the COVID period and a focus on exposing NEDs, executives and Governors to patient settings; LC, leaving at end-March after four decades in nursing and leadership; and MC, Chief People Officer, whose NHS career began in ICU in 1984 before moving into HR, and who is looking forward to grandparenting.
- The success of December's multi-agency discharge event (MADE). NK reiterated that MADE events were not possible as BAU, however the focus was on embedding and sustaining learning, from each event.
- TUPE phase-2 consultations were ongoing with BCH colleagues, WHH one-to-ones for affected staff, and the MARS scheme which had generated more interest than anticipated and was being assessed for affordability.
- flu vaccination uptake had moved from the mid-forties to over 50% (1,683 vaccinations at the time), placing WHH in a good position both nationally and regionally; he credited colleagues across both organisations for this improvement and linked it to the need to reduce sickness.
- Thank You Awards (16 May 2026) planning was progressing with 500+ nominations, early ticket booking was encouraged.
- The junior/resident doctors' strike mandate extension required continued planning even as national talks evolved;
- It was explained that the system phrase "big leaps" was being used for significant gains in RTT, A&E and finance.
- There had been leadership changes at the ICB, including Jude Adams joining in a senior turnaround delivery role, with whom WHH was engaging with
- The Provider Collaborative remained busy, with dermatology AI skin-analytics progressing from pilot to recurrent funding, meaning the Trust must now fund the service from its resources.
- Staff Sickness levels remained high in the wider Cheshire and Merseyside cohort with WHH mid-pack

Performance and risks (quality, access, people, finance):

NK highlighted pressures on incidents over 40 days and pressure ulcers, and the need to watch HSMR/SHMI context. He noted the Trust's 4-hour ED performance remained challenging and that 12-hour ED waits placed WHH worst nationally (120/120) in the current weekly snapshot, driven in large part by No Criteria To Reside (NCTR) levels equivalent to about two wards' worth of beds; he observed that reaching the regional average could free around 60 beds, with nearer 90 if the Trust moved toward zero, and he confirmed

micromanagement of 65-week RTT waits had delivered zero, with the focus now moving to the percentage of the list over 52 weeks (target ≤1%).

In regard to finance NK explained the push on recurrent vs non-recurrent CIP, NK noted the draft undertakings and acknowledged that the Trust was not currently meeting the improvement programme, as previously discussed at the January FSPCiC meeting. NK further advised that a meeting with PwC was scheduled for March to discuss the Trust's 2025/26 exit position, with the Trust's 2026/27 plans forming a key part of that discussion.

JJ queried how much of the 12-hour issue was linked to mental health assessment waits and asked about quieter, private waiting areas for this cohort. Zoe (ED) explained that while MH cases are a small numerical subset, they can experience the longest waits when formal admission is needed; concurrent assessment was not always achieved because some interfaces still expect physical sign-off first, which can delay MH pathways; an interview room and cohorting are used where possible but the department was not designed for prolonged MH care. LC cautioned that external partners might prefer a given model but the Trust is not obliged to follow it if it disadvantages patients; PF said work led with MerseyCare (including a named clinical lead) was progressing to a concurrent pathway and asked that QAC receive a deep-dive. CR emphasised strengthening the dual-diagnosis approach.

AC raised reputational risk from weekly national data and asked for visible system action. The Board noted that NK and SMcG would send formal letters to Warrington and Halton Council Leaders, and to involve the ICB Chair, seeking an urgent system plan to reduce NCTR and improve 12-hour performance.

ZH outlined changes including preserving a rapid-turnover treatment area during congestion, restarting GP-led streaming at the front door (achieving roughly 9% deflection in its first half-month, with an expected 3–3.5% gain once embedded), and noted the absence of a co-located UTC hampered optimal deflection. She described the plan for a super-stranded (>21 days) focus week in which internal senior teams would assure actions rather than do ward work for staff, to avoid "learned helplessness." PF added that occupancy was at 100% at points before Christmas and that even with some bed availability the Trust still recorded 12-hour breaches, so internal standards around ED flow, specialty response and ward rounds would be rewritten and relaunched from 1 April. He observed that about one in four beds were occupied by patients with NCTR, and if those patients were not in acute beds there would be no corridor care; he also referenced work to quantify the human cost (falls, deconditioning) of avoidable days in hospital.

CR reflected that with ready access to community diagnostics, district nursing and GP risk-sharing, a significant number of admissions might be avoided; however, without those system supports, ED clinicians will default to admission.

	It was agreed the COO/Divisions leads would to run the super-stranded assurance meetings and report measurable impact on 12-hour breaches; furthermore publish refreshed internal standards by 1 April and include GP-streaming impact in the next IPR. **The Trust Board noted the Chair's updates and the Governor Elections results.**
BM/26/02/151	**Chairs Report** SMcG confirmed that he and NK had met the incoming ICB leadership with a focus on tackling 12-hour waits, and that, following NK's letters to local authority Chief Executives, he and AC would send coordinated letters to Council Leaders and MPs to secure an urgent cross-system plan. **The Trust Board noted the Chief Executive's Report**
BM/26/02/152	**Board Assurance Framework (BAF)** JC introduced the report which provided the Board with an update on each of the Trust's 11 strategic risks and proposed the following key changes for approval by the Board: • reducing Risk 2253 (Integration) likelihood 3→2 (score 9→6) in light of progress; JJ asked whether Bridgewater's Board was adjusting the same risk; JC would confirm alignment. • increasing Risk 115 (Minimum clinical staffing levels) likelihood 3→4 (score 12→16) due to sustained high sickness; SMcG cautioned that elevating Risk 115 must not become a licence to seek temporary staffing without equal focus on reducing sickness • a likely EPR risk description change after market engagement. Finance Committee had discussed • finance risk 134 rating may increase to 25 given undertakings; this would return via the usual route through FSPCiC. **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 reflected the risks in the BAF.**
BM/26/02/153	**Integrated Performance Report** SMcG introduced the Integrated Performance Report by drawing together themes which had already been discussed in detail during the Chief Executive Report item. The supporting slides highlighted those areas demonstrating significant negative variation or sustained underperformance. NK emphasised that the indicators within the IPR were now being examined through a more strategic lens, aligning with the Board's earlier discussions on urgent care, mental health flow, fragile services, infection control, and operational leadership.

The Board moved into a detailed conversation which reflected both the live operational pressures and the longer-term systemic challenges. AC opened by querying infection control performance, noting that almost every key IPC metric for the period was not being met, and sought assurance on the root causes and the improvement trajectory. AK responded that the Trust's position required careful interpretation: while CDI rates had increased significantly, WHH remained a positive outlier regionally, with recent outbreaks now stabilising. She explained that MRSA cases had reduced, with only two definitively attributable to the Trust this period, and that E. coli infections continued to be driven largely by catheter-related issues, consistent with regional patterns. She emphasised the link between infection risk and the complexity of the Trust's inpatients, many of whom were medically optimised but unable to leave hospital due to NCTR delays, resulting in overcrowded wards and greater environmental risk.

CR reinforced this point, observing that the issue was not only compliance but also the appropriateness of catheter use and insertion technique. PF added that the clinical environment particularly for patients waiting excessive periods in ED or escalation areas was "not a good environment for those patients" and that both falls and pressure ulcers were being aggravated by prolonged stays linked to flow issues. He confirmed that he and AK were commissioning a piece of work to quantify the human impact of NCTR on falls and harm, building on qualitative feedback from ward teams.

The Board then scrutinised the recurring concerns within the one of the fragile services and planned care portfolios. CR highlighted the rise in quality incidents from those areas, including repeated radiology delays, sharps incidents, theatre prosthesis issues and pharmacy delays, querying what additional escalation was needed around delivery given this is where assurance lacked, and assurance on governance was high which was not having appositive impact on delivery.. PF agreed that some services were "not improving at the rate required", citing Fragile Neck of Femur (FNOF) as the most concerning example. He warned that mortality indicators were nearing national outlier thresholds, and that without rapid improvement the Trust could formally be designated an outlier, triggering external regulatory scrutiny.

He confirmed that this had prompted a shift from supportive oversight to a formal recovery and performance management process, with weekly reporting to the Executive Team and clear expectations around job plan changes and clinical leadership behaviours. If no improvement was seen within weeks not months the Trust would need to move into further escalation, including potential contractual consequences for individuals. JS reflected frustration that "the dial doesn't shift", noting that governance processes were robust but delivery failures were persistent, creating a risk that Board assurance processes appeared disconnected from operational outcomes.

	The Board also discussed capacity, flow and the acute environment. JJ queried whether overcrowding in ED highlighted earlier as a factor in IPC and patient safety performance was being addressed in a joined-up way with the elective and medical divisions. PF confirmed that GIRFT was supported by work on board rounds, specialty response times, and professional standards for medical review were being implemented with tighter accountability mechanisms. He reiterated that two factors continued to dominate performance deterioration: ED overcrowding and high bed occupancy driven by NCTR, which the Board had already discussed at length earlier in the meeting. NK summarised that the IPR showed a Trust under severe operational pressure, with key risks clustering around urgent care, IPC, fragile services, ED performance and delayed discharge. He reminded the Board that, despite these pressures, WHH continued to achieve zero 65-week waits, but that 52-week waits were the next nationally mandated threshold and would bring additional scrutiny. **The Trust Board noted the contents of the report and the Committee Assurance reports and approved the cash support request.**
QUALITY	
BM/26/02/154	**Fragile Clinical Services Update** PF provided an update on the Trust's fragile clinical services, confirming that Urology, Cancer Services, Rheumatology, Chronic Pain, and Orthopaedics (FNOF) remained under enhanced oversight. • Urology was now relatively stable and progressing toward a sustainable blueprint. • Cancer Services continued to improve, particularly in pathway validation, and PF expected the service could soon exit fragile status once automated upgrade functionality for the cancer tracking system was fully implemented. • Rheumatology - some improvement had been reported by it was acknowledged that long waits persisted, meaning the service could not yet be de-escalated. • The most significant area of concern remained Orthopaedics, specifically Fractured Neck of Femur (FNOF). PF warned that the Trust was at real risk of becoming an official mortality outlier if one further adverse outcome occurred. He explained that promised improvements in time-to-theatre and theatre access had not materialised at the required pace and that recent months had exposed a lack of sufficient operational grip. JJ and CR expressed frustration that FNOF had been escalated as a fragile service for three years with limited progress, and that committee oversight often repeated the same issues without visible improvement. PF acknowledged

	these concerns openly, stating that whilst governance had been strong, delivery had not kept pace, partly due to gaps in leadership. PF confirmed that he had now formally written to the Orthopaedic team setting expectations and requiring job plan changes to secure the additional trauma lists needed. These changes would need to be actioned within 14 days, after which formal performance management would begin if compliance was not achieved. JS asked for clarity on next steps should performance not improve; PF confirmed that contractual and role-based consequences would be considered if required. NK agreed that the strengthened Quality Recovery Programme, led by the Executive Medical Director with twice-weekly reporting to Execs, would provide the operational discipline needed for improvement. Delivery Unit oversight would ensure progress was independently validated. Both QAC and Board would continue to receive assurance updates. **The Board noted the fragile services list, clinical risks and progress updates**
BM/26/02/155	**Maternity Update** TM presented the **Maternity Incentive Scheme Year 7 update**, explaining that the Trust had completed detailed self-assessments against all ten safety actions between May and November 2025. They confirmed that the LMNS had reviewed evidence for Safety Actions 3–9 throughout the year and had raised no concerns, particularly acknowledging the strength of the Trust's transitional care work, updated policies and quality improvement projects. For the externally validated Safety Actions 1, 2 and 10, the Trust had already received confirmation of compliance for Action 2, and although confirmation for Actions 1 and 10 was still awaited, both AK and the LMNS advised there was no indication of non-compliance given the data submitted in July 2025. LMNS representatives CM and DG confirmed they had met regularly with the maternity leadership team and that the Trust's evidence met the technical MIS requirements. They emphasised that if there had been any risk to compliance—particularly in Safety Action 1, which is difficult nationally—the Trust would already have been notified. In the Board discussion, SMcG welcomed the assurance but reminded the Board that MIS compliance is not the same as achieving the best possible outcomes for every family. Referring to the earlier discussion on the Pippa Gillibrand inquest, he stressed the importance of ensuring that compliance translates into real improvement in maternity experiences. JJ reinforced this, asking how the Board can be confident that when serious incidents occur, learning is fully embedded and clearly communicated. She requested clearer, plain-language reporting on maternity incidents and learning, so Non-Executives can properly evaluate progress.

	AK agreed and committed to strengthening how maternity incidents and learning are presented at QAC, ensuring clarity on what happened and what changed. She also noted the Trust's involvement in regional and national work on home-birth service review, and confirmed that current staffing and safety requirements are being met, with adjustments expected once new national guidance is issued. AK confirmed that the value of successful MIS compliance was £500,000, which the Trust would receive on achieving all ten actions, noting that this funding is contingent on robust safety evidence, not just paperwork. The following report were noted: **Maternity & Neonatal Quality Review Report** Closing the item, SMcG emphasised that the Board must continue balancing technical compliance with listening to the lived experiences of families, especially where harm has occurred. He asked that the previously agreed reflective assurance work (with JJ and MOC) incorporate insights from the MIS review and the inquest. **The Trust Board noted the content of the reports**
BM/26/02/156	**Mortuary Licensed Activity Report - Including Fuller update** AK presented the biannual report, explaining that it provided an update on the Trust's progress following the Fuller Inquiry and subsequent HTA oversight. She reminded the Board that an unannounced HTA inspection took place in April 2025 and that, following a detailed internal gap analysis, the Trust achieved full compliance in all 71 areas it had identified as requiring action. The HTA inspection resulted in only two recommendations relating to consent processes, both of which the Trust addressed promptly and which the HTA has since closed. AK confirmed that out of 22 Fuller recommendations relevant to the Trust, 18 are now fully compliant and 4 remain partially compliant, largely relating to estates and infrastructure tasks such as completion of swipe-to-exit systems, finalisation of the Designated Individual's job plan, installation of CCTV for temporary storage units ("nutwells"), and outstanding SLAs. All remaining items are expected to be completed by Q1 2026/27. It was reported that mortuary security controls remain strong, with access lists reviewed monthly and CCTV checks undertaken routinely. Although there had been one case of attempted unauthorised access, it had been dealt with immediately, including removal of outdated access permissions. There were no serious incidents during the reporting period. AK also updated the Board on operational considerations, including learning from a previous bariatric transfer incident, confirming that equipment requirements have since been strengthened. She added that the Cheshire

	Coroner was exploring the development of a centralised post-mortem hub at Halton, potentially funded by the Home Office, which the Trust views positively and would continue to support. The Board noted the substantial progress made and the positive external feedback from the HTA. **The Trust Board noted the contents of the report.**
PEOPLE	
BM/26/02/157	**Bimonthly Communications and Engagement Report** KH presented the report and noted that communication activity over the period had been particularly intense due to the demands of the integration programme. She explained that much of the team's focus had been on coordinating consistent, clear messaging across both organisations, producing regular staff updates, integration FAQs and leadership briefings to support colleagues through the transition toward 1 April. Ensuring both organisations received aligned information had been a major operational priority. KH reported that the Patient and Public Reference Group, independently chaired by Healthwatch, had now met twice. The group was already proving valuable in shaping the Trust's approach to public messaging, providing early feedback on how integration and service changes were perceived within local communities. KH highlighted that this insight was informing communications around areas of high public sensitivity, such as redesign of clinical pathways and urgent care access. KH also updated the Board on preparations for the first joint WHH/BCH Thank You Awards, explaining that judging was underway and that the awards continued to be funded entirely through external sponsorship, not NHS resources. KH encouraged colleagues to assist in identifying any remaining sponsorship opportunities and reminded the Board that demand for tickets was expected to exceed previous years. In terms of charity and wider engagement, KH reported a noticeable increase in public interest during November and December, including a spike in website activity following a high-profile engagement visit. The Christmas appeal had also been well received, supporting both staff morale and community engagement during the busy winter period. The Board recognised the significant volume of communications work required during integration and thanked KH and her team for their sustained efforts. **The Trust Board noted the report**
BM/26/02/1587	**Charity update - Charity Commission Fundraising Checklist for Trustees and 2024/25 Charity Impact Report**

	KH introduced the report, confirming that the Board, acting as Corporate Trustee, had received the **Fundraising Checklist for Trustees and the 2024/25 Impact Report** for assurance. KH noted that, in light of the recent maternity inquest, a related fundraising stream has been temporarily paused as a precautionary measure. The Board further noted that staff-facing facilities funded and/or supported via the Charity continue to be managed to support staff networks and training priorities. It was also noted for the record that the Charity Annual Report was presented and approved at the Trust Board meeting on 7 January 2026, and that this report was now published on the Charity website. **The Trust Board noted the report**
SUSTAINABILITY	
BM/26/02/159	**Integration Update Branding** KH presented the branding proposals building on the previously approved organisation name and values. Engagement feedback led to adjustments, including flexibility not to use icons where they may confuse and minor tweaks to iconography; JJ remained unconvinced that the "Fair" icon read clearly and cited public feedback suggesting scales; KH replied that scales tested as judgemental for some audiences and that the emphasis would be on plain-word values with limited use of icons. SMcG stated that public recognition rests primarily on the NHS identity and familiar place names (e.g., Warrington Hospital, Halton Hospital) and cautioned against over-agonising iconography. On cost, work to date had been in-house; any signage changes would be phased and proportionate within an estimated included in the integration programme, and future branding would minimise fixed signage to avoid waste. **The Trust Board approved the Branding approach with phased implementation and spend tracking via the integration programme.**
BM/26/02/160	**Bimonthly Strategy Highlight Report** LG reported strong engagement with MPs and both organisations Councils of Governors, confirming support for integration and alignment with the Health & Wellbeing Board. She described three capital-bid opportunities in the last ten days across the North West Estates Safety Fund and two ICB streams (Urgent & Emergency Care and Community), with thirteen submissions including a UTC and a multi-storey car park; she also confirmed that construction was complete on the Runcorn hub, to be known as WELL Runcorn, with opening dependent on CQC registration sequencing and recruitment to a hub manager role after an initial appointment fell through. On inter-site bus arrangements, hours had been reduced based on usage data; although not a commissioned NHS service and thus not subject to formal public

	consultation, the Trust had conducted QIA and Equality & Health Inequalities assessments, and would consider options including contributions from users; there had been no recorded public complaints, though some staff feedback had been received. Estates rationalisation across around 100 sites many leased, very few owned would be developed, including exploration of LIFT purchase opportunities and better town-centre access where locations (e.g., Widnes) are not optimal. **The Trust Board noted the report.**
BM/26/02/161	**Biannual Strategy Delivery Report** LG presented progress against 58 KPIs and noted two behind plan without mitigations: • the deficit/cash position (to Finance) and • Research & Development growth where Principal Investigators had increased by one against a plan of four; PF agreed to bring a realistic plan for growing Principal Investigators and clinical engagement in research She confirmed that a light refresh of the strategy for 26/27 had integrated BCH elements and that revised KPIs would come to the Board in June. **The Trust Board noted the report.**
GOVERNANCE	
BM/26/02/162	**Quality, Safety & Assurance Committee in Common Terms of Reference and Cycle of Business** JC introduced the Terms of Reference (ToR) and Cycle of Business for the new Quality, Safety & Assurance Committee in Common, explaining that this committee is a key component of the governance architecture required as the Trust moves toward integration with BCH. He noted that a shared committee is necessary to ensure that both organisations operate under aligned, consistent and transparent arrangements for monitoring quality, patient safety, safeguarding, maternity performance, infection prevention, clinical standards and regulatory compliance. The ToR clearly set out the committee's purpose, authority, membership, quorum and reporting structure, ensuring that both Boards receive a unified view of quality and safety related assurance. **The Trust Board approved the Terms of reference and Cycle of Business for the Quality, Safety & Assurance Committee in Common**
Supplementary Papers – To note for Assurance	

BM/26/02/163 BM/26/02/164 BM/26/02/165 BM/26/02/166 BM/26/02/167 BM/26/02/168 BM/26/02/169	**Safe Nurse Staffing** **Learning from Deaths Q2** **Infection Prevention and Control Board Assurance Framework C** **Violence Reduction Strategy** **Health and Wellbeing Report** **Equality Delivery System (EDS) 2026** **Trust Senior Management Organograms**
Closing	
BM/26/02/170	**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/26/02/171	**Any Other Business** No further business was raised. **Meeting ended at 12:47pm**
Date and time of next meeting – 10am, Wednesday 1 April 2026 February 2026 – Education Centre, Halton Hospital	

Signed:
Position: Chair
Date:

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Thursday 12 March 2026, 2 – 3pm Trust Conference Room, Warrington Hospital and via MS Teams	
Present	
Steve McGuirk (SMcG)	Chair
Nikhil Khashu (NK)	Chief Executive
Cliff Richards (CR)	Non-Executive Director & Deputy Chair
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
Andy Carter (AC)	Associate Non-Executive Director/Chair Designate
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
Lucy Gardner (LG)	Chief Strategy and Partnerships Officer
Kate Henry (KH)	Director of Communications & Engagement
Michelle Cloney (MC)	Chief People Officer
John Culshaw (JC)	Company Secretary
Apologies	
Lynne Carter (LC)	Director of Delivery Unit
Observing	
Sue Fitzpatrick	Lead Governor – Public Governor, Warrington and Halton
Diane Nield	Deputy Lead Governor – Public Governor, Warrington and Halton
Catherine Ardern	Public Governor, Warrington and Halton
Stephen Walton	Public Governor, Warrington and Halton
Alan Davies	Public Governor, Warrington and Halton
Dorcas Akeju	Public Governor, Rest of England
Suresh Arni Sukumaran	Staff Governor, Estates, Administration, Managerial

Agenda Ref	Agenda Item
BM/26/03/172	**Welcome, Apologies and Declarations of Interest** SMcG opened the extraordinary public Board meeting welcoming Board members and governors and noting the significance of the meeting as the final

	assurance step prior to submission of the acquisition documents. SMcG confirmed there were no apologies and emphasised that the meeting had been scheduled following Bridgewater's Board and Council of Governors meetings earlier that day 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/26/03/173	**Matters Arising** No other matters were raised. **The Trust Board noted that there were no matters arising.**
Matters for decision	
BM/26/03/174	**Integration: Transaction documents for approval** • **Application Letter** • **New Constitution** • **Transaction Agreement** LG provided an update from the meetings that had taken place earlier in the morning. She explained that Bridgewater's extraordinary Trust Board had approved all three documents swiftly, reflecting the clarity and maturity of the work. LG also reported that at the Bridgewater extraordinary Council of Governors. LG and colleagues had once again gone through the documents carefully. Eleven governors were present, and eight were required to approve the submission of the application letter and the new constitution. Ten governors voted in favour with one unable to cast a vote. LG presented the three final documents for WHH Board approval: the Application Letter, the New Constitution, and the Transaction Agreement. She confirmed that all had been approved in principle by both Boards and both Councils of Governors in February. The principal update was inclusion of the confirmed transaction risk rating (Amber) from NHS England. Minor wording amendments had been made to the Constitution following NHSE review but none were material. LG confirmed that Amber is normal for a transaction of this scale and reflects NHSE's focus on deliverability during implementation. SMcG sought clarification on the formal sign-off process and LG confirmed that once the WHH Board and its governors approved the documents, the documents, along with the minutes of the respective Board and Governor meetings, would be submitted to NHSE the following morning. NHSE were

	already engaging the Secretary of State, from whom a decision was expected by 20 March. Subject to approval, the final grant of acquisition would be signed by Louise Shepherd on 26 March. **Following confirmation that all Board members had no further questions, SMcG asked for approval. The Board unanimously approved the:** • **Application Letter** • **New Constitution** • **Transaction Agreement**
Closing	
BM/26/03/175	**Any Other Business** SMcG offered extended reflections on the scale of work undertaken, praising Executive colleagues for exceptional leadership across both organisations and for delivering a fast and cost-effective transaction. He acknowledged the complexity of the period since late 2024 and the substantial workload borne by the leadership teams. He then reflected personally on his tenure as Chair, expressing gratitude for the privilege of serving the Trust, praising both the current and previous Non-Executive Directors and expressing confidence in the organisation's ability to meet future challenges. He welcomed AC as his successor, stating that the Board had made an excellent appointment. **Post meeting note:** SMcG also recognised MC for her service to the Trust as Chief People Officer and wished her well in her retirement.
Date and time of next meeting – 10am, Wednesday 1 April 2026 – Education Centre, Halton Hospital	

Signed:
Position: Chair
Date:

North Cheshire and Mersey
NHS Foundation Trust

Trust Board - Action Log

Agenda reference:	BM/26/04/003iii	Subject:	Action Log Trust Board	Date of meeting:	1 April 2026

1. Actions on agenda

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

2. Actions completed and closed off since last meeting

Minute ref	Meeting date	Item	Action	Owner	Due date	Completed date	Progress report	RAG Status
BM/25/10/99	01.10.25	Board Assurance Framework (BAF)	Hold a Risk Summit for NEDs to discuss BCM and WHH combined risks	JC	March 2026	4 March 2026	Proposed NCM BAF presented and discussed at BDD	
BM/25/12/129	03.12.25	Integration Update	Schedule extraordianry Public Board and Council of Governors meetings in March to align	JC	March 2026	12.03.2026	Extraordinary Public Board and Council of Governors – approved: • Application Letter	

			NHSE approval timelines				• New Constitution • Transaction Agreement	
BM/26/02/150	04.02.26	Chief Executive's Report	Formal letters to be sent to Warrington and Halton Council Leaders, ICB Chair, seeking system-wide plan to reduce No Criteria to Reside (NCTR) and improve 12-hour ED performance.	Chief Executive / Chair	March	23.02.25	Letters sent and meetings arranged	
BM/26/02/150	04.02.26	Chief Executive's Report	A reflective assurance paper on learning following inquest, focused on assurance beyond governance, to be developed and brought through the Quality Committee.	Chief Executive / Quality Committee	Q4	March 2026	JD NED Maternity Champion has met with Chief Nurse – action plans have been drawn to be reported through the Quality Committee – Board to receive updates through committee assurace reporting	

Rolling tracker of outstanding actions

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

RAG Key

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/04/005**			
Subject:	**Chief Executive's Report**			
Date of meeting:	1 April 2026			
Action required:	**Noting**			
Author(s):	Nikhil Khashu, Chief Executive			
Executive director sponsor:	Nikhil Khashu, Chief Executive			
Link to strategic aim:	All			
Link to risks on the board assurance framework:	All			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
				✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
Executive summary:	This report provides an update on key developments since the last Board meeting, including the formal acquisition of Bridgewater Community Healthcare NHS FT by Warrington and Halton Teaching Hospitals NHS FT (WHH), and the renaming of WHH to become North Cheshire and Mersey NHS Foundation Trust from 1 April. It highlights leadership changes, staff experience and wellbeing, performance and oversight arrangements with NHS England, and progress in access, elective and cancer care, alongside ongoing challenges in urgent care and financial sustainability. Overall, it reflects steady progress during a period of significant change, with a continued focus on delivering safe, high-quality and sustainable care for our communities			
Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**	
Recommendation:	The Board is asked to note the content of the Chief Executive's report.			
Previously considered by:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			

	Summary of Outcome	
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***None***	
Freedom of information status (foia):	Release Document in Full	
Freedom of information exemptions applied: ***(if relevant)***	None	

1. Background/context

This report provides the Trust Board with an overview of a range of strategic and operational issues since the last meeting on 4 February 2026, some of which are not covered elsewhere on the agenda for this meeting.

2. Key elements

2.1 Trust News

Integration with Bridgewater Community Healthcare NHS Foundation Trust

I am delighted to say that the Secretary of State for Health and Social Care has formally approved our plans to bring Warrington and Halton Teaching Hospitals NHS Foundation Trust and Bridgewater Community Healthcare NHS Foundation Trust together.

This approval means that, from 1 April, we will legally operate as a single organisation under the name North Cheshire and Mersey NHS Foundation Trust.

We have already made substantial progress in working as one organisation and have reached this point following an exceptionally rigorous and transparent process. This has included the establishment of joint executive leadership and governance arrangements, development of a comprehensive Full Business Case setting out the strategic rationale and benefits of the transaction, extensive due diligence, wide ranging staff engagement and consultation, and regular and detailed scrutiny by NHS England and NHS Cheshire and Merseyside.

Bringing our organisations together will further strengthen our services, improve our resilience, and enhance our ability to respond to the challenges we face, enabling us to deliver the best possible care for the people and communities we serve.

This milestone reflects an enormous collective effort. I would like to thank colleagues across both organisations for their professionalism, flexibility and commitment in embracing change, particularly at a time of significant operational pressure and ongoing service improvement. Achieving this alongside our continued focus on quality and performance is a considerable achievement and one we should rightly recognise.

Recognition of Bridgewater Non-Executive Directors and Governors

I would also like to formally recognise the important contribution made by the Non-Executive Directors and Council of Governors of Bridgewater Community Healthcare NHS Foundation Trust during the integration process and in supporting the final stages of the transaction. At the recent Extraordinary Meeting of the Council of Governors, governors completed their formal role in approving the constitution and supporting the Board's decision to proceed, following confirmation that both Trust Boards had completed the approvals required for the acquisition. Their scrutiny,

support and constructive challenge throughout this period have helped ensure that the process was robust, well governed and concluded appropriately. I would particularly like to acknowledge the leadership of Martyn Taylor as Chair, alongside the wider contribution of Bridgewater's governors and Non-Executive colleagues, and to place on record my sincere thanks for their commitment, professionalism and stewardship during a significant period of change

Farewell to the Chair

I would like to take this opportunity to recognise and pay tribute to Prof Steve McGuirk as he stepped down as Chair of the Trust at the end of March, having served in the role since April 2015.

Throughout his tenure, Steve brought a deep sense of public service, strong personal commitment and a clear belief in the central role the Trust plays within its community. His connection to our organisation has always been both professional and personal, informed not only by his leadership responsibilities but also by his own and his family's direct experience of our services. This perspective shaped his approach as Chair and reinforced his unwavering focus on quality, compassion and patient centred care.

Under Steve's leadership, the Trust has achieved a number of significant milestones. These include sustained improvements in our CQC ratings, with the organisation moving from requires improvement to good, and achieving good ratings for maternity services on two occasions. Alongside this, the Trust has overseen major service and infrastructure developments, including investment in diagnostic capacity, expansion of same day emergency care, additional theatres, community diagnostic centres and the growth of outreach and integrated care services, all supporting more modern care delivered closer to home.

The most challenging period of Steve's time as Chair was undoubtedly the pandemic. During this time, his leadership was characterised by calm, clarity and an unrelenting focus on supporting staff and maintaining safe services. He consistently championed the resilience, compassion and innovation shown by colleagues across the organisation, and reminded us that the strength of the NHS lies in its people.

Perhaps Steve's most enduring contribution has been his role in shaping the culture of the Trust. He has consistently promoted openness, collaboration and learning, and has placed equal importance on caring for our workforce as for our patients. As we approach the next phase of our journey, including the creation of an integrated organisation from 1 April, this cultural legacy provides a strong foundation for the future.

On behalf of the Board, governors and colleagues across the Trust, I would like to thank Steve for his outstanding service, leadership and commitment over more than a decade. We wish him well for the future and record our sincere appreciation for the contribution he has made to the organisation and the communities we serve.

Executive Retirements

I would also like recognise two retirements within our joint Executive Management Team. On 31 March, Lynne Carter and Michelle Cloney both retired, bringing to a close nearly 90 years of combined service to the NHS.

Lynne served as Director of the Delivery Unit across both organisations and Deputy Chief Executive at Bridgewater. A registered general and learning disability nurse, Lynne joined Bridgewater eight years ago as Chief Nurse and has contributed an exceptional 48 years of NHS service. She has played a pivotal role in strengthening leadership, delivery and integration across our organisations and has been instrumental in supporting us through a period of significant change. Lynne now plans to relocate to Brighton and spend more time with her family.

Michelle served as Chief People Officer at Warrington and Halton Teaching Hospitals for the past nine years. She began her NHS career in nursing in 1984, initially as an intensive care nurse, before moving into human resources and organisational development in 1997. Michelle has provided steadfast leadership across workforce, culture and organisational development, particularly during some of the most challenging periods the Trust has faced. As she prepares to welcome her first grandchild, she is looking forward to spending more time with family and pursuing new opportunities and experiences.

The retirement of both Lynne and Michelle represents a significant loss of experience, expertise and leadership. They have each made an outstanding contribution to their respective organisations and to the wider NHS, and they will be greatly missed by colleagues.

I would like to place on record my sincere thanks to Lynne and Michelle for their dedication, professionalism and commitment over so many years, and to wish them both a long, healthy and fulfilling retirement.

Thanks and Recognition

I would also like to mark the departure of Nick Gallagher, Bridgewater's Director of Finance, who leaves the organisation this week after more than 30 years of dedicated service to the NHS, including the past nine years at Bridgewater. Nick was appointed Director of Finance in December 2018 and has played a significant role as a valued and trusted member of the Bridgewater Board throughout a period of considerable change and challenge. His experience, professionalism and commitment have made an important contribution to the organisation, and he will be greatly missed.

Appointment of Chief People Officer

I am pleased to welcome Paula Woods as Chief People Officer for North Cheshire and Mersey NHS Foundation Trust from 1 April 2026, following the integration of Warrington and Halton Teaching Hospitals and Bridgewater Community Healthcare.

Paula previously served as Director of People and Organisational Development at Bridgewater. A Fellow of the Chartered Institute of Personnel and Development, she has worked in the NHS since 2004 and held a number of senior workforce leadership roles before being appointed to director level in 2020. Prior to joining the NHS, Paula worked in the housing association sector in Merseyside as an Assistant Director of Human Resources.

I would like to offer Paula a warm welcome to her new role. I look forward to working with her as we continue to build North Cheshire and Mersey NHS Foundation Trust and ensure we remain a supportive, inclusive and high performing organisation for our staff and the communities we serve.

Staff Survey Results

NHS England has published the results of the 2025 NHS Staff Survey, which was completed by colleagues last autumn. Across Warrington and Halton Teaching Hospitals and Bridgewater Community Healthcare, 2,633 staff took part. This level of participation provides a valuable and honest insight into how people are feeling about working in our organisations.

You can view the results for WHH here and BCH here.

The results highlight a number of important strengths. Colleagues continue to describe strong levels of compassion, kindness, inclusion and mutual support. These qualities remain central to our culture and are evident even during periods of significant pressure.

The survey also shows that many staff are feeling the strain of ongoing workload and operational challenges. Scores relating to morale, confidence in speaking up, psychological safety and advocacy have reduced. Feedback also points to concerns around workload, access to development opportunities and feeling valued at work. These findings reflect real experiences and are being taken seriously.

Initial analysis of the results has now been completed. By the end of March we will have received the full set of written comments from staff, which will provide deeper insight and help shape the actions we take. The Trust Board will oversee progress and ensure improvements are delivered.

Early areas of focus include improving leadership visibility, strengthening how we listen and respond to feedback, supporting staff to speak up safely, tackling bullying and unacceptable behaviour, improving recognition, and providing clearer information about career development, appraisals and training. We will also identify and spread good practice already taking place across our services.

A simple and practical approach will be developed to support teams to act on feedback that matters most to them and to sustain improvements over time. Further updates will be shared as this work progresses.

I would like to thank all colleagues who took part in the survey and for their continued dedication to our patients, communities and each other as we come together as North Cheshire and Mersey NHS Foundation Trust. Listening to staff and making visible, meaningful improvements will remain a clear priority for the Executive Team and the Board.

Thank You Awards

I am pleased to share an update on our Thank You Awards for 2025-26, which recognise and celebrate the outstanding contribution of colleagues and volunteers across our services. This year marks the first awards as North Cheshire and Mersey Foundation Trust and recognises staff from both Warrington and Halton Teaching Hospitals and Bridgewater Community Healthcare.

More than 500 nominations were received from colleagues, patients and members of the public, highlighting the exceptional dedication, compassion and professionalism shown across both organisations. Following a thorough judging process, a shortlist of 33 finalists has now been confirmed across a wide range of categories, including clinical and non-clinical teams, individual colleagues, leadership, innovation, equality and inclusion, and community and charity support.

The high number and quality of nominations demonstrate the significant impact our staff and volunteers continue to have on patients, families and each other, even during a period of sustained operational and financial pressure. All nominations will be acknowledged, with feedback shared after the awards ceremony.

I would like to thank everyone who took the time to submit a nomination and congratulate all those shortlisted. Taking time to recognise and celebrate success remains an important part of valuing our people and reinforcing the positive culture we continue to build together.

So please join me in congratulating our 2025-26 finalists (listed in alphabetical order within each category):

Clinical Team of the Year

- CT Radiology Team
- Frailty Teams (acute and community)
- Paediatric Respiratory Team

Non-Clinical Team of the Year

- Halton Community Safeguarding Team
- Medical Engineering Team
- Organisation Development Teams (acute and community)

Clinical Colleague of the Year

- Dr Furhan Razzaq, Consultant Radiologist and Director of Breast Screening, Breast Screening
- Lucy Phelan, Senior Dental Officer, Bolton Dental
- Milimo Mwiinga, Midwife, Maternity

Non-Clinical Colleague of the Year

- Gill Matthews, Governance Manager, Radiology
- Julie Cartledge, Admin and Clerical Officer, Diabetic Foot Clinic
- Matthew Percival, Supplies Operative, Supplies

Rising Star Award

- Bethany Stanley, Dietetic Assistant Practitioner, Dietetics
- Faye Riley-Joyce, The Nest/Maternity Triage Manager, Maternity
- Paula Salmon, Health Visitor, Halton 0-19 Service

Inspiring Leader Award

- Adam Harrison-Moran, Associate Chief People Officer - Strategic Workforce Development and Culture, People Directorate
- Ailsa Witherington, Clinical Team Manager, Physiotherapy
- Paula Brereton, Head of Clinical Coding & Service Development, Clinical Coding

Innovation, Improvement and Research Award

- Ambient Voice Technology Project Team, Digital Services
- Neurodevelopment Pathway and supporting corporate teams
- Paediatric Diabetes Team

Healthcare Hero

- Jade Ward, District Nurse, District Nursing Service
- Keith Knowles, Estates Mechanical Engineer, Estates
- Sharon Sunter, District Nurse, Halton District Nursing Service

Diversity and Inclusion Award

- Firdous Patel, Midwife, Maternity
- Women's Staff Network
- Zetta Edwards, Learning Disability and Autism Matron, Learning Disability and Safeguarding

Charity Champion

- Laurence Barrow, Barrow Electrical
- Sacred Heart Catholic Primary School
- Shaun Ryan, Protive Security

People's Choice Award

- Cristobelle Federico, Care Support Worker, General Medicine
- Dr Kate Hunter, Consultant, Children's Epilepsy
- Lucy Atley, Health Visitor, Warrington Health Visiting Service

The winners will be announced at our Thank You Awards ceremony on Friday 15 May at the Titanic Hotel in Liverpool, where we will be celebrating the contribution made by all of our colleagues and volunteers over the past 12 months. A special Outstanding Achievement Award will also be presented on the night.

Marking the start of Ramadan

The Trust marked the start of Ramadan, the holiest month in the Islamic calendar, which is observed by Muslims around the world. Ramadan lasts for around a month and is a time focused on reflection, self-discipline, prayer and community.

During Ramadan, many Muslims fast during daylight hours and focus on positive behaviours such as patience, compassion and supporting others. Families often gather to break the fast together in the evening, spend time in prayer, and give food or support to those in need. The month concluded with the celebration of Eid, a time of joy, family gatherings and community celebration.

Sharing these experiences helps raise awareness and understanding of the diverse backgrounds, cultures and beliefs of our workforce. Recognising and celebrating important religious and cultural events is an important part of creating an inclusive and supportive environment where colleagues feel respected and valued.

Menopause Friendly Employer Accreditation

The Trust has recently been awarded Menopause Friendly Employer accreditation, recognising our commitment to supporting colleagues through all stages of their working lives and to treating menopause as an important workplace health and wellbeing issue.

This accreditation reflects the progress made in creating a more open, supportive and informed environment where menopause can be discussed positively and without stigma. With strong support from senior leaders, menopause is increasingly recognised as something that can affect people differently and may require understanding, compassion and practical workplace adjustments.

As part of this work, the Trust now has clear menopause guidance for staff and managers, a growing network of trained menopause advocates, and regular menopause cafés that are well attended and valued by colleagues. Feedback from staff indicates greater confidence in starting conversations, asking for reasonable adjustments and feeling supported rather than struggling in silence.

Supporting colleagues to stay well at work is an important part of delivering high-quality patient care, and this accreditation marks a positive step forward in strengthening our culture of care and respect for all staff.

2.2 National, Regional & ICB News

Actions agreed with NHS England

The Trust has agreed a set of additional conditions with NHS England relating to urgent and emergency care performance and financial sustainability. These conditions, known legally as *enforcement undertakings*, reflect areas that are already a priority focus for the organisation.

Like many NHS trusts, we are facing significant challenges. These include long waiting times in the Emergency Department and a financial deficit, meaning the Trust is currently spending more than it receives. Progress is already being made, but there is further work required to deliver sustained improvement.

The Trust is not alone in this position. Most hospital providers across the region, as well as NHS Cheshire and Merseyside itself, are operating under similar arrangements with NHS England, reflecting the wider pressures across the health and care system.

Under the agreed undertakings, the Trust has committed to improving waiting times for patients attending the Emergency Department, including reducing the number of people waiting more than 12 hours, and to delivering its financial plans. This includes making steady, ongoing improvements to the Trust's financial position and attending regular oversight meetings with NHS England to review progress.

NHS England has recognised the efforts made to date and has acknowledged that the integration of acute and community services is a key part of achieving long-term sustainability for services across Warrington and Halton. The Trust will continue to work closely with NHS England and system partners, while also focusing on the improvements within its own control.

While there are no quick solutions, patients and staff remain the Trust's priority. By continuing to work together and building on the progress already made, the Trust is committed to delivering safer, more sustainable and more responsive services for the communities it serves.

NHS England Quarter 4 Tiering Position

NHS England has confirmed the Trust's performance oversight position for Quarter 4 of 2025/26. Following a regional review of performance, Warrington and Halton Teaching Hospitals NHS Foundation Trust will remain in Tier 1 for Urgent and Emergency Care and Tier 2 for Elective Care for the final quarter of the year.

Tiering is part of the national system used by NHS England to monitor how well NHS organisations are performing against key standards, including urgent and emergency care, planned care, cancer and diagnostics. Remaining in Tier 1 for urgent and emergency care reflects the Trust's continued focus on maintaining safe services

during a challenging winter period. The Tier 2 position for elective care recognises both the progress being made and the further work required to reduce long waits.

NHS England has acknowledged the significant operational pressures faced over the winter, including increased sickness levels and industrial action, and has thanked staff for their continued efforts to reduce long waiting times. The Trust will continue to work closely with NHS England during the Quarter 4 performance sprint to maximise opportunities to improve access to care for patients.

Segmentation and Ranking under NHS Oversight Framework

NHS England has published updated performance information for Quarter 3 of 202526 under the NHS Oversight Framework. This framework is used nationally to assess how NHS organisations are performing across a range of areas, including access to services, quality, workforce and financial sustainability.

For Quarter 3, Warrington and Halton Teaching Hospitals NHS Foundation Trust remains in Segment 4, which is unchanged from Quarter 2. Segment 4 indicates that, while improvements are being made in some areas, further progress is required overall. However, the Trust's national ranking has improved, moving from 125th to 106th out of 134 acute and specialist trusts, reflecting recent operational improvements.

Performance has improved in several key areas. Access to services, elective recovery and cancer performance have all shown consistent progress, with shorter waits and better national rankings. Cancer standards, including faster diagnosis and referral to treatment times, have improved, and elective care performance has strengthened, with more patients being treated within expected timeframes and fewer long waits.

Urgent and emergency care performance shows a mixed picture. While some improvement has been seen more recently, particularly in reducing the number of very long waits, this has not yet fully translated into improved national rankings.

There have also been positive improvements in patient flow and discharge, with patients spending less time waiting to leave hospital once they are medically ready. Patient safety measures remain stable, with some improvement in infection-related indicators.

These operational improvements are currently offset by challenges in financial performance and productivity.

Across Quarter 1 to Quarter 3, the overall picture is one of gradual improvement, with clear progress in access, elective care and cancer services, but with further work needed to achieve sustained improvement across all areas.

The latest national rankings provide reassurance that the Trust is moving in the right direction, reflecting the continued hard work and dedication of staff. Performance

information will continue to be updated quarterly, and the Trust's segment and ranking may change as further progress is made.

Appointment of NHS England North West Regional Chair

NHS England has announced the appointment of Kathy Cowell as the new North West Regional Chair, a newly created role intended to strengthen leadership, governance and oversight across the region. Taking up post on 1 May 2026, Kathy will provide independent, non-executive leadership, working with NHS organisations and system partners to support high-performing boards, improve health outcomes, reduce inequalities and deliver long-term NHS priorities such as better access to care, care closer to home and improved productivity. Kathy brings extensive NHS and public service experience and will act as a direct point of contact for provider and system Chairs, with NHS England highlighting the importance of this role in supporting organisations during a period of significant change.

North Cheshire & Merseyside Integrated Care Board Update

Dr Fiona Lemmens has been appointed as Executive Clinical Director and will provide senior clinical leadership, with a focus on maintaining safe, high-quality, person-centred care and strengthening clinical governance and quality improvement across the system. In addition, Ben Vinter has been appointed as Executive Director of Corporate Services and Governance. Ben joins from Liverpool Heart and Chest Hospital and will lead the Trust's corporate functions, ensuring strong governance, legal compliance and organisational resilience to support the delivery of high-quality services.

2.3 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 11 – February 2026. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside the relevant Committee Assurance Reports.

2.4 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:

February 2026

- LGBT History Month
- National Healthy Heart Month
- World Obesity Day
- World Cancer Day
- National Apprenticeship Week

- Chinese Lunar New Year
- Ramadan/ Eid Al Fitr
- Eating Disorder Awareness Week

March 2026

- Zero Discrimination Day
- Lymphoedema Awareness Month
- Brain Tumour Awareness Month
- Ovarian Cancer Awareness Month
- Prostate Cancer Awareness Month
- Ramadan/ Eid Al Fitr
- International Women's Day
- World Hearing Day
- Overseas NHS Workers' Day
- World Lymphoedema Day
- Safer Sleep Week
- World Delirium Awareness
- World Tuberculosis Day
- National supported Internship Day
- World Autism Acceptance Week
- International Transgender Day of Visibility

2.5 Signed under Seal

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

2.6 Meetings Attended

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

- Sir Jim Mackey, NHS England Chief Executive, Corridor Care Summit
- 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
- Cheshire & Merseyside Provider Collaborative (CMPC) Leadership meeting
- Cheshire & Merseyside Provider Collaborative (CMPC Delivery Board
- PricewaterhouseCoopers (PwC)
- Linda Buckley, Managing Director CMPC
- CMPC Blueprint meeting

3. Recommendations

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

Appendix 1: CEO Dashboard – Month 11 (February 2026)

Appendix 1 - CEO Dashboard Month 11 – February 2026

Quality

Operational Performance

Indicator	Target/Limit	Actual	SPC
Diagnostic waiting times - 6 Weeks	above 95%	98.38%	?
RTT 18 Weeks	above 92%	63.02%	F
RTT - patients waiting 52+ Weeks	0	564	F
RTT - patients waiting 65+ Weeks	0	1	F
Elective Outpatient activity	104%	99%	?
A&E % patients seen within 4 hours	Below 78.00%	62.64%	F
A&E % waiting longer than 12 hours	Below 2.00%	25.07%	F
Cancer 28 Day Faster Diagnostic Standard	above 75%	77.70%	F
Cancer 62 Day Wait	above 85%	84.20%	F
Ambulance Vehicle Handovers within 45 mins	100%	76.73%	F
Cancelled Operations – not rearranged within 28 days	0	5	F
Capped Theatre Utilisation	above 85%	79.00%	F

Quality of Care

Indicator	Target/Limit	Actual	SPC
Incidents open over 40 days	0	88	F
Sepsis Screening Emergency	above 90%	69.00%	F
Sepsis Screening Inpatients	above 90%	86.00%	F
Sepsis Antibiotics Emergency	above 90%	55.00%	F
Sepsis Antibiotics Inpatient	above 90%	79.00%	F
Inpatient Falls	30 (10% reduction from 2024/25)	39	?
VTE	above 95%	95.28%	F
Pressure Ulcers (Category 2 and above)	11 (20% reduction from 2024/25)	8	?
Medication Reconciliation (within 24 hrs)	above 80%	47.33%	F
Complaints over 6 months	0	1	F
Healthcare Infections - MRSA	0	0 YTD	?
Healthcare Infections - MSSA	below 29 YTD	34 YTD	F
Healthcare Infections – CDI (cumulative)	below 55 YTD	74 YTD	F
Healthcare Infections - E. coli (cumulative)	below 72 YTD	65 YTD	?
Healthcare Infections – Klebsiella (cumulative)	below 25 YTD	26 YTD	F
Healthcare Infections - P. aeruginosa (cumulative)	below 7 YTD	10 YTD	F
Maternity Postpartum Haemorrhage >1500ml	below 3.7%	4.60%	?
MUST nutritional assessment completion	above 85%	73.65%	F

Sustainability

Finance

Indicator	Target/Limit	Actual	SPC
Income & Expenditure (£m)	-£3.20	-£3.55	No SPC
Capital Spend (£m)	£21.28	£9.43	F
Cash Balance (£m)	£3.70	£17.17	No SPC
Better Practice Payment Code (£m)	above 95%	69%	F
Agency Reduction (£m)	£2.42 (30% reduction from 2024/25 plan)	£2.67	?
Bank Reduction (£m)	£22.87 (10% reduction from 2024/25 plan)	£28.50	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%	5.92%	F
Turnover	Below 13%	11.20%	P
Core/Mandatory Training	above 85%	89.82%	P
PDR Compliance	above 85%	81.49%	F

Strategy

- At the end of February, WHH and BCH received feedback on the recent NHS England review of the full business case for the Better Care Together integration programme. The feedback was positive and the NHSE 'Amber' rating means that the integration programme is able to continue as planned to a scheduled acquisition date of 1 April 2026. On this date, both organisations will formally come together as one, to become North Cheshire and Mersey NHS Foundation Trust. In the meantime, the focus of both partner organisations is on delivery of a safe and successful 'day one' for the new integrated Trust with significant work taking place across all core workstreams.
- The Runcorn Health and Education Hub is due open services from June 2026.
- The Living Well Warrington digital platform has been shortlisted in two categories for the upcoming HSJ Digital awards 2026. The team will present to the judging panel in March and the awards ceremony is in May.
- The Living Well Hub in Warrington welcomed its 50,000th visitor in February and continues to attract interest from around the country with recent site visits including teams from Bradford and Rotherham.
- 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 has been approved by Board and submitted.

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/04/007**			
Subject:	**NCM Board Assurance Framework** **NCM Risk Appetite Statement 2026/27**			
Date of meeting:	1 April 2026			
Action required:	**To approve**			
Author(s):	Emily Kelso, Head of Corporate Governance			
Executive director sponsor:	Nikhil Khashu, Chief Executive			
Link to strategic aim:	All			
Link to risks on the board assurance framework:	All			
Equality considerations:	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓	✓	✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
			✓	
	Further Information / Comments:			
Executive summary:	A Board Assurance Framework (BAF) is the principal mechanism through which NHS Boards gain visibility of the strategic risks that could compromise delivery of their statutory duties, including quality of care, patient safety, finance, workforce, performance and regulatory compliance. It provides a clear line of sight between organisational objectives, the risks that threaten their delivery, the controls in place, and the strength of assurance available to the Board, enabling informed, evidence-based decision-making and effective resource allocation. The proposed consolidated Board Assurance Framework unifies the legacy BAFs of Warrington & Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCH), providing North Cheshire and Mersey NHS Foundation Trust with a modernised, strategic and coherent approach to risk and assurance. The consolidation removes duplication, ensures consistency in risk scoring and			

<table>
<tr><td></td><td colspan="3">escalation, and strengthens alignment with NHS England expectations, the Well-Led Framework, the Fit for the Future: 10-Year Health Plan for England, and Cheshire & Merseyside Integrated Care System requirements.

The consolidated BAF elevates only true strategic risks for Board-level oversight, ensuring that operational risks are appropriately managed through the Corporate Risk Register and existing committee and divisional governance structures. The move from a bi-monthly to a quarterly reporting cycle supports more meaningful risk movement between reporting periods and enhances the quality and depth of assurance presented to the Board, in line with regional and ICS-level best practice.

Overall, the consolidated BAF provides a clearer, more strategic and forward-looking view of organisational risk, strengthens governance maturity through a refined Three Lines of Defence model, and supports greater transparency, accountability and strategic focus across the enlarged organisation.

The Board is now asked to approve the consolidated Board Assurance Framework for North Cheshire and Mersey NHS Foundation Trust.

NCM Risk Appetite Statement
In addition, The Board is asked to approve the unified 2026/27 Risk Appetite Statement for North Cheshire and Mersey NHS FT (Appendix 3). The statement aligns the former WHH and BCH approaches into a single framework that sets clear boundaries for the level of risk the Trust is willing to accept in delivering its strategic aims. It supports consistent decision-making, strengthens governance across the enlarged organisation, and aligns with the integrated Board Assurance Framework. Annual review will ensure it remains current and responsive to organisational priorities.</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:
1. Approve the nine consolidated strategic BAF risks (Appendix 1)
2. Note the legacy risk mapping (Appendix 2).
3. Approve the quarterly reporting model.</td></tr>
</table>

	4. Approve the NCM Risk Appetite Statement for 2026/27 **(Appendix 3)** The consolidated BAF positions the Trust to operate with a modern, efficient and strategically coherent governance structure aligned with local, regional and national expectations	
Previously considered by:	**Committee**	All
	Agenda Ref.	**QSACiC/26/03/32, SPCiC/26/03/230, FSPCiC/26/03/223**
	Date of meeting	10.03.2026, 18.03.2026, 23.03.2026
	Summary of Outcome	supported
Freedom of information status (foia):	Release Document in Full	
Freedom of information exemptions applied: ***(if relevant)***	None	

1. Background/context

A Board Assurance Framework (BAF) is a core governance tool used across the NHS to provide Boards with a clear, strategic view of the principal risks that could threaten delivery of organisational objectives. Its purpose is to support Boards in discharging their accountability for quality, safety, performance, finance and regulatory compliance by ensuring they have a consolidated, evidence-based understanding of the Trust's most significant strategic risks. A BAF also enables the Board to assess whether the controls and assurances in place are sufficient, where gaps exist, and where further action or scrutiny is required. In line with NHS England guidance and the Well-Led Framework, a well-designed BAF strengthens transparency, enhances decision-making and improves organisational maturity by clearly showing the connection between risks, controls, mitigations, assurances and outcomes.

Within the two legacy organisations Warrington & Halton Teaching Hospitals NHS FT (WHH) and Bridgewater Community Healthcare NHS FT (BCH) different approaches to strategic risk management were in place. At WHH, a significant number of high-scoring operational risks were routinely escalated to Board level, resulting in a detailed and operationally heavy BAF that at times duplicated information already provided through the IPR and other assurance reports. In contrast, BCH operated a more thematic BAF, structured around broader organisational priorities such as quality, health equity, EDI, workforce and partnerships.

These legacy differences created challenges in alignment, escalation, scoring and assurance.

The enlarged organisation requires a unified, coherent BAF that provides:

- A single strategic lens on risk across acute and community services.
- Clearer alignment with NHS England, ICS and regulatory expectations.
- Separation of operational risk into appropriate divisional and committee oversight structures.
- A more mature assurance architecture aligned to the Three Lines of Defence.

The consolidation of the legacy BAFs is therefore essential to establish a modern, transparent and strategically focused assurance framework that supports the Board in fulfilling its statutory responsibilities and provides a consistent risk narrative to system partners and regulators.

2. Key elements

2.1 Approach and Methodology

A comprehensive six-stage methodology has ensured consolidation has been evidence-based, transparent and robust:

I. Review of all legacy risks – including WHH risk IDs (1757, 1114, 224, 1215, 2001, 115, 1134, 134, 2273, 2253,1372) and BCH's thematic categories.
II. Thematic analysis – identifying overlap, duplication and gaps.
III. Creation of nine unified strategic risks – each with clear ownership, controls and SMART actions.
IV. Strengthening of assurance – aligning First, Second and Third Lines of Defence.
V. Removal of operational detail – operational risks redirected to divisional and corporate oversight.
VI. Benchmarking – aligning with best practice from UHLG, Mersey Care, Countess of Chester, NWL, ICS-level models, and national risk management guidance issued by NHSE.

This methodology ensures full traceability and defensibility, reinforcing regulatory confidence.

2.2 New Strategic Risk Architecture

The proposed nine strategic risks establish a modern, streamlined assurance framework that reflects the Trust's expanded service footprint and integrated care ambitions, while aligning with NCMs commitment to the NHSE *Fit for the Future: 10-Year Health Plan for England*:

1. **Quality & Patient Safety** – Focus on avoidable harm, learning systems, safety culture.
2. **Urgent & Emergency Care Flow** – System-wide flow challenges, admission avoidance, discharge processes.
3. **Planned Care Access & Elective Recovery** – Theatre productivity, diagnostics, recovery trajectories.
4. **Health Equity** – Alignment to Core20PLUS5, population health and reducing inequalities.
5. **Workforce Capacity & Wellbeing** – Safe staffing, leadership, recruitment, retention, wellbeing.
6. **Financial Sustainability** – Long-term stewardship, efficiency, ability to invest.
7. **Digital Resilience, Cyber & EPR** – Cybersecurity, DSPT compliance, EPR deployment.
8. **Estates & Infrastructure** – Backlog maintenance, safety, resilience, capacity.
9. **Partnership & System Integration** – ICS engagement, joint governance, cross-organisational pathways.

Each risk excludes operational KPIs (which are reported via assurance reports and the IPR to Committee and Trust Board), ensuring the BAF remains strictly strategic.

Appendix 1 (Proposed NCM Board Assurance Framework) sets out the proposed nine Board Assurance Framework (BAF) risks. These risks were presented to the designated Oversight Committees in Common during March 2026, where they were discussed and refined in response to committee feedback. Following these discussions, each risk was further reviewed and refined with the relevant Executive Leads.

2.3 Legacy Risk Mapping

A comprehensive review has ensured every legacy WHH and BCH risk has been accounted for and transparently mapped to the new strategic structure. Full details of this exercise are provided in **Appendix 2: Legacy Risk Cross-Mapping**, which sets out the complete lineage of each historic risk, its original controls and assurances, and its new aligned position within the nine proposed strategic BAF risks.

This ensures the Board can clearly see how historic risks have been transitioned, where they now sit within the risk management framework, and provides assurance that no legacy content has been lost in the consolidation process.

A comprehensive risk alignment has ensured every legacy WHH and BCH risk has been accounted for: Examples:

- WHH 224 → BAF 2 (UEC Flow)
- WHH 1215 → BAF 3 (Elective Access)
- BCH BAF 2 (Quality) → BAF 1 (Quality & Safety)
- BCH BAF 7 (Partnerships) → BAF 9 (System Integration)

The mapping preserves all historic content while improving strategic alignment.

2.4 Assurance Strengthening – Three Lines of Defence

The Trust Board receives assurance through the Trust's Three Lines of Defence model, enabling it to exercise effective oversight of the organisation's strategic risks. The consolidated Board Assurance Framework (BAF) has strengthened how these three assurance layers interact, ensuring clearer accountability, appropriate escalation and improved Board-level visibility of control effectiveness.

1. First Line of Defence

Operational managers, clinical teams and divisions responsible for implementing controls, managing risks, and identifying emerging issues.

2. Second Line of Defence
Corporate functions and Board committees responsible for testing the effectiveness of controls, triangulating data and providing oversight of strategic themes prior to escalation to the Trust Board.

3. Third Line of Defence
Independent assurance provided through Internal Audit, External Audit, CQC, NHS England, GIRFT and other external scrutiny mechanisms.

The consolidated BAF enhances alignment between these three lines and clarifies escalation pathways to the Trust Board. For each strategic risk, controls are mapped to First Line activity, triangulated with Second Line oversight and independently tested through Third Line assurance. Risks escalate through the following pathway:

Divisional governance → Risk Review Group → Committee (including robust reporting on the Corporate Risk Register) → Trust Board

This approach ensures that the Trust Board has clear visibility of significant risks and confidence that appropriate controls and mitigations are in place, while avoiding duplication of operational detail already provided through routine committee reports and, where appropriate, hot topics and deep dives.

2.5 Benchmarking Insight

Benchmarking was undertaken to ensure the consolidated BAF reflects best practice across the NHS. Activity included:

- Reviewing BAF structures from comparable acute, community and integrated Trusts.
- Assessing alignment with ICS expectations and NHSE guidance.
- Comparing reporting cycles and committee assurance arrangements.

Key findings:

- Strategic-only BAFs with quarterly reporting represent sector best practice.
- Clear delineation between operational and strategic risk improves assurance quality.
- Streamlined risk sets strengthen Board and committee focus.

These findings provide assurance that the proposed BAF and reporting cycle are appropriate for the enlarged organisation (NCM).

2.7 Risk Scoring

Risk scoring within the consolidated BAF will align to a single, unified methodology across the enlarged organisation. WHH uses the Datix risk management digital platform, which will remain the risk platform for the new organisation. BCH historically used the Ulysses system; however, all BCH risks are now being transferred into Datix to ensure full alignment in how risks are captured, monitored and escalated. The consolidated BAF will adopt the Datix 5×5 risk scoring matrix, which assesses each risk using **Likelihood (L)** and **Consequence (C)**.

This L×C model is well established across the NHS, benchmarks strongly with national and regional providers, and provides a clear, proportionate and transparent method for assessing strategic risk severity.

Fig 1: *The image is the 5×5 DATIX grid depicting the risk assessment matrix for NCM. The rows represent the Likelihood levels from Rare to Almost Certain, while the columns show the Consequence levels from Negligible to Catastrophic.*

2.7 Quarterly Reporting Model

A quarterly reporting cycle is being proposed which aims to:

- Provide clearer strategic focus.
- Allow meaningful shifts in risk profile and accountability
- Reduce administrative duplication.
- Align with ICS, and peer models along with NHSE recommended best practice.
- Strengthen Board scrutiny by ensuring operational assurance is sought and received at committee level and escalated appropriately through the BAF.

3. North Cheshire and Mersey NHS Foundation Trust - Risk Appetite Statement

As part of its responsibilities for effective governance, the Trust Board is required to review and approve a Risk Appetite Statement for the enlarged North Cheshire and Mersey NHS Foundation Trust (NCM) and, thereafter, to undertake this review on an

annual basis. This ensures the Board maintains clear and current oversight of the level of risk it is willing to accept in pursuit of the Trust's strategic aims.

Risk appetite reflects the amount and type of risk the organisation is prepared to pursue, retain or tolerate in delivering its strategic objectives. It requires active consideration of the opportunities created through innovation, transformation and partnership working, balanced against the threats that change and operational pressures can present. A clearly articulated risk appetite supports transparent decision-making, consistent judgement, and an aligned organisational response to risk.

The proposed NCM Risk Appetite Statement has been developed by consolidating and harmonising the approaches of the two legacy organisations:

- Warrington and Halton Teaching Hospitals NHS FT (WHH) – whose Risk Appetite Statement has been reviewed annually (last approved Trust Board 5th February 2025) since its development with the support of the Good Governance Institute in 2022/23.
- Bridgewater Community Healthcare NHS FT (BCH) – whose Risk Appetite Statement formed part of the BCH Risk Management Framework, last reviewed in April 2025.

This integrated approach ensures continuity of assurance, a shared understanding of risk thresholds, and alignment with the operating environment of the new organisation.

The proposed **2026/27 Risk Appetite Statement for NCM (Appendix 3)** builds on established principles from both legacy Trusts and aligns risk appetite categories with the Trust's strategic aims across Quality & Safety, People, Sustainability and System Integration. It also reflects the consolidated Board Assurance Framework, which brings together the nine high-level strategic risks inherited from WHH and BCH into a unified structure for the new organisation.

The Board is asked to discuss and approve the proposed 2026/27 NCM Risk Appetite Statement, noting that it will serve as a key reference point for risk identification, escalation, assurance and decision-making across the integrated Trust. An annual review will ensure that the Statement remains responsive to the organisation's evolving context, operational pressures and strategic priorities.

4. Recommendations

The Trust Board is asked to:

5. Approve the nine consolidated strategic BAF risks **(Appendix 1)**
6. Note the legacy risk mapping **(Appendix 2).**
7. Approve the quarterly reporting model.
8. Approve the NCM Risk Appetite Statement for 2026/27 **(Appendix 3)**

The consolidated BAF positions the Trust to operate with a modern, efficient and strategically coherent governance structure aligned with local, regional and national expectations

Appendix 1 – Proposed NCM Board Assurance Framework

North Cheshire and Mersey
NHS Foundation Trust

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	CQC Domain(s)	Risk Appetite	Monitoring Committee
BAF 1	CN and EMD	**Quality of Care & Patient Safety (includes Fragile Services)** If we fail to deliver consistently safe, effective, and high-quality care across clinical pathways, then patients may experience avoidable harm, poorer clinical outcomes, and a diminished overall experience, resulting in reduced public confidence, potential regulatory concerns, and reputational damage.	1	16 (L4xC4)	4 (L2xC2)	Safe Responsive	Minimal	Quality, Safety & Assurance Committee
BAF 2	COO	**Urgent & Emergency Care Flow** If we cannot effectively balance demand, capacity and flow across urgent and emergency care pathways, then delays, overcrowding and clinical risk will increase, resulting in reduced ability to provide safe and timely care and reliance on corridor care.	1	20 (L5xC4)	4 (L2xC2)	Safe Responsive	Minimal	Quality, Safety & Assurance Committee
BAF 3	COO	**Planned Care Access & Elective Recovery** If we cannot sustain sufficient elective, outpatient and diagnostic capacity, then long waits and clinical risk will increase, resulting in reduced ability to deliver timely, equitable and effective planned care	1	12 (L3xC4)	6 (L3xC2)	Safe Effective	Cautious	Quality, Safety & Assurance Committee
BAF 4	CN	**Embedded Health Equity** If we do not take coordinated action to reduce health inequalities and ensure equitable access, outcomes and experience across all communities, then avoidable variation in health and service utilisation may persist, resulting in entrenched inequities and poorer population health	3	9 (L3xC3)	4 (L2xC2)	Responsive	Cautious	Quality, Safety & Assurance Committee
BAF 5	CPO	**Workforce Capacity, Capability & Wellbeing** If we are unable to build and sustain a capable, flexible and high-performing workforce aligned to service needs, then our ability to deliver safe, high-quality care and meet objectives will be compromised, resulting in increased risk to quality, staff experience and delivery	2	12 (L4xC3)	6 (L3x2)	Well-Led	Minimal	Strategic People Committee
BAF 6	CFO	**Financial Sustainability** If the Trust does not maintain a balanced and recurrent financial position, then financial resilience, regulatory compliance and our ability to invest in priority services will be compromised, resulting in constrained service delivery and increased regulatory risk.	3	20 (L5xC4)	9 (L3xC3)	Effective, Well-Led	Open	Finance, Sustainability & Performance Committee
BAF 7	EMD	**Digital Resilience, Cyber Security & EPR**	3	16 (L4xC4)	6 (L3 xC2)	Well-Led	Cautious	Finance, Sustainability

		If our digital infrastructure, cyber defences and EPR programme are not mature or resilient, then we may face operational disruption, cyber attack, data loss and reduced productivity, resulting in risks to patient safety, data compliance and efficiency.				Safe Effective		& Performance Committee
BAF 8	COO	**Estates, Infrastructure & Capital Planning** If we cannot maintain, modernise or safely operate our estate, then we may fail to provide safe facilities, meet statutory requirements or support service transformation, resulting in increased safety risk and delayed improvement.	3	16 (L4xC4)	9 (L3xC3)	Well-Led Responsive	Open	Finance, Sustainability & Performance Committee
BAF 9	CSPO	**Partnership, Integration & System Working** If we do not integrate services effectively and fail to collaborate successfully with system partners, then fragmentation of pathways will continue, and outcomes diminish resulting in failure to meet increased demands and reduced long-term sustainability	3	9 (L3xC3)	4 (L2xC2)	Responsive, Safe, Well-Led	Open	Finance, Sustainability & Performance Committee

Strategic Aims:

1. **QUALITY** - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience.
2. **PEOPLE** - We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future with staff developing, growing and thriving.
3. **SUSTAINABILITY** - We will work in partnership with others to achieve social and economic wellbeing in our communities, and improve equity in health outcomes.

North Cheshire and Mersey
NHS Foundation Trust

BAF1: Quality of Care & Patient Safety (includes Fragile Services)

If we fail to deliver consistently safe, effective, and high-quality care across clinical pathways, then patients may experience avoidable harm, poorer clinical outcomes, and a diminished overall experience, resulting in reduced public confidence, potential regulatory concerns, and reputational damage.

Risk Scoring								
Inherent Score			Current Score			Target Score		
L	C		L	C		L	C	
5	4	20	4	4	16	2	2	4

CQC Domain(s)	Safe, Responsive
Executive Lead	Executive Medical Director and Chief Nurse
Strategic Aim	We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience.
Monitoring Committee	Quality, Safety and Assurance Committee
Risk Appetite	Minimal

Risk Scoring 2026/27			
Q1	Q2	Q3	Q4

Linked High Scoring Corporate Risks (12 and above)		
Risk ID	**Risk Description**	**Scoring**
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.	**20**
1805	If the Trust does not exceed a 20% reduction in pressure ulcers then this may adversely impact on patient length of stay, mobility, pain, experience of care and resulting in the Trust not meeting the WHH Quality Priority for hospital acquired pressure ulcers	**12**
1939	If the Trust implements the Accelerated Transfer SOP which supports the nursing of patients in temporary escalation spaces. Then there may be an additional patients on ACCU, A4, A6, A7, A8, A10, B14, B18, C20, C21, K25 for accelerated transfers/boarding and A9, B12 and B19 for boarding only. Resulting in a decompression of ED and a reduction to risks for patient in ED balanced against risks of additional patients in escalated inpatient wards e.g. disturbed sleep for patients or different call bell arrangements may increase the risk of slips, trips and falls and a potential adverse impact of patient experience e.g. privacy and dignity.	**12**

Controls

Clinical Governance & Safety Controls

- Incident reporting system (Datix), SI framework, mortality & morbidity reviews
- Clinical policies, pathways and Quality Impact Assessment processes
- Senior safety huddles (daily in acute, weekly in community)
- Learning from Deaths, PSIRF implementation, thematic reviews (WHH + BCH)
- Clinical audit programme including internal, external, and commissioner audits
- NICE guidance tracking and assurance
- Quality compliance dashboards
- Clinical Harm Reviews

Fragile Services Oversight

- Formal identification and designation process
- Prioritised senior support for fragile specialties: Orthopaedics (Fractured Neck of Femur), Urology, Chronic Pain Service, Rheumatology.
- Workforce and diagnostic sustainability programme (BCH & WHH alignment)
- Bi-monthly/quarterly oversight to Quality Committees (QSAC / PSCESC)

Quality Improvement & Service Transformation

- Includes BCH BOOST programme and WHH QI programmes:
- Ward accreditation and community quality visits
- Quality Indicators
- Service transformation (BOOST, pathway redesign, winter plan schemes)
- Workforce resilience plans and EDI strategies

Patient Experience

- FFT returns, complaints/PALS learning, patient stories
- Enhanced equality impact assessments
- In Patient Survey results

Assurances

1st line – Operational Assurance	2nd line – Corporate Oversight	3rd line – Independent./External
• Divisional quality performance reviews • Harm panels and mortality reviews • Incident learning reviews and safety huddles • Real-time quality dashboards and QI metrics • Safer staffing dashboards and CHPPD monitoring • PTL and pathway review meetings (elective & cancer) • Daily UEC flow escalation and site management logs	• Quality, Safety & Assurance Committee (QSAC) • Corporate Safer Care metrics, quality dashboards • Matron / Head of Nursing assurance rounds • Patient Safety and Clinical Effectiveness Committee oversight • Safeguarding Committee / Core20PLUS5 oversight • Strategic People Committee oversight of workforce risks • UEC Board, RTT/flow performance reviews • Finance & Sustainability Committee (cross-cutting risks) • Integrated Performance Report	• Internal Audit reviews of clinical governance, DSPT, risk management • External regulatory assurance (CQC engagement, Well Led Review) • External Clinical Audit programmes • External peer reviews (GIRFT, specialty reviews) • NHSE assurance (urgent care, elective recovery, digital) • External safeguarding boards & partnership oversight

Gaps

- Variation in safety bundle compliance and documentation (high-pressure areas)
- Limited resilience in fragile specialty workforce and diagnostic capacity
- Capacity constraints across theatres, outpatient and diagnostic services
- Variation in pathway equity / access (health inequalities)
- High agency reliance in hotspot areas; variable leadership capacity
- Digital infrastructure legacy systems and cyber vulnerability (cross-impact on care)
- Estates constraints affecting care environments and patient flow

Action Description	Responsible Officer	Deadline	Completion Date
Standardise safety bundles with monthly audit & feedback loops including cross-divisional peer review and hotspot escalation.	Chief Nurse	Q1–Q2	
Implement fragile specialty sustainability programme covering workforce, diagnostics, job planning, escalation triggers and networked support.	Executive Medical Director	Ongoing	
Develop Trust-wide health inequalities dashboard with deprivation, ethnicity, LD/SMI stratification; embed into IQPR; quarterly deep dives.	Chief Nurse	Q2	
Reduce agency in hotspot areas via conversion plans, targeted recruitment campaigns, retention bundles, careers clinics, leadership support.	Chief People Officer	Q1–Q3	
Strengthen PSIRF learning adoption including thematic reviews, human factors training, learning briefs, and cross-site learning huddles.	Executive Medical Director / Chief Nurse	Q1–Q4	
Improve documentation compliance via digital optimisation, audits, coaching, standard templates and AMaT integration.	Executive Medical Director / Chief Nurse	Q2–Q4	

North Cheshire and Mersey
NHS Foundation Trust

BAF2: Urgent & Emergency Care Flow

If we cannot effectively balance demand, capacity and flow across urgent and emergency care pathways, then delays, overcrowding and clinical risk will increase, resulting in reduced ability to provide safe and timely care and reliance on corridor care.

Risk Scoring								
Inherent Score			Current Score			Target Score		
L	C		L	C		L	C	
5	5	25	5	4	20	2	2	4

CQC Domain(s)	Safe, Responsive
Executive Lead	Chief Operating Officer
Strategic Aim	We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience.
Monitoring Committee	Quality, Safety and Assurance Committee
Risk Appetite	Minimal

Risk Scoring 2026/27			
Q1	**Q2**	**Q3**	**Q4**

Linked High Scoring Corporate Risks (12 and above)		
Risk ID	**Risk Description**	**Scoring**
1749	If Emergency Department (ED) nursing vacancies persist at levels exceeding 25%, despite sustained and targeted recruitment efforts, the department will be unable to maintain safe staffing levels comprising adequately qualified, competent, and experienced nursing personnel. This shortfall will compromise the department's capacity to meet patient care demands and may result in non-compliance with Regulation 18(1), which mandates the provision of sufficient staffing to ensure safe and effective service delivery.	**12**

Controls

Command & Capacity Management
- 4× daily Trust-wide capacity meetings and 6× per day bed reports
- Tactical/Strategic/Operational command structure with trained tactical managers (bi-annual training)
- Daily C&M system control calls for escalation of system delays
- SHREWD used daily for site decision making
- Additional senior manager on-call and site coordinator support

Emergency Department Controls
- ED escalation processes, intentional rounding with senior decision makers
- Manchester Triage with streaming to SDEC/UTC
- Enhanced Paediatric ED – more cubicles, larger footprint
- Co-located minors/UTC model
- Senior doctor at triage function; ED progress chaser role

Front-door Assessment Units
- SDEC 24/7, reconfigured to Type 5 model
- Emergency Frailty Department (EFD) – 5 days/week
- Gynae Assessment Unit (GAU) and Paediatric Assessment Unit (PAU) – 7 days/week
- CT scanner co-located in ED to reduce delays

Discharge & Flow Controls

- Daily Integrated Discharge Team (IDT) huddles with social care
- Additional Local Authority step-down capacity (Statham Manor, Oak Meadow, etc.)
- Strengthened D2A pathways and intermediate care escalation
- Enhanced monitoring of GPAU/ambulatory pathways and capacity

Seasonal & Surge Controls

- Winter escalation capacity (A10, B4)
- Workforce review to increase evening and weekend cover for peak demand
- Business case for earlier diagnostics (phlebotomy, AMU flow)

Assurances

1st line – Operational Assurance	2nd line – Corporate Oversight	3rd line – Independent./External
• ED/flow dashboards, revised "ED at a Glance" tools • Daily SITREP, 4× bed meetings, continuous flow logs • Incident reviews for delays, ambulance handover monitoring • Live monitoring of escalation beds and corridor care documentation	• UEC Improvement Group with Executive oversight • Performance Improvement & Oversight Group → Finance, Productivity Sustainability Committee • Quality, Safety & Assurance Committee oversight of harms and risk trajectory	• GIRFT UEC support (Tier 1 national escalation) • Newton Europe review and flow recommendations • ICS-level Urgent & Emergency Care System Improvement Group (5-workstream programme) • RCEM guidance implemented and achieved

Gaps

- No co-located Urgent Treatment Centre (UTC)
- Ongoing **industrial action** impacting multiple staffing groups, including junior doctors
- Persistent system-wide constraints in **primary care access**, increasing ED demand
- Intermittent community discharge capacity limits (LA & private provider)
- Increasing higher acuity (Types 1 & 3) driven by demographic need
- Residual corridor care risk despite mitigation efforts
- Limited assurance of sustainable reduction in LOS without system-wide alignment
- Mental Health – Lack of 136 Provision
- Restrictive Estate – Inadequate capacity to meet demand
- Risk of inadequate ICB resource post restructure

Action Description	Responsible Officer	Deadline	Completion Date
Optimise SDEC and UTC/minors streaming to reduce front-door pressure	Chief Operating Officer	Q1–Q2	
Deliver system-wide UEC improvement programme (5 workstreams)	UEC Programme Lead	Ongoing	
Maintain escalation of 4-hour and 12-hr DTA standards via command structure	Chief Operating Officer	Continuous	
GIRFT Corridor Care Plan Phase 1	Chief Operating Officer	Q1	
Improvement in paediatric pathway to be >90%	Chief Operating Officer	Q1–Q2	
SDEC – test separation of medical and surgical pathways to increase capacity	Chief Operating Officer	Q1	
Minors to continue >95%	Chief Operating Officer	Ongoing	
Continue to implement Ambulance Handover 45 (H45) recommendations	Chief Operating Officer	Q1	

North Cheshire and Mersey
NHS Foundation Trust

BAF3: Planned Care Access & Elective Recovery

If we cannot sustain sufficient elective, outpatient and diagnostic capacity, then long waits and clinical risk will increase, resulting in reduced ability to deliver timely, equitable and effective planned care

Risk Scoring								
Inherent Score			Current Score			Target Score		
L	C		L	C		L	C	
5	4	20	3	4	12	3	2	6

CQC Domain(s)	Safe, Effective
Executive Lead	Chief Operating Officer
Strategic Aim	We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience.
Monitoring Committee	Quality, Safety and Assurance Committee
Risk Appetite	Cautious

Risk Scoring 2026/27			
Q1	**Q2**	**Q3**	**Q4**

Linked High Scoring Corporate Risks (12 and above)		
Risk ID	**Risk Description**	**Scoring**
1048	If the speciality doctors don't have the full competency and a number of consultants retire there may be the inability to deliver the expected levels of activity for their budgeted establishment, then service capacity will not meet current demand across all points of delivery, which will increase backlogs and overall waiting times resulting in delays to diagnosis and treatment.	**16**

Controls

Elective Site & Theatre Capacity Controls

- Halton site established as a cold elective hub to protect elective work from UEC pressures.
- Modular build operational at Halton to expand pre-operative assessment capacity.
- Targeted Investment Fund (TIF) capital investment: additional two theatres at Nightingale completed, additional endoscopy room operational.
- Post-Anaesthetic Care Unit (PACU) operational since Jan 2021.
- New Clinical Treatment Suite opened in Nightingale (May 2022) to expand chronic pain and elective capacity.

Diagnostics & CDC Controls

- CDC Phases 1, 2, & 3 all operational
- Weekly mutual aid reviews with C&M diagnostics hub.
- Live utilisation dashboards for theatres and endoscopy.

Waiting List & PTL Controls

- Weekly PTL review meetings for long waiters (52+ weeks; 65+ weeks).
- Ongoing validation of RTT and follow-up lists to ensure data quality.
- Prioritisation of urgent cancers and clinically urgent patients.
- Use of Elective Recovery Funding to reduce the longest waiting patients
- GIRFT Productivity Programme

Workforce Controls

- Continuous review of ward and theatre staffing.

- WLI review used to inform pay incentives and overtime capacity.
- Workforce planning for elective centre expansion.

System & Flow Controls Supporting Elective Care

- Daily Bed Meetings to ensure adequate elective capacity.
- Bioquell pods in ICU and ED to support IPC and reduce escalations into Main Theatre.
- Ongoing independent sector and insourcing/outsourcing arrangements.

Assurances

1st line – Operational Assurance	2nd line – Corporate Oversight	3rd line – Independent/External
• Weekly PTL reporting packs and activity dashboards. • Endoscopy hub utilisation and CDC reporting. • Live recovery dashboards monitored via Performance Review Group. • Clinical harm review outputs for long waiters	• Access & Performance governance structure. • Productivity Improvement Oversight Group monitoring theatre, outpatient and diagnostics productivity. • Reporting to Quality, Safety & Assurance Committee and Finance, Sustainability and Performance Committee	• Regional/NHSE performance oversight

Gaps

Capacity Gaps

- Limited estate footprint at Warrington (A5 elective areas).
- Workforce gaps in medical staffing and specialised elective services.
- Diagnostic bottlenecks despite CDC expansion.

Estate & Infrastructure Gaps

- Further estates work required to complete full Elective Centre development at Halton.
- Reconfiguration needed for day-case facilities.

Quality & Safety Gaps

- Fragile specialties requiring additional support.
- Variation in theatre productivity and job plan alignment

Action Description	Responsible Officer	Deadline	Completion Date
Implement theatre productivity programme (6-4-2, job plan alignment, start/finish discipline)	Chief Operating Officer / Executive Medical Director	Q1–Q2	
Expand CDC sessions and increase reporting capacity	Chief Operating Officer	Q1	
Continue use of independent sector and mutual aid to reduce waits	Chief Operating Officer	Ongoing	
Strengthen waiting list validation and clinical harm review processes	Chief Operating Officer / Divisional Directors	Q1–Q4	
Complete elective centre estate reconfiguration at Halton	Chief Operating Officer / Estates	Q2–Q4	
Increase sessional uptake to >75% in 2026/27	Chief Operating Officer	Q1–Q4	

North Cheshire and Mersey
NHS Foundation Trust

BAF 4 – Embedded Health Equity

If we do not take coordinated action to reduce health inequalities and ensure equitable access, outcomes and experience across all communities, then avoidable variation in health and service utilisation may persist, resulting in entrenched inequities and poorer population health

Risk Scoring								
Inherent Score			Current Score			Target Score		
L	C		L	C		L	C	
4	4	16	3	3	9	2	2	4

CQC Domain(s)	Responsive
Executive Lead	Chief Nurse
Strategic Aim	We will work in partnership with others to achieve social and economic wellbeing in our communities, and improve equity in health outcomes.
Monitoring Committee	Quality, Safety and Assurance Committee
Risk Appetite	Cautious

Risk Scoring 2026/27			
Q1	**Q2**	**Q3**	**Q4**

Linked High Scoring Corporate Risks (12 and above)		
Risk ID	**Risk Description**	**Scoring**

Controls

Health Inequalities, Access & Population Health Controls
- Health Inequalities & Prevention Pledge with Trust Board oversight.
- Embedding health equity expectations into governance (Board, QSAC, QIA panels).
- Exec leadership within ICS, Provider Collaborative and Children's Services development.
- Understanding access variation through activity, referral and cohort data (e.g., deprivation, ethnicity, LD/SMI).
- Integrated Care Partnership involvement: Warrington Together, One Halton, Dental Networks.

Safeguarding, Inclusion & Accessible Care Controls
- MCA/DoLS/LPS, PREVENT, Domestic Abuse policies and MASH pathways.
- Accessible Information Standard; interpreting services.
- Core20PLUS5 implementation across services.
- EDI impact assessments for service change.

Partnership & System Controls
- Joint working with commissioners/local authority on health equity and demand (e.g., paediatrics).
- Senior Responsible Officer (SRO) system roles for Executives.
- Memoranda of Understanding for collaborative service delivery.
- Anchor Institution commitments.

Assurances

1st line – Operational Assurance	2nd line – Corporate Oversight	3rd line – Independent./External
• Safeguarding audits; patient experience metrics segmented by protected groups.	• QSAC oversight of Core20PLUS5, safeguarding, and inequalities metrics. • Public Sector Equality Duty reporting. • EDI improvement plan monitoring.	• External safeguarding boards (Adults & Children). • NHSE/CQC oversight. • ICS/Provider Collaborative governance structures.

• Understanding activity and referral data for access and variation.	• Programme oversight of the Prevention & Health Inequalities Pledge	• External audits (Risk Management, PSIRF, Quality Spot Checks, Dermatology etc.). • Anchor Institution assessment framework.

Gaps

System & Data Gaps

- Health equity improvement depends on system-wide action, limiting unilateral control.
- Immature health equity indicators and need for strengthened stratified reporting.
- Variation in access where system factors (commissioning, community services) drive inequity..

Operational Gaps

- Need for standardised, Trust-wide approach to EDI impact assessments.
- Opportunities to strengthen joint planning with community/VCFSE partners

Action Description	Responsible Officer	Deadline	Completion Date
Develop and embed a comprehensive health equity dashboard (stratified by deprivation, ethnicity, LD/SMI, carers) into IQPR	Chief Nurse / Medical Director	Q2	
Deliver system-wide Core20PLUS5 programmes with PCNs and ICPs	Chief Nurse	Ongoing	
Standardise EDI impact assessments for service changes and business cases	Chief Nurse / EDI Lead	Q1–Q3	
Improve accessibility and interpreting standards compliance across pathways	COO / Chief Nurse	Q1–Q4	
Strengthen partnership governance and joint initiatives through ICP/ICS roles	Executive Team	Ongoing	

North Cheshire and Mersey
NHS Foundation Trust

BAF 5 – Workforce Capacity, Capability & Wellbeing

If we are unable to build and sustain a capable, flexible and high-performing workforce aligned to service needs, then our ability to deliver safe, high-quality care and meet objectives will be compromised, resulting in increased risk to quality, staff experience and delivery.

Risk Scoring								
Inherent Score			Current Score			Target Score		
L	C		L	C		L	C	
4	4	16	4	3	12	3	2	6

CQC Domain(s)	Well-Led
Executive Lead	Chief People Officer
Strategic Aim	We will be the best place to work, with a diverse and enlarged workforce that is fit for now and the future with staff developing, growing and thriving.
Monitoring Committee	Strategic People Committee
Risk Appetite	Cautious

Risk Scoring 2026/27			
Q1	Q2	Q3	Q4

Linked High Scoring Corporate Risks (12 and above)		
Risk ID	**Risk Description**	**Scoring**
200	If there continue to be high levels of sickness above the trust target then this will cause staffing shortages resulting in an impact to service delivery, and risk financial targets for temporary staffing / agency spend	**15**
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.	**16**
2103	If the Trust does not reduce the disparate amount of bullying and harassment towards staff with specific protected characteristics compared with others, then there may be an increase in staff harm, poor wellbeing and employee relations activities.	**12**
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.	**12**

Controls

Safe Staffing & Rostering Controls

- Twice-daily SafeCare acuity-based staffing reviews
- Matron sign-off of rosters; e-rostering KPIs; weekly KPI oversight meetings
- Workforce Review Group monitoring recruitment/retention progress
- Daily Gold Command review of skill mix and red flag staffing risks
- Agency reduction plan; NHS Professionals bank first model; local nursing workforce plans

Attendance, Wellbeing & Sickness Controls

- Supporting Attendance Policy and clinics; internal audits; MDT absence reviews
- OH services, wellbeing hub, mental health responders, physiotherapy, smoking cessation support
- 'Improving Attendance Together' programme – system-wide initiative
- Health & wellbeing programmes, Check-in Conversations, Menopause cafés, grief support
- Enhanced staff wellbeing surveys, temperature checks, action plans

Recruitment, Attraction & Retention Controls

- VCP vacancy panel scrutiny; TRAC recruitment improvements

- Apprenticeship & widening participation programmes
- Student nurse recruitment/engagement; STEPP; CSWD pipeline
- Internal transfer process to reduce turnover and improve retention
- Social media attraction strategy; improved benefits package; flexible retirement options

EDI, Culture & Leadership Controls

- Choose Kindness campaign; sexual safety campaign
- Talent management and succession planning ("Scope for Growth")
- Leadership development, coaching and resilience training
- Bi-monthly Staff Side meetings; FTSU; POD Council; LNC/JNCC

Workforce Planning & System Controls

- Workforce planning for pressured services (ED, maternity, district nursing)
- Delivery Unit oversight for workforce KPIs
- Strategic People Committee for shared oversight

Industrial Action

- Updated IA policies and clear Trust-wide approach.
- Early workforce planning through advance rostering and standardised templates.
- Established IA governance: tactical meetings, escalation routes, EMD-led oversight and sign-off.
- Staff communications maintained; national guidance followed.
- Rate card used to secure medical staffing and maintain service continuity.

Assurances

1st line – Operational Assurance	2nd line – Corporate Oversight	3rd line – Independent./External
• Sickness dashboards; turnover/vacancy reporting; bank/agency usage reports • Red flag reviews and safe staffing outputs • E-Roster system reporting and rostering compliance • PDR and mandatory training compliance • 2025 IA periods delivered safely with strong operational planning and oversight. Clear rota approval process and controlled approach to elective cancellations	• Strategic People Committee; Safe Staffing Committee • Recruitment & retention reports, ER casework, wellbeing triangulation • EDI oversight including Anti-Racist Framework accreditation progress • Workforce reporting to Quality & Safety Committee for safe staffing risks • IA Response Group provided structured oversight and embedded learning into future planning. Reporting in place for workforce, activity and financial impacts.	• National Staff Survey & engagement results • Internal Audit: Attendance management, bank/agency controls, FTSU (High) • External benchmarking of sickness absence, turnover, apprentice completion • WHH & BCH joint assurance through People Plans & NHS LTWP alignment • Trust compliant with national IA guidance; no derogations required. • External assurance gained through ICS/NHSE engagement and national/regional IA forums.

Gaps

Workforce Gaps & Safe Staffing

- Persistent vacancies in hotspot areas (ED, paediatrics, maternity)
- Increased red flags in escalation areas & enhanced care
- Delay in filling posts due to recruitment timelines

Attendance, Sickness & Wellbeing Gaps

- Sickness absence above target with no sustained improvement
- High temporary staffing reliance and increased unplanned bed capacity requiring escalation areas
- Exit interview completion rates remain low

Culture, EDI & Engagement Gaps

- Variable leadership capacity in pressured services
- Variation in staff experience and engagement between teams
- Ongoing need to embed person-centred absence management approach

Industrial Action

- Ongoing and potential new industrial action across multiple staff groups, with several ballots active or pending.
- Risk of further cancellation of elective and outpatient activity to maintain safe staffing.
- Financial and recovery impacts expected from cancelled activity and IA-related staffing costs.
- Limited visibility on timing of next Resident Doctor IA; possible overlap with peak winter pressure.
- Requirement to respond to system information requests via EPRR and ensure alignment with ICB planning.

Action Description	Responsible Officer	Deadline	Completion Date
Convert long-term agency to bank/permanent roles; maintain rate card discipline	Chief People Officer	Q1–Q3	
Strengthen safe staffing oversight incl. acuity reviews and red flag response	Chief Nurse	Ongoing	
Deliver leadership development & coaching for key pressured services	Chief People Officer / OD Lead	Q2	
Enhance recruitment pipeline: apprenticeships, SNA/CSWD cohorts, student nurse engagement	Chief People Officer / Workforce Leads	Q1–Q4	
Reduce agency/bank in hotspot areas via conversion plans, targeted recruitment campaigns, retention bundles, careers clinics, leadership support.	Chief People Officer	Q1–Q3	
Improve exit interviews, stay conversations, and retention KPIs	Chief People Officer	Q2–Q4	
Roll out preference rostering & flexible working expansion (#MYFlex)	Associate Chief People Officer / E-Roster Team	Q1–Q4	
Refine wellbeing offer based on NHS Wellbeing Framework	Chief People Officer / People Promise Manager	Q1–Q2	
Focused HR support in areas of high sickness	Chief People Officer / Workforce Leads	Q1–Q4	
Continue monitoring all intelligence, ballots and emerging industrial action across staff groups and coordinate the Trust's response in line with national and ICB guidance.	Executive Medical Director	Q1	
Apply the Trust's IA operating procedures, embedding learning from previous events, and work collaboratively with Trade Unions and the People Directorate to plan for any workforce impacts.	Executive Medical Director	Q1	

North Cheshire and Mersey
NHS Foundation Trust

BAF 6 – Financial Sustainability

If the Trust does not maintain a balanced and recurrent financial position, then financial resilience, regulatory compliance and our ability to invest in priority services will be compromised, resulting in constrained service delivery and increased regulatory risk.

Risk Scoring								
Inherent Score			Current Score			Target Score		
L	C		L	C		L	C	
5	5	25	5	4	20	3	3	9

CQC Domain(s)	Effective, Well-Led
Executive Lead	Chief Finance Officer
Strategic Aim	We will work in partnership with others to achieve social and economic wellbeing in our communities, and improve equity in health outcomes
Monitoring Committee	Finance, Sustainability and Performance Committee
Risk Appetite	Open

Risk Scoring 2026/27			
Q1	**Q2**	**Q3**	**Q4**

Linked High Scoring Corporate Risks (12 and above)		
Risk ID	**Risk Description**	**Scoring**
2099	If the Trust does not achieve the assumed target variable activity for 2025/26 (included in the operational plan) income will be clawed back under the principles of the Aligned Payment and Incentive (API) contract. This will increase the Trust financial deficit, posing a significant risk to the Trust financial position. If performance exceeds 100% this may generate additional income for the Trust, however there is a risk of non-payment of overperformance due to Commissioner affordability.	**15**
2100	If the Trust does not adequately identify and deliver the full balance of CIP schemes recurrently from a target of £21.5m. This will pose a significant risk to the Trust achieving its control total in 2025/26.	**12**

Controls

Core Financial Management Controls

- Financial Recovery Plan; forecasting and scenario modelling
- Standing Financial Instructions (SFI) and Scheme of Reservation & Delegation (SoRD)
- QIA processes and benefits tracking to ledger
- Capital Controls: Monthly capital planning group oversight
- Cash controls: daily cashflow and 12 month rolling forecast
- Procurement controls: tender waivers scrutiny, training and reporting to the Audit Committee
- Executive approval required for new revenue spend (self-funding or safety cases only)

Resource Sustainability Controls

- Integrated Finance and Workforce operational planning
- Delivery Unit structure (workforce & non-pay and productivity focussed meetings)
- Vacancy control panels; enhanced temporary staffing controls

System & Partnership Controls

- NHSE/ICS oversight, returns and assurance meetings
- System wide sustainability groups.
- Joint planning with ICB and Provider Collaboratives for financial recovery
- External reviews (PwC, MIAA) informing improvement plans

Assurances		

1st line – Operational Assurance
• Monthly I&E, cashflow, capital, workforce and CIP reporting
• OPS, non-pay expenditure controls, bank/agency reporting
• Capital Planning Group
• Financial Resources Group (FRG)
  ○ Activity and income delivery monitoring; dynamic plans for RTT, cancer & diagnostics
  ○ Staff sickness, variable pay, and vacancy tracking (linked to financial impact)
	2nd line – Corporate Oversight
	• Finance, Performance & Sustainability Committee,
	• Quality Committee – QIAs for CIP schemes
	• Strategic People Committee – CIP delivery of workforce
	• Delivery Unit – CIP assurance and benefits realisation
		3rd line – Independent/External
		• Internal Audit: high assurance ratings for AR, AP, GL, treasury
		• External Audit: unqualified accounts opinion
		• PWC and NHSE/ICB monitoring and assurance of financial plans

Gaps

Recurrent Financial Gaps

- Significant proportion of CIP remains non-recurrent or unidentified
- Structural deficit requiring ongoing cash support
- Insufficient external funding for key strategic developments (e.g., estates programmes)

Activity & Income Risks

- Risk of under-delivery of activity impacting PbR income
- Potential loss of income due to contract caps, over-performance limits or industrial action
- Unplanned escalation capacity driving cost pressures

Capacity & System Risks

- Social care delays - resulting in a high proportion of the bed base being occupied by patients with No Criteria to Reside.
- Productivity gaps and variable pay reliance impacting financial sustainability
- CIP delivery requirement in excess of national average

Action Description	Responsible Officer	Deadline	Completion Date
Expand recurrent CIP/GIRFT pipeline (productivity, demand management, benchmarking)	Chief Finance Officer / Chief Operating Officer	Q1–Q4	
Deliver dynamic activity & income plan to maximise PbR delivery	Chief Operating Officer	Q1–Q4	
Maintain tighter controls on temporary staffing and variable pay	Chief People Officer / Chief Finance Officer / Chief Nurse, Chief Operating Officer	Q1–Q4	
Continue delivery and expansion of Delivery Unit (workforce & non-pay and productivity) oversight	Chief Finance Officer / Chief Executive	Ongoing	
Strengthen system partnership working for long-term financial sustainability	Executive Team	Ongoing	
Improve reporting and monitoring of unfunded pressures and emerging risks	Chief Finance Officer	Q1–Q2	

North Cheshire and Mersey
NHS Foundation Trust

BAF 7 – Digital Resilience, Cyber Security & EPR

If our digital infrastructure, cyber defences and EPR programme are not mature or resilient, then we may face operational disruption, cyber-attack, data loss and reduced productivity, resulting in risks to patient safety, data compliance and efficiency.

Risk Scoring								
Inherent Score			Current Score			Target Score		
L	C		L	C		L	C	
5	5	25	4	4	16	3	2	6

CQC Domain(s)	Well-Led, Safe, Effective
Executive Lead	Executive Medical Director
Strategic Aim	We will work in partnership with others to achieve social and economic wellbeing in our communities, and improve equity in health outcomes
Monitoring Committee	Finance, Sustainability and Performance Committee
Risk Appetite	Cautious

Risk Scoring 2026/27			
Q1	Q2	Q3	Q4

Linked High Scoring Corporate Risks (12 and above)		
Risk ID	**Risk Description**	**Scoring**
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.	**16**
1372	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	**16**

Controls

Cyber Security Controls

- DSPT compliance and ongoing cyber assurance improvements.
- Monthly penetration testing through NHS England VMS service.
- SOC monitoring, phishing simulations, threat intelligence feeds (NCSC, NHSE CSOC, CAN).
- Patch management automation, firewall controls, antivirus monitoring.
- Local firewalls enabled on devices; remote devices routed through secure proxy.
- Segmented network architecture; MFA in place for NHSMail.
- Secondary secure backup at Halton Data Centre.
- Device upgrades: Windows 11 programme (93.7% complete); Server 2016 migrations (65% complete).
- Cyber training for Board and key digital leaders.

Digital Infrastructure & Technical Debt Controls

- Replacement of end-of-life systems (e.g., Clinisys Ice upgrade, MUSE migration, Unisoft upgrade).
- Governance groups: Digital Governance Board, IG & Records Sub-Committee, Risk Register Reviews, Change Advisory Group.
- Business Continuity & Disaster Recovery governance, including DR testing.

EPR Programme Controls

- Contract extension for incumbent EPR to cover procurement window.
- EPR Programme Board, Digital Strategy Group, PMO oversight, PEB governance.
- Clinical safety case development and data migration plans.

- Collaborative single-instance EPR procurement with partner Trusts.
- Legal guidance confirming requirement for single-host contract.
- Joint development of OBC/FBC with NHSE and FD.
- Standardisation of clinical pathways for single-instance design.

System & Partnership Controls

- Active participation in ICS cyber security groups and EPR programme forums.
- External reviews: MIAA, NHSE, PwC (where relevant).
- Regional cyber intelligence and escalation networks.

Assurances

1st line – Operational Assurance	2nd line – Corporate Oversight	3rd line – Independent/External
• Cyber KPI dashboards (patch age, vulnerability closure, phishing results). • EPR RAID logs, testing outputs, readiness assessments. • Windows 11 and Server 2016 upgrade progress reporting. • Incident response logs, DR test outcomes	• Digital Governance Board and Clinical Safety Officer oversight. • PMO reporting on EPR procurement and deployment readiness. • Information Governance reporting (DSPT, Data Incidents, GDPR compliance). • Risk Register reviews (cyber and EPR). • Finance & Sustainability Committee oversight of digital investment and risk	• MIAA audits (Data Security, vendor management, IG, cyber controls). • External cyber maturity assessments and national benchmarking. • NHSE cyber groups and DSPT verification. • External programme reviews of EPR readiness and procurement

Gaps

Cyber Security Gaps

- Lack of real-time zero-day detection due to incomplete logging tool.
- No Privileged Access Management (PAM) implemented for admin accounts.
- Limited MFA coverage beyond NHSMail.
- Absence of centralised SIEM/log aggregation and actionable alerting.
- Limited 24/7 cyber cover.
- Unsupported systems in use (e.g., BadgerNet components, SharePoint 2010, Clinisys Ice version).
- Weak 3rd-party vendor cyber controls.
- Bluetooth control gaps and unsupported IoT/medical device scanning capability.

Infrastructure & Technical Debt Gaps

- Windows 10 end-of-life devices requiring replacement.
- Server 2016 support ending in 2026 with migration backlog.
- CISCO network hardware requiring refresh.
- Upgraded Badgernet to mitigate for unsupported software
- Extended Microsoft security patch to support Windows 11 migration

EPR Programme Gaps

- Complexities of single-instance procurement and contract requirements.
- Funding gaps linked to Frontline Digitisation sunset (March 2026) and new Frontline Productivity scheme.
- Risks from coterminous LIMS implementation.
- End-of-life legacy EPR features and rising operational risk.

Action Description	Responsible Officer	Deadline	Completion Date
Complete PAM implementation for privileged users and 3rd-party vendors	SIRO / Head of Digital Compliance & DSD Lead	31/03/2026	
Complete Server 2016 migration/decommissioning programme	Head of Digital Compliance & DSD Lead	30/10/2026	

Decommission legacy systems aligned to EPR roadmap	SIRO / EPR Programme Director	Q2–Q4 2026	
Deliver single OBC/FBC for EPR procurement	Medical Director/ EPR Programme Director	Nov 2025–Mar 2026	
Develop consolidated SIEM/logging solution with real-time alerting	SIRO / Head of Digital Compliance & DSD Lead	Q2–Q3 2026	
Implement MFA expansion across all critical systems	IT Services	Q1–Q3 2026	
Replace non-Windows-11-compliant hardware	Head of Digital Compliance & DSD Lead	Q1–Q4 2026	
Strengthen readiness assessment and clinical safety case for EPR deployment	Clinical Safety Officer / EPR Programme Director	Ongoing	

North Cheshire and Mersey
NHS Foundation Trust

BAF 8. Estates, Infrastructure & Capital Planning

If we cannot maintain, modernise or safely operate our estate, then we may fail to provide safe facilities, meet statutory requirements or support service transformation, resulting in increased safety risk and delayed improvement.

Risk Scoring								
Inherent Score			Current Score			Target Score		
L	C		L	C		L	C	
4	5	20	4	4	16	3	3	9

CQC Domain(s)	Well-Led, Responsive
Executive Lead	Chief Operating Officer
Strategic Aim	We will work in partnership with others to achieve social and economic wellbeing in our communities, and improve equity in health outcomes
Monitoring Committee	Finance, Sustainability & Performance Committee
Risk Appetite	Seek

Risk Scoring 2026/27			
Q1	Q2	Q3	Q4

Linked High Scoring Corporate Risks (12 and above)		
Risk ID	**Risk Description**	**Scoring**
125	If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns	**15**
423	If lifts are not maintained and replaced at end of lifecycle then there may be preventable occurrences of lifts breaking down resulting in reputational damage, negative financial impact, operational challenges and possible staff and patient safety issues	**15**
421	If there is no future investment in hospital ventilation then the built environment may not be fit for purpose in relation to compliance with HTM resulting in possible loss of several clinical services and non compliance with HTM.	**12**

Controls

Core Estates & Compliance Controls (WHH 2273)

- Annual Six-Facet Survey informing backlog maintenance priorities.
- Full PPM programme and reactive maintenance via CAFMS.
- Annual update of 10-year capital maintenance plan using Six-Facet outputs.
- HTM/HBN compliance, H&S governance, Fire Safety audits.
- RAAC survey completed; NHSE-funded remedial works underway.
- Capital Planning Group overseeing allocation of depreciation-based mandated capital.

Strategic Capital & Redevelopment Controls

- Estates strategy for new hospital plans completed.
- Town Deal infrastructure schemes: Living Well Hub, Runcorn Health & Education Hub (opening Q1 2026/27).
- One Public Estate funding in place for Halton redevelopment and Warrington estate review.
- Strategic planning alignment with ICS Infrastructure Plan & CMAST priorities.
- Full Business Case planning for Pathology Hub with MWL.

Operational Estate Controls (Cross-BAF Alignment)

- Critical infrastructure upgrades aligned to Digital Disaster Recovery (BAF7).
- Capacity and layout improvements supporting UEC flow (BAF2) and elective expansion (BAF3).
- Elective TIF programme (2 theatres, endoscopy, ward) completed.

- PLACE, H&S and compliance reporting to operational governance.

System & Partnership Controls

- WHH leadership roles in Warrington Together, One Halton, ICB committees and Town Deal Boards.
- Ongoing partner advocacy for new hospital programme.
- Shared system governance influencing future capital prioritisation.

Assurances

1st line – Operational Assurance	2nd line – Corporate Oversight	3rd line – Independent/External
• PPM completion dashboards & compliance reporting. • Incident logs linked to estate failures. • PLACE assessments; H&S audits. • Monitoring of reactive maintenance demand.	• Capital Planning Group (CPG), Tactical Estates Group (TEG), Health & Safety Sub-Committee. • Reporting to Finance, Performance & Sustainability Committee (FPSC). • Oversight of capital bids, decant plans, and statutory compliance.	• External compliance audits (HTM/HBN, Fire Authority, environmental health). • NHSE oversight of Town Deal, RAAC funding and CDC compliance. • External estate condition surveys, RAAC verification, financial due diligence.

Gaps

Capital & Funding Gaps

- Failure to secure New Hospital Programme (NHP) Phase 3 funding; no national capital for new hospital until post-2040.
- National capital scarcity and inflation limiting ability to address backlog.
- Lengthy timelines for full design costing and approval of capital schemes.
- Reliance on depreciation-generated capital for statutory works only.

Operational Estate Constraints

- Lack of permanent decant space impacts ability to refurbish/upgrade wards.
- Ageing buildings and plant affecting reliability and patient environment.
- High reactive maintenance burden from ageing infrastructure.
- Equipment difficult to maintain due to location/age.

Infrastructure Resilience (Cross-BAF Gaps)

- Estates constraints limiting UEC flow (BAF2) and elective expansion (BAF3).
- Estate condition limits full deployment of digital DR and EPR-ready infrastructure (BAF7).
- Non-clinical workforce constraints affecting estates delivery (BAF5 link).

System & Governance Gaps

- Variation in maturity of Place governance (Halton earlier stage than Warrington).
- Need for further alignment on system capital priorities

Action Description	Responsible Officer	Deadline	Completion Date
Develop multi-phase redevelopment plan with architects and cost advisors	Chief Strategy and Partnerships Officer / Chief Operating Officer	31/12/2026	
Reallocate capital via CPG/FSC to support phased works	Chief Operating Officer / Chief Finance Officer	Q1–Q4	
Deliver critical infrastructure upgrades aligned to Digital DR	Associate Director of Estates and Facilities / Chief Information Officer	Q2	
Strengthen decant strategy and prioritised refurbishment plan	Associate Director of Estates and Facilities	Q2–Q3	
Continue partner advocacy for new hospitals plan	Chief Strategy and Partnerships Officer	Ongoing	
Update financial, economic and strategic cases for new hospital	Chief Strategy and Partnerships Officer/ Chief Finance Officer	Q2–Q4	
Enhance assurance on statutory compliance (H&S, Fire, HTM)	Associate Director of Estates / Chief Operating Officer	Q1–Q4	

Align estate infrastructure upgrades with EPR & digital roadmap	Associate Director of Estates and Facilities / Chief Information Officer	Q1–Q4	

North Cheshire and Mersey
NHS Foundation Trust

BAF 9 - Partnership, Integration & System Working

If we do not integrate services effectively and fail to collaborate successfully with system partners, then fragmentation of pathways will continue, and outcomes diminish resulting in failure to meet increased demands and reduced long-term sustainability

Risk Scoring								
Inherent Score			Current Score			Target Score		
L	C		L	C		L	C	
4	4	16	3	3	9	2	2	4

CQC Domain(s)	Responsive, Safe, Well-Led
Executive Lead	Chief Strategy and Partnerships Officer
Strategic Aim	We will work in partnership with others to achieve social and economic wellbeing in our communities, and improve equity in health outcomes
Monitoring Committee	Finance, Sustainability & Performance Committee
Risk Appetite	Open

Risk Scoring 2026/27			
Q1	**Q2**	**Q3**	**Q4**

Linked High Scoring Corporate Risks (12 and above)		
Risk ID	**Risk Description**	**Scoring**

Controls

Governance

- successful transaction for the enlarged organisation North Cheshire and Mersey NHS FT from 1st April 2026, shared priorities with ICB/place; clinical networks for fragile/specialist services.

Partnership & System Working Controls

- Strong leadership and participation in system partnerships: place, Chesshire and Merseyside and nationally
- Engagement with Primary Care Networks, local authorities, Voluntary, Community, Faith and Social Enterprise (VCFSE) partners, other NHS providers and wider community stakeholders

Clinical & Operational Alignment Controls

- developing NCM strategy – aligned to local regional and national priorities

Clinical services integration programme Influencing neighbourhood health development **System Leadership & Strategic Controls**

- participation in Cheshire & Mersey Provider Collaborative (CMPC) CEO Group and Blueprint Delivery Groups

Assurances

1st line – Operational Assurance	2nd line – Corporate Oversight	3rd line – Independent/External
• Integration workstream plans, milestone trackers and KPIs •	• Integration Delivery Group. • Blueprint delivery group • Cheshire & Mersey Provider Collaborative (CMPC) CEO Group	• NHSE continued review of delivery of integration benefits • ICBs accountable to NHSE regional team

Gaps

Governance & Integration Gaps

- Maturity of integrated governance structures still developing.
- Variability in pathway standards across organisations.

System & Partnership Gaps

- risk of lack of capability and capacity at Place

- Pressures in system partners (e.g., finance, UEC demand)
- Need for shared benefits tracking across organisational boundaries.

Cultural & Workforce Gaps

- Change management and alignment of organisational cultures still in development.
- capacity, capability and productivity challenges

Action Description	Responsible Officer	Deadline	Completion Date
Continue Better Care Together workstreams with 6/12/24-month milestones	Chief Strategy and Partnerships Officer	Q1–Q4	
Implement shared clinical standards, outcomes and audit processes	Executive Medical Director	Q1–Q4	
Strengthen place-based partnerships	Executive Team		
Finalise and implement full post transaction integration plan (PTIP)	Chief Strategy and Partnerships Officer	Apr 2027	
Extend community engagement and co-production for integrated pathways	Chief Nurse / Director of Communications and Engagement	Q1–Q4	
Review of Better Care Together deliver governance	Chief Strategy and Partnerships Officer, Company Secretary	Q1	

Appendix 2

North Cheshire and Mersey NHS Foundation Trust

Legacy-to-New BAF Risk Cross-Mapping Table

Legacy Risk	Legacy Risk Score	Legacy Description	Mapped to New BAF Risk
WHH 224	20	**UEC capacity, 4hr performance, overcrowding -** 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.	BAF 2 – Urgent & Emergency Care Flow
WHH 1215	20	**Elective capacity, theatres, diagnostics -** 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.	BAF 3 – Planned Care Access & Elective Recovery
WHH 2001 – will be managed via the Corporate Risk Register with QSAC oversight	20	**Fragile services-** 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.	BAF 1 – Quality of Care & Patient Safety
WHH 115 – will be managed via the Corporate Risk Register with QSAC oversight	16	**Minimum safe staffing -** 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.	BAF 5 – Workforce Capacity & Wellbeing
WHH 1134 – to be split into separate risks on the corporate risk register with SPC oversight: • Sickness Absence • Turnover and Attraction • Temporary Staffing and Agency spend	12	**Workforce gaps-** 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	BAF 5 – Workforce Capacity & Wellbeing
WHH 1757 – will be managed via the Corporate Risk Register with SPC oversight	12	**Industrial Action -** 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.	BAF 5 – Workforce Capacity & Wellbeing
WHH 134	20	**Financial sustainability -** 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	BAF 6 – Financial

		of Warrington & Halton	Sustainability
WHH 1114 - will be managed via the Corporate Risk Register with FSPC oversight	**16**	**Cyber security risk -** 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.	BAF 7 – Digital Resilience, Cyber & EPR
WHH 1372 - will be managed via the Corporate Risk Register with FSPC oversight	**16**	**EPR procurement & readiness -** 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	BAF 7 – Digital Resilience, Cyber & EPR
WHH 2273	**16**	**Backlog, decant, infrastructure constraints -** 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	BAF 8 – Estates, Infrastructure & Capital Planning
WHH 2253	**16**	**Integration with BCH (transaction risk)-** 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	BAF 9 – Partnership, Integration & System Working
BCH BAF 1 – moved to the divisional risk register managed by the Company Secretary, would be escalated via the Audit committee is Risk to strategic aims became apparent.	**8**	**Governance -** Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy	not seen as a strategic risk for the NCM
BCH BAF 2	**15**	**Quality -** Failure to deliver quality services and continually improve	BAF 1 – Quality of Care & Patient Safety
BCH BAF 3	**12**	**Health Equity -** Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients	BAF 4 – Embedded Health Equity

BCH BAF 4	**16**	**Staff -** Failure to create an environment for staff to grow and thrive	BAF 5 – Workforce Capacity & Wellbeing
BCH BAF 5	**16**	**Resources -** Failure to use our resources in a sustainable and effective way	BAF 6 – Financial Sustainability
BCH BAF 6	**12**	**EDI -** Failure to build a culture that champions equality, diversity and inclusion for patients and staff	BAF 4 – Embedded Health Equity
BCH BAF 7	**9**	**Partnerships & Integration with WHH-** Failure to work in close collaboration with partners and staff in place and across the system	BAF 9 – Partnership, Integration & System Working

North Cheshire and Mersey
NHS Foundation Trust

Risk Appetite Statement for North Cheshire and Mersey NHS Foundation Trust

Introduction

North Cheshire and Mersey NHS Foundation Trust (NCM) is an ambitious organisation – ambitious for its patients, its communities, and each other. Our purpose and direction are guided by our newly established Mission, Vision and Aims:

Our Mission

We will be exceptional for our patients, our communities and each other.

Our Vision

We will be a great organisation providing excellent healthcare and opportunities to work and learn.

Our Aims

- **QUALITY** – We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience.
- **PEOPLE** – We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future with staff developing, growing and thriving.
- **SUSTAINABILITY** – We will work in partnership with others to achieve social and economic wellbeing in our communities and improve equity in health outcomes.

These commitments shape how we approach risk. We recognise the significant economic, operational and demographic challenges facing the NHS and our local communities. Achieving our goals requires innovation, collaboration and carefully calibrated risk-taking that supports improved outcomes for patients, staff and communities.

Accordingly, we are guided by our Risk Management Policy to understand, assess, and control risk. Our corporate risk register and Board Assurance Framework (BAF) are used to monitor significant risks and ensure alignment with the Board's defined risk appetite.

Defining Our Risk Appetite

Our risk appetite represents a collective agreement by the Board regarding the level of risk we are prepared to accept, balancing opportunities and threats. To ensure clarity, we categorise risk into five main areas commonly faced by NHS provider organisations:

- Quality
- People
- Financial and Operational Sustainability
- Regulation
- Reputation

Risk Appetite by Category

Quality

Providing the best possible care is our primary purpose. We will actively avoid risks to the quality of clinical services, taking a cautious and balanced approach. Where innovation may improve quality, we are more open to risk. All major service decisions will include explicit consideration of risks to safety, patient experience, and clinical effectiveness, supported by appropriate controls and ongoing monitoring.

People

We aim to deliver a supportive, inclusive working culture where individuals and teams can thrive. Decisions affecting staff may entail risk, and we are open to accepting such risk where longer-term benefits to patient care can be demonstrated. Staff engagement will be central to shaping proposals, maximising positive impact and mitigating adverse effects.

Financial and Operational Sustainability

We aim to be productive, high-performing, and financially sustainable, delivering constitutional standards and value for money. We are open to seeking out risk through innovation and improvement, supported by appropriate procedures and controls.

Regulation

We aim to provide safe, effective care in a well-governed environment. Our regulated status supports assurance of quality, safety, and efficiency. We are open to regulatory risk where this supports innovation, collaboration, and the pursuit of outstanding care.

Reputation

We are an outward-looking organisation committed to full participation in system-wide partnership working. Engagement with patients and the public is central to decision-making. We are open to and accept reputational risk where decisions can clearly demonstrate improved outcomes for patients, staff, and communities.

General Principles

Methods for controlling risk must be balanced. The Trust may accept some high risks due to the cost of mitigation, in pursuit of innovation, or to use resources creatively where substantial benefits exist.

As a general principle, the Trust has a low tolerance for risks that may:

- Expose patients, staff, visitors, or stakeholders to harm
- Compromise the delivery of operational services
- Adversely impact the Trust's reputation
- Cause severe financial consequences affecting future viability
- Lead to non-compliance with laws or regulations

Risk Appetite Levels

The Trust adopts the Good Governance Institute's definitions:

Level	Description
None	Avoidance of risk is a key organisational objective.
Minimal	Preference for very safe options with low inherent risk and limited reward.
Cautious	Preference for safe options with low residual risk and limited reward.
Open	Willing to consider a range of options with acceptable reward.
Seek	Eager to innovate and pursue higher reward despite greater risk.
Significant	Confident in high-risk options due to strong controls and responsive systems.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/04/009i**			
Subject:	**Integrated Performance Report Refresh**			
Date of meeting:	1 April 2026			
Action required:	Trust Board to approve the proposed amendments to the IPR dashboard for 2026/27.			
Author(s):	Andrew Hatfield, Senior Performance and Systems Development Lead Jane Hurst, Chief Finance Officer Daniel Moore, Chief Operating Officer & Deputy Chief Executive Zoe Harris, Director of Operations and Performance and Deputy Chief Operating Officer Ali Kennah, Chief Nurse Jennie Dwerryhouse, Deputy Chief People Officer Paul Fitzsimmons, Executive Medical Director			
Executive director sponsor:	Jane Hurst, Chief Finance Officer Daniel Moore, Chief Operating Officer & Deputy Chief Executive Ali Kennah, Chief Nurse Michelle Cloney, Chief People Officer Paul Fitzsimmons, Executive Medical Director			
Link to strategic aim:	1. 1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience 2. 2. PEOPLE - We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future with staff developing, growing and thriving. 3. 3. SUSTAINABILITY - We will work in partnership with others to achieve social and economic wellbeing in our communities and improve equity in health outcomes.			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety BAF 4: Embedded Health Equity BAF 6: Financial Sustainability			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓	✓	
	Are there any equality considerations linked	**Yes**	**No**	**N/A**
				✓

	to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:			
	Further Information / Comments:			
Executive summary:	The Trust Integrated Performance Report (IPR) Dashboard is reviewed at least annually in line with the Trust's Performance Assurance Framework (PAF) to ensure all indicators remain relevant and up to date. This paper outlines the recommended updates, including metrics to be removed and included in the Trust Board's IPR from 2026/27.			
Purpose: (please select as appropriate)	**Approval** ✓	**To note** ✓	**Decision**	
Recommendation:	The Trust Board is asked to: 1. Approve the proposed amendments to the IPR Dashboard for 2026/27. 2. Note the contents of this report.			
Previously considered by:	**Committee**	Strategic People Committee in Common Quality, Safety and Assurance Committee in Common Finance, Sustainability and Performance Committee in Common		
	Agenda Ref.	SPCiC/26/02/212 QSACiC/26/03/32 FSPCiC/26/03/230		
	Date of meeting	18/02/2026 10/03/2026 23/03/2026		
	Summary of Outcome	KPI adjustments approved by all corresponding committees.		
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***None***			
Freedom of information status (foia):	Whole FOIA Exemption			
Freedom of information exemptions applied: ***(if relevant)***	Section 22 – information intended for future publication			

1. Background/context

In April 2017, the Trust Board approved the implementation of the PAF which sets out the approach for ensuring effective systems are in place for monitoring, managing, and improving Trust performance.

As part of the introduction of the PAF, the Trust IPR dashboard which brings together indicators from a range of sources including Contractual Standards, CQC Insight Indicators and Indicators relating to the NHSE System Oversight Framework. This dashboard provides assurance and oversight of performance at Trust Board level.

All IPR indicators are reviewed at least annually to ensure they remain relevant and up to date and to introduce any new indicators which are required. For 2026/27 this review has also incorporated an assessment of the NOF to ensure the indicators within the IPR align with this.

This paper outlines the recommended changes to the IPR metrics including new, updated and removed metrics, reviewed targets, integration of Warrington and Bridgewater, inclusion of NOF and changes to exception reporting. The Trust Board is asked to support these changes.

2. NHS Oversight Framework (NOF)

The NOF sets out the nationally assessed metrics used to monitor provider performance. As Warrington and Halton Teaching Hospitals and Bridgewater Community Healthcare move towards integration, it is essential that the developing Integrated Performance Report aligns closely with relevant Oversight Framework indicators to ensure clear, consistent visibility of performance for the Board.

Governance and Reporting Implications

The performance of the NOF indicators for both Trusts are not routinely reported to the Board through the IPR. To ensure the Board has clear and ongoing oversight of all NOF performance measures, it is proposed that a **dedicated NOF slide** is incorporated into the IPR (**see Appendix 1**).

Where NOF indicators can be calculated locally, they have been incorporated into the IPR, these are detailed section 3. Where NOF indicators cannot be calculated locally or are measured annually, these would form part of the oversight summary but not monitored monthly in the IPR.

Presenting NOF indicators in a single, standardised table will:

- Enable consistent monitoring of performance against nationally assessed metrics
- Ensure emerging risks are captured through the existing narrative-by-exception process

- Support early identification and escalation of indicators that could impact the Trust's overall NOF segment
- Maintain clear visibility of indicators that are not showing improvement, ensuring they remain a priority for action and oversight

Clear escalation rules will be applied so that any indicator demonstrating deterioration, or with a direct impact on the Trust's NOF segmentation, is explicitly highlighted in the Board narrative where appropriate.

The proposed table will include:

- Each NOF metric
- Refresh frequency and latest reporting period
- Current national ranking
- Comparison to the previous reporting period
- Direction and scale of change in ranking

Changes in ranking will be expressed numerically, with negative values indicating improved relative performance. Colour shading will be used to highlight the magnitude of movement and support rapid interpretation at Board level.

3. IPR Indicator changes

The Performance Team has met with Executive and Operational leads to review current indicators and to ascertain requirements for new indicators, changes to targets and integration of indicators between Warrington and Halton and Bridgewater. In addition, the NHSE Oversight Framework has been reviewed to understand changes which may affect performance monitoring. The recommendations outlined have been supported by the relevant committees and are show in Tables **1-4**.

Removed Indicators
Table 1 proposes the removal of Trust Indicators.

Table 1: Indicators to be Removed

KPI	Rationale
Quality	
10.Total Pressure Ulcers (Categories 2 and above)	Amended to 4 boxes to make clearer metric remains on IPR
10.2.Total Pressure Ulcers (Category 3)	Amended to 4 boxes to make clearer metric remains on IPR
10.3.Total Pressure Ulcers (Category 4)	Amended to 4 boxes to make clearer metric remains on IPR
10.4.Community Acquired Pressure Ulcers	Amended to 4 boxes to make clearer metric remains on IPR
19.Sepsis Emergency Patient Screening	No longer required following agreement of new metrics

19.2.Sepsis Emergency Patient Screen Lactate within 1 hour	No longer required following agreement of new metrics
20.Sepsis Inpatient Screening	No longer required following agreement of new metrics
20.2.Sepsis Inpatient Patient Screen Lactate within 1 hour	No longer required following agreement of new metrics
QU01.Number of Never Events	Incorporate into Never Events - WHH Indicator 1.4
QU14.% of BCHFT patient safety incidents that are medication incidents	% metrics hard to validate as denominator not included to understand quantity of risk
QU18.Information Governance Training	Reported in workforce papers
QU19.Safeguarding Childrens Level 1	Reported in workforce papers
QU20.Safeguarding Childrens Level 2	Reported in workforce papers
QU21.Safeguarding Childrens Level 3	Reported in workforce papers
QU22.Safeguarding Adults Level 1	Reported in workforce papers
QU23.Safeguarding Adults Level 2	Reported in workforce papers
QU24.Safeguarding Adults Level 3	Reported in workforce papers
QU32.% of BCHFT risks managed in line with policy ie risks with in date reviews	Reported to QAC
QU33.Percentage of BCHFT risks identified as 12 or above	Reported to all sub committees
QU36.% of BCHFT patient safety falls identified as serious	Harm level fluctuates as incidents are downgraded following review , inconsistent metric
QU37.BCHFT patient safety Falls per 1,000 bed days - bed based	Incorporate into WHH Indicator 9.3
QU41.Total number of BCHFT acquired pressure ulcers	Incorporated into Pressure Ulcers
QU46.% of Category 4 Pressure Ulcers acquired in Bridgewater	Incorporated into Pressure Ulcers
QU48.MRSA - Total Number of outbreaks (Community)	Monitored Via IPC / QSACic by exception
QU49.C.Diff - Total Number of outbreaks (Community)	Monitored Via IPC / QSACic by exception
QU50.E Coli- Total Number of outbreaks (Community)	Monitored Via IPC / QSACic by exception
QU51.Bacteraemia - Total Number of outbreaks	Monitored Via IPC / QSACic by exception

QU55.Complaints that are managed within the policy timelines	Incorporated into Complaints
QU60.National Patient Safety Alerts opened and managed in line with policy timescales	Incorporated into PSII
QU62.% of all policies within review date	Monitored Via Safety Oversight Meeting/ QSACic by exception
QU63.IPC assurance audit compliance	Monitored via IPC/ QSACic by exception
QU64.Record keeping Audit completion compliance	Monitored via Operational Patient Safety/QSACic by exception
QU70.Overall CQC rating (Yearly)	Visual across the Trust / website - not a frequently changing metric
QU76.% of incidents causing moderate harm (Score 3)	Harm level fluctuates as incidents are downgraded following review , inconsistent metric
QU77.% of incidents causing severe/fatal harm (Score 4-5)	Harm level fluctuates as incidents are downgraded following review , inconsistent metric
QU78.% of Patient safety medication incidents causing moderate harm (Score 3)	Harm level fluctuates as incidents are downgraded following review , inconsistent metric
QU79.% of Patient safety medication incidents causing severe/fatal harm (Score 4-5)	Harm level fluctuates as incidents are downgraded following review , inconsistent metric
QU80.% Incidents reported within 48 hrs of discovering an incident has occurred	Assurance cannot be given that this is carried out consistently in this metric - data unreliable focus should be quality, completeness, or safety-learning value of the incident report.
QU81.Patient Safety Incident Investigations compliance submitted within 90 days	Monitored Via Safety Oversight Meeting/ QSACic by exception
QU83.% of Cat 3 Pressure Ulcers acquired in Bridgewater	Incorporated into Pressure Ulcers
Access & Performance	
Warrington Dermatology Cancer 2-week referrals (urgent GP)	Does not follow national cancer reporting measurements.
Warrington Dermatology Cancer 31-day 2nd treatment comprising surgery	Duplicated with WHH.
Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment	Duplicated with WHH
Warrington Dermatology Cancer Combined 31-day General Standard	Duplicated with WHH
Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral) 28-day Faster Diagnosis Standard	Duplicated with WHH Duplicated with WHH

A&E: Total time in A&E (% of pts who have waited <= 4hrs)	Duplicated with WHH
Total time in A&E - 95th Percentile (Mins)	To be reported via the corporate report and FSC. Does not warrant board oversight.
Total time in A&E - Median (Mins)	To be reported via the corporate report and FSC. Does not warrant board oversight.
A&E Time to treatment decision (median) <=60 mins (Mins)	To be reported via the corporate report and FSC. Does not warrant board oversight.
A&E Time to treatment decision 95th percentile <=60 mins (Mins)	To be reported via the corporate report and FSC. Does not warrant board oversight.
A&E Unplanned re-attendance rate <=5%	To be reported via the corporate report and FSC. Does not warrant board oversight.
A&E left without being seen <=5% (left before treatment completed)	To be reported via the corporate report and FSC. Does not warrant board oversight.
Data Quality Maturity Index (DQMI) (monthly internal reporting)	To be reported via the corporate report and FSC. Does not warrant board oversight. Not an NHS Oversight Indicator.
Data Quality Maturity index (DQMI) Monthly published score (3 months in arears)	To be reported via the corporate report and FSC. Does not warrant board oversight. Not an NHS Oversight Indicator. To out of date for board oversight.
Percentage of was not brought - Children's	To be reported via the corporate report and FSC. Does not warrant board oversight.
Percentage of DNAs/Was not brought - Warrington Adults	To be reported via the corporate report and FSC. Does not warrant board oversight.
Percentage of DNAs/Was not brought - Halton Adults	To be reported via the corporate report and FSC. Does not warrant board oversight.
Audiology - Number of 6 weeks diagnostic breaches	Duplicated with WHH. To be included in Diagnostic waiting times.
Referrals to plan - Children's	To be reported via the corporate report and FSC. Does not warrant board oversight.
Referrals to plan - Warrington Adults	To be reported via the corporate report and FSC. Does not warrant board oversight.
Referrals to plan - Halton Adults	To be reported via the corporate report and FSC. Does not warrant board oversight.
Warrington Adults Activity Variance	To be reported via the corporate report and FSC. Does not warrant board oversight.
Warrington Children's Activity Variance	To be reported via the corporate report and FSC. Does not warrant board oversight.
Halton Adults Activity Variance	To be reported via the corporate report and FSC. Does not warrant board oversight.
Halton Children's Activity Variance	To be reported via the corporate report and FSC. Does not warrant board oversight.

Number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above - Halton	To be reported via the corporate report and FSC. Does not warrant board oversight.
Percentage of births that receive a face-to-face NBV within 14 days by a Health Visitor - Halton	To be reported via the corporate report and FSC. Does not warrant board oversight.
Percentage of children who received a 6–8-week review by the time they were 8 weeks - Halton	To be reported via the corporate report and FSC. Does not warrant board oversight.
Percentage of children who turned 12 months in the quarter, who received a 12-month review, by the age of 12 months - Halton	To be reported via the corporate report and FSC. Does not warrant board oversight.
Percentage of children who turned 15 months in the quarter, who received a 12-month review, by the age of 15 months - Halton	To be reported via the corporate report and FSC. Does not warrant board oversight.
Percentage of children who received a 2-2½ year review, by the age of 2½ years - Halton	To be reported via the corporate report and FSC. Does not warrant board oversight.
Percentage of children who received a 2-2½ year review in the quarter, using ASQ 3 - Halton	To be reported via the corporate report and FSC. Does not warrant board oversight.
Number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above - Warrington	To be reported via the corporate report and FSC. Does not warrant board oversight.
Percentage of births that receive a face-to-face NBV within 14 days by a Health Visitor - Warrington	To be reported via the corporate report and FSC. Does not warrant board oversight.
Percentage of children who received a 6–8-week review by the time they were 8 weeks - Warrington	To be reported via the corporate report and FSC. Does not warrant board oversight.
Percentage of children who turned 12 months in the quarter, who received a 12-month review, by the age of 12 months - Warrington	To be reported via the corporate report and FSC. Does not warrant board oversight.
Percentage of children who turned 15 months in the quarter, who received a 12-month review, by the age of 15 months - Warrington	To be reported via the corporate report and FSC. Does not warrant board oversight.

Percentage of children who received a 2-2½ year review, by the age of 2½ years - Warrington	To be reported via the corporate report and FSC. Does not warrant board oversight.
Percentage of children who received a 2-2½ year review in the quarter, using ASQ 3 - Warrington	To be reported via the corporate report and FSC. Does not warrant board oversight.
Available Virtual Ward Capacity per 100,000 head of population	To be reported via the corporate report and FSC. Does not warrant board oversight.
Community Health Services Sitrep - % of waiters under 18 weeks (one month in arrears)	To be reported via the corporate report and FSC. Does not warrant board oversight. Not an NHS Oversight Framework Indicator
Workforce	
Turnover	The Trusts are reliant on turnover to achieve the Workforce Plans, therefore although high turnover still indicates potential cause of concern, which will be reviewed at a local level and within sub committees; for the foreseeable future either low or high turnover could be deemed as a positive and/or negative, therefore no requirement for Trust oversight at board level.
Finance	
FI01 - Income	This is a locally defined Bridgewater metric with limited-assurance status at Board level. It is already monitored through FSPCiC .
FI02 - Expenditure - Pay	This is a locally defined Bridgewater metric with limited-assurance status at Board level. It is already monitored through FSPCiC.
FI03 - Expenditure Pay - Integration Savings	This is a locally defined Bridgewater metric with limited-assurance status at Board level. It is already monitored through FSPCiC.
FI04 - Expenditure - Agency	Duplicated with Indicator 62
FI05 - Expenditure - Non-Pay	This is a locally defined Bridgewater metric with limited-assurance status at Board level. It is already monitored through FSPCiC.
FI06 - Expenditure - Non-Pay - Integration Savings	This is a locally defined Bridgewater metric with limited-assurance status at Board level. It is already monitored through FSPCiC.
FI07 - EBITA	This is a locally defined Bridgewater metric with limited-assurance status at Board level. It is already monitored through FSPCiC.
FI08 - Financing	This is a locally defined Bridgewater metric with limited-assurance status at Board level. It is already monitored through FSPCiC.
FI09 - Normalised (Surplus)/Deficit	This is a locally defined Bridgewater metric with limited-assurance status at Board level. It is already monitored through FSPCiC and is also reported as part of the combined indicator number 56 aligned to the NHS Oversight Framework.
FI010 - Exceptional Costs	This is a locally defined Bridgewater metric with limited-assurance status at Board level. It is already monitored through FSPCiC.

FI011 - Net (Surplus)/Deficit after Exceptional Items	This is a locally defined Bridgewater metric with limited-assurance status at Board level. It is already monitored through FSPCiC.
FI012 - Other Adjustments	This is a locally defined Bridgewater metric with limited-assurance status at Board level. It is already monitored through FSPCiC.
FI013 - Adjusted Net (Surplus) / Deficit	This is a locally defined Bridgewater metric with limited-assurance status at Board level. It is already monitored through FSPCiC and is also reported as part of the combined indicator number 56 aligned to the NHS Oversight Framework.
FI014 - Savings - CIP Levels 1 & 2	Duplicated with Indicator 60
FI015 - Savings - CIP Levels 3	Duplicated with Indicator 60
FI016 - Capital	Duplicated with Indicator 58
FI017 - Cash	Duplicated with Indicator 57

Updated Indicators

Table 2 provides details of updates required to Trust Indicators.

Table 2: Indicators to be Updated

Proposed KPI	Update
Quality	
Number of incidents open over 40 days.	Include Bridgewater Data
Total Incidents recorded in month.	Include Bridgewater Data
Number of never events reported in month.	Include Bridgewater Data
Meticillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans.	Rename to confirm Acute
MSSA, or methicillin-susceptible Staphylococcus aureus, is an infection caused by a type of bacteria commonly found on the skin.	Rename to confirm Acute
Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel.	Rename to confirm Acute
Escherichia coli (E-Coli) bacteraemia which is one of the largest gram negative bloodstream infections.	Rename to confirm Acute

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.	Rename to confirm Acute
Pseudomonas aeruginosa can cause infections in the blood, lungs (pneumonia), or other parts of the body after surgery.	Rename to confirm Acute
Total number of inpatient falls which have occurred in month.	Include Bridgewater Data (Padgate only)
Total number of falls which have occurred in month.	Include Bridgewater Data
Moderate and above inpatient and ED falls	Include Bridgewater Data (Padgate only)
Inpatient Falls per 1000 bed days in month.	Include Bridgewater Data (Padgate only)
Total Pressure Ulcers (Category 2)	Rename to confirm Acute
% Medication reconciliation within 24 hours	Rename to Acute
% Medication reconciliation throughout the inpatient stay.	Rename to Acute
Staffing - Average Fill Rate	Include Bridgewater Data (Padgate only)
Staffing - Average Fill Rate - Day nurses/midwives	Include Bridgewater Data (Padgate only)
Staffing - Average Fill Rate - Day nurses/midwives	Include Bridgewater Data (Padgate only)
Staffing - Average Fill Rate - Day care staff	Include Bridgewater Data (Padgate only)
Staffing - Average Fill Rate - Night nurses/midwives	Include Bridgewater Data (Padgate only)
Staffing - Average Fill Rate - Night care staff	Include Bridgewater Data (Padgate only)
Total number of cases over 6 months old in month.	Include Bridgewater Data
Complaints - Dissatisfies opened in month	Include Bridgewater Data
Complaints - New Complaints	Include Bridgewater Data
Number of PALS complaints received and closed in month.	Include Bridgewater Data
Number of community acquired Acute Kidney Injuries (AKI) in month.	Include Bridgewater Data

MUST Nutrition assessment completion	Include Bridgewater Data
Access & Performance	
36 - Diagnostic Waiting Times 6 Weeks	Provide a separate combined position 36.1 with Bridgewater data until further notice from NHS England.
37 - Referral to treatment Open Pathways	Provide a separate combined position 37.1 with Bridgewater data until further notice from NHS England.
38 - Referral to treatment - Number of patients waiting 52+ weeks	Provide a separate combined position 38.1 with Bridgewater data until further notice from NHS England.
39 - 28 Day Faster Cancer Diagnosis Standard	Provide a separate combined position 39.1 with Bridgewater data until further notice from NHS England.
40 - Cancer 31 Day Wait	Provide a separate combined position 40.1 with Bridgewater data until further notice from NHS England.
41- Cancer 62 Day Wait	Provide a separate combined position 41.1 with Bridgewater data until further notice from NHS England.
Workforce	
Supporting Attendance (Monthly)	Include Bridgewater data. Target to be aligned to 5.0% absence limit
CSTF Training	Include Bridgewater data. No change. Target 85%
PDR	Include Bridgewater data. No change. Target 85%
Finance	
56. Trust Financial Position	Include Bridgewater data. This is a grouped indicator which confirms in month and cumulative position against plan. There are two finance **NHS Oversight Framework** indicators, planned surplus/deficit and Variance year to date to financial plan. This Indicator provides both. The combined finance NHS Oversight Framework Indicator is the grouping of the two, by calculating the score based on the planned surplus/deficit and variance year to data to financial plan.
57. Cash Balance	Include Bridgewater data.
58. Capital Programme	Include Bridgewater data.
59. Better Payment Practice Code	Include Bridgewater data.
60. Cost Improvement Programme (Recurrent and Non-recurrent) – In Year	Include Bridgewater data.
61. Cost Improvement Programme (Recurrent) – In Year	Include Bridgewater data.
62. Agency Reduction	Include Bridgewater data.
63. Bank Reduction	Include Bridgewater data.

New Indicators

Table 3 provides details of a newly proposed Trust Indicators.

Table 3: New Indicators

New KPI	Rationale
Quality	
Total Pressure Ulcers (Category 3 & 4) - Acute	New Indicator which combines acute Total Pressure Ulcers (categories 2 and above), Total Pressure Ulcers (Category 3) and Total Pressure Ulcers (Category 4) into one indicator to make it clearer on IPR.
Community Acquired Pressure Ulcers (Category 2)	New Community Indicator
Community Acquired Pressure Ulcers (Category 3 & 4)	New Community Indicator
number of medication incidents WHH	Significant refresh of Medication safety including monitoring medication incidents for Acute
number of medication incidents BW	Significant refresh of Medication safety including monitoring medication incidents for Community
Percentage of Community patients responding as “Very Good” or “Good”. Patients are asked - Overall, how was your experience of our service?	The trust is now submitting Community Friends and Family
DOC (Duty of Candour) for moderate harms and above 10-day compliance	Reintroduced as Community compliance can be variable
Access & Performance	
Average number of days from discharge ready date to actual discharge date (including zero days)	Currently an NHS Oversight Framework indicator for Acute trusts. WHH currently rank 112 out of 125 Trusts for this metric.
Urgent Community Response (UCR) 2-hour performance	Currently an NHS Oversight Framework indicator for community services. BCH currently rank 4 out of 38 Trusts for this metric. This metric is on the NHS Oversight Framework for MWL and Mid Cheshire.
Percentages of Patients waiting over 52 weeks for community services (excluding dental and dermatology)	Currently an NHS Oversight Framework indicator for community services. BCH currently rank 35 out of 41 trusts for this metric. This metric iso the NHS Oversight framework for Mersey West Lancashire Trust and Mid Cheshire Hospital Trust. This data excludes dental and dermatology waiting times as they are not within scope of the submission. These waiting times do include Neurodevelopment Waiting times for access.

Number of Patients waiting over 104 weeks for community services (excluding dental and dermatology)	This is not a current NHS Oversight Framework Indicator, however there are patients waiting over 104 weeks which need to be monitored. Percentage may be influenced by increased referrals to track improvement a decision has been made to illustrate the number of patients.
Percentage of UTC attendances referred on to A+E	Current Bridgewater IPR indicator to monitor the numbers of patients referred on to A+E. To include Runcorn UTC figures.
Number of Patients waiting over 52 weeks to access Community services (including Dental and Dermatology)	Current Bridgewater IPR indicator to monitor total number of patients waiting to access community services including Dental and Dermatology. This is to ensure there is visibility of long waits for access of services not within scope of the Community services Sitrep which is feeds directly to the NOF indicator.
Number of Patients waiting over 65 weeks to access Community services (including Dental and Dermatology)	Current Bridgewater IPR indicator to monitor total number of patients waiting to access community services including Dental and Dermatology. This is to ensure there is visibility of long waits for access of services not within scope of the Community services Sitrep which is feeds directly to the NOF indicator.
Number of Patients waiting over 104 weeks to access Community services (including Dental and Dermatology)	Current Bridgewater IPR indicator to monitor total number of patients waiting to access community services including Dental and Dermatology. This is to ensure there is visibility of long waits for access of services not within scope of the Community services Sitrep which is feeds directly to the NOF indicator
Workforce	
Workforce FTE Plan Compliance	Achievement of the workforce plan will be a key priority and challenge in 26/27 and therefore it is recommended Trust board receive a summary on progress against the Workforce plan.
Finance	
There are no new indicators for Finance.	

The proposed changes will result in an increase of the KPIs from 94 to 104 as follows:

	2025/26	2026/27
Quality	55	54
Access & Performance	27	38
Workforce	4	4
Finance	8	8
Total	**94**	**104**

Updated IPR Targets

Table 4 provides an overview of the IPR metrics with the current 2024/25 and 2025/26 proposed targets/trajectories.

Table 4: 2025/26 KPIs and Targets

Old ID	New ID	Access and Performance KPIs	2025/26 Target or Threshold	2026/27 Target or Threshold

Quality				
1	1	Number of incidents open over 40 days.	0	0
1.2	1.2	Total Incidents recorded in month.	No Target set	No Target set
1.3	1.3	Total PSIIs recorded in month.	No Target set	No Target set
1.4	1.4	Number of never events reported in month.	0	0
2	2	Acute - Healthcare Acquired Infections MRSA	0	0
3	3	Acute - Healthcare Acquired Infections MSSA	No Target set	No Target set
4	4	Acute - Healthcare Acquired Infections C. difficile	Less than 60 for 2025/26	Thresholds not yet received for 2026/27
5	5	Acute - Healthcare Acquired Infections E-Coli	Less than 79 for 2025/26	
6	6	Acute - Healthcare Acquired Infections Klebsiella	Less than28 for 2025/26	
7	7	Acute - Healthcare Acquired Infections Pseudomonas aeruginosa	Less than 8 for 2025/26	
8	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%	95%
9	9	Total number of inpatient falls which have occurred in month.	10% reduction from previous year	10% reduction from previous year
9.1	9.1	Total number of falls which have occurred in month.	No Target set	No Target set
9.2	9.2	Moderate and above inpatient and ED falls	No Target set	No Target set
9.3	9.3	Inpatient Falls per 1000 bed days in month.	No Target set	No Target set
New	10	Acute - Total Pressure Ulcers (Category 2)	20% reduction from previous year	20% reduction from previous year
New	11	Total Pressure Ulcers (Category 3 & 4) - Acute	20% reduction from previous year	20% reduction from previous year
New	12	Community Acquired Pressure Ulcers (Category 2)	New	20% reduction from

				previous year
New	13	Community Acquired Pressure Ulcers (Category 3 & 4)	New	20% reduction from previous year
13	14	HSMR	No Target set	No Target set
14	15	SHMI	No Target set	No Target set
11	16	Acute - % Medication reconciliation within 24 hours	80%	80%
11.1	16.1	Acute - % Medication reconciliation throughout the inpatient stay.	80%	80%
11.2	16.2	number of medication incidents WHH	New	No Target set
11.3	16.3	number of medication incidents BW	New	No Target set
12.1	17	Staffing - Average Fill Rate - Day nurses/midwives	90%	90%
12.3	18	Staffing - Average Fill Rate - Day care staff	90%	90%
12.4	19	Staffing - Average Fill Rate - Night nurses/midwives	90%	90%
12.5	20	Staffing - Average Fill Rate - Night care staff	90%	90%
15	21	Total number of cases over 6 months old in month.	Zero complaints open over 6 months old/in the backlog	0
15.1	21.1	Complaints - Dissatisfies opened in month	No Target set	0
15.2	21.2	Complaints - New Complaints	No Target set	No Target set
15.3	21.3	Number of PALS complaints received and closed in month.	No Target set	No Target set
16	22	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%	95%
17	23	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%	87%
17.1	24	Percentage of Community patients responding as “Very Good” or “Good”.	New	90%

		Patients are asked - Overall, how was your experience of our service?		
18	25	Number of MSA Breaches in month (ITU).	0	0
18	26	Sepsis Emergency Patient Screening	90%	90%
19	27	Sepsis Emergency Patient Screen Blood cultures within 1 hour	90%	90%
19.1	27.1	Sepsis Emergency Patient Screen Lactate within 1 hour	90%	90%
19.2	27.2	Sepsis Inpatient Screening	90%	90%
20	28	Sepsis Inpatient Patient Screen Blood cultures within 1 hour	90%	90%
20.1	28.1	Sepsis Inpatient Patient Screen Lactate within 1 hour	90%	90%
20.2	28.2	Sepsis Emergency Patient Antibiotics (within 1hr)	90%	90%
21	29	Sepsis Emergency Patient Antibiotics (within 6hrs)	90%	90%
21.1	29.1	Sepsis Inpatient Screening (within 1hr)	90%	90%
22	30	Sepsis Inpatient Screening (within 6hrs)	90%	90%
22.1	31	Number of hospital acquired Acute Kidney Injuries (AKI) in month.	Less than previous month	Less than previous month
23.2	31.1	Average Length of Stay (LoS) of patients within a AKI.	No Target set	No Target set
24	32	To monitor rates of PPH (Postpartum haemorrhage) >1500mls against North West Coast Regional Dashboard.	3.70%	3.70%
25	33	The % of patients treated in line with Best Practice Tariff (BPT).	Best Practice Tariff	Best Practice Tariff
25.1	34	% of patients receiving surgery within 36hrs of admission	No Target set	No Target set
26	35	MUST Nutrition assessment completion	above 85%	above 85%
QU11	36	DOC (Duty of Candour) for moderate harms and above 10-day compliance	100%	100%
Access & Performance				
27	37	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (excluding WUTC).	75%	85%
28	38	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (including WUTC).	75%	85%

29	39	A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	2% or less
30	40	Average time in department ED	No Target	No Target
31	41	Ambulance Handovers within 15 minutes	65%	65%
32	42	Ambulance Handovers within 30 minutes	95%	95%
33	43	Ambulance Handovers within 45 minutes	100%	100%
34	44	Type 5 attendances	No Target Set	No Target Set
35	45	Patients seen in the Fracture Clinic within 72 hours	95%	95%
OP14	46	Percentage referred onto A+E (UTC)	3%	3%
36	47	Diagnostic Waiting Times 6 Weeks (Excluding Bridgewater)	95%	95%
New	47.1	Diagnostic Waiting Times 6 Weeks (Including Bridgewater)	95%	95%
37	48	Referral to treatment Open Pathways (Excluding Bridgewater)	92%	92%
New	48.1	Referral to treatment Open Pathways (Including Bridgewater)	92%	92%
38	49	Referral to treatment - Number of patients waiting 52+ weeks (Excluding Bridgewater)	Less than 1% of total waiting list by March 26	Less than 1% of total waiting list by March 27
New	49.1	Referral to treatment - Number of patients waiting 52+ weeks (Including Bridgewater)	Less than 1% of total waiting list by March 26	Less than 1% of total waiting list by March 27
39	50	28 Day Faster Cancer Diagnosis Standard	75%	75%
40	51	Cancer 31 Day Wait (Excluding Bridgewater)	96%	96%
New		Cancer 31 Day Wait (Including Bridgewater)	96%	96%
41	52	Cancer 62 Day Wait (Excluding Bridgewater)	85%	85%
New		Cancer 31 Day Wait (Including Bridgewater)	85%	85%
42	53	Reduction in Outpatient Follow Ups compared to 19/20 activity	No Target Set	No Target Set

43	54	Elective Recovery Activity (Grouped SPCs)	104% (% activity is against activity in the same month in previous year)	104% (% activity is against activity in the same month in previous year)
44	55	Elective Recovery Diagnostic Activity (Grouped SPCs)	104% (% activity is against activity in the same month in previous year)	104% (% activity is against activity in the same month in previous year)
45	56	Elective Outpatient Activity	104%	104%
46	57	Super Stranded Patients	No Target Set	No Target Set
NEW	58	Average number of days from discharge ready date to actual discharge date (including zero days)	No Target Set	Less than 1 day
47	59	No Criteria to Reside (NCTR)	No Target Set	No Target Set
48	60	% Patients discharged to their usual place of residence	No Target Set	No Target Set
49	61	Cancelled Operations on the day for a non-clinical reason	Less than 2%	Less than 2%
50	62	Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation.	0	0
51	63	Capped Theatre Utilisation	85%	85%
OP35	64	Urgent Community Response (UCR) 2-hour performance	70%	70%
OP68	65	Percentages of Patients waiting over 52 weeks for community services (excluding dental and dermatology)	0%	0%
OP70	66	Number of Patients waiting over 104 weeks for community services (excluding dental and dermatology)	0%	0%
OP71	67	Number of Patients waiting over 52 weeks to access Community services (including Dental and Dermatology)	0%	0%
OP45	68	Number of Patients waiting over 65 weeks to access Community services (including Dental and Dermatology)	0%	0%

OP46	69	Number of Patients waiting over 104 weeks to access Community services (including Dental and Dermatology)	0%	0%
Workforce				
52	70	Supporting Attendance (Monthly)	5.00%	5.00%
54	71	CSTF Training	85.00%	85.00%
55	72	PDR	85.00%	85.00%
New	73	Workforce FTE Plan Compliance	No Target Set	100% compliance with plan
Finance				
56	74	Trust Financial Position	Plan	Plan
57	75	Cash Balance	Plan	Plan
58	76	Capital Programme	Plan	Plan
59	77	Better Payment Practice Code	>95%	>95%
60	78	Cost Improvement Programme – In year	>90% plan	>90% plan
61	79	Cost Improvement Programme recurrent – In year	>90% plan	>90% plan
62	80	Agency Reduction	Reduction of 30% of 2024/25 plan	Reduction of 30% of 2025/26 forecast outturn in line with planning guidance
63	81	Bank Reduction	Reduction of 10% of 2024/25 plan	Reduction of 15% of 2025/26 M6 forecast outturn in line with planning guidance

The Trust Board is asked to approve the proposed amendments to the IPR Dashboard for 2026/27.

If approved by the Trust Board, these changes will be implemented from the June 2026 Board report (April 2026 data).

4. Actions Required

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

5. Assurance Committees

The following Committees provide assurance to the Trust Board:

- Finance, Sustainability and Performance Committee
- Quality and Safety Assurance Committee
- Strategic People Committee

6. Recommendations

The Trust Board is asked to:

1. Approve the proposed amendments to the IPR Dashboard for 2026/27.
2. Note the contents of this report.

NHS
North Cheshire and Mersey
NHS Foundation Trust

Appendix 1 – IPR NOF update table

Access to services			Current					Previous	
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Rank**	**Change**	**Trend**	**Narrative provided**	**Reporting Date**	**Rank**
Cancer Care	28 day Cancer diagnosis	Quaterly	Q2 2025/26	**79** out of 118	-14	▼		Q1 25/26	**93** out of 118
Cancer Care	62 day cancer treatment	Quaterly	Q2 2025/26	**24** out of 118	10	▲	Within Exception Slides	Q1 25/26	**14** out of 118
Elective Care	% of patients waiting more than 52 Weeks for elective treatment	Quaterly	Sep-25	**117** out of 131	-7	▼		Jun-25	**124** out of 131
Elective Care	% of patients waiting more or less than 18 weeks for elective treatment	Quaterly	Sep-25	**83** out of 131	-17	▼		Jun-25	**100** out of 131
Elective care	Difference between planned and actual 18 week performance	Quaterly	Sep-25	**98** out of 131	-26	▼		Jun-25	**124** out of 131
Urgent and emergency care	A&E within 4 hours	Quaterly	Q2 2025/26	**112** out of 123	9	▲	Within Exception Slides	Q1 25/26	**103** out of 123
Urgent and emergency care	A&E within 12 hours	Quaterly	Q2 2025/26	**117** out of 119	-3	▼		Q1 25/26	**120** out of 123

Effectiveness and experience			Current					Previous	
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Rank**	**Change**	**Trend**	**Narrative provided**	**Reporting Date**	**Rank**
Effective flow and discharge	Average number of days from discharge ready date to actual discharge date	Quaterly	Sep-25	**112** out of 125	-11	▼		Jun-25	**123** out of 126
Patient experience	Summary Hospital-level mortality indicator	Annually	July 24 - June 25	Not Ranked					
Patient experience	CQC Inpatient survey satisfaction rate	Annually	July 24 - June 25	Not Ranked					

Finance and productivity			Current					Previous	
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Rank**	**Change**	**Trend**	**Narrative provided**	**Reporting Date**	**Rank**
Finance	Planned surplus/deficit	Quaterly	Q2 2025/26	**126** out of 134	2	▲	Within Exception Slides	Q1 25/26	**124** out of 134
Finance	Variance year-to-date to financial plan	Quaterly	Month 6 2025	**124** out of 134	70	▲	Within Exception Slides	Month 3 2025	**54** out of 134
Finance	Combined finance	Quaterly	Q2 2025/26	Not Ranked					
Productivity	Implied productivity level	Quaterly	Q1 25/26 vs. Q1 24/25	**117** out of 134	58	▲	Within Exception Slides	M12 24/25 vs 23/24	**59** out of 134

Patient Safety			Current					Previous	
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Rank**	**Change**	**Trend**	**Narrative provided**	**Reporting Date**	**Rank**
Patient Safety	Number of MRSA bacteraemia cases	Quaterly	Oct 24 - Sep 25	**54** out of 134	-1	▼		Jul 24 to Jun 25	**55** out of 134
Patient Safety	Proportion of E. coli bacteraemia	Quaterly	Oct 24 - Sep 25	**1** out of 134	-38	▼		Jul 24 to Jun 25	**39** out of 134
Patient Safety	NHS Staff Surgery - raising concerns sub-score	Annually	2024	**37** out of 134					
Patient Safety	Proportion of C. difficile infections	Quaterly	Oct 24 - Sep 25	**92** out of 134	-3	▼		Jul 24 to Jun 25	**95** out of 134

People and Workforce			Current					Previous	
Sub-domain	**Description**	**Refreshed**	**Reporting Date**	**Rank**		**Trend**	**Narrative provided**	**Reporting Date**	**Rank**
Retention and culture	Sickness absence rate	Quaterly	Q1 2025/26	**125** out of 134	-1	▼		Q4 - 2024/25	**126** out of 134
Retention and culture	NHS Staff survey engagement theme sub-score	Annually	2024	**58** out of 134					

Key

▶ No Change
▼ Improvement
▲ Concern

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/04/009ii**			
Subject:	Performance Assurance Framework (PAF) Refresh			
Date of meeting:	1 April 2026			
Action required:	Trust Board to approve the amendments to the PAF as part of the annual refresh.			
Author(s):	Andrew Hatfield, Senior Performance and Systems Development Lead			
Executive director sponsor:	Jane Hurst, Chief Finance Officer			
Link to strategic aim:	1. 1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience 2. 2. PEOPLE - We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future with staff developing, growing and thriving. 3. 3. SUSTAINABILITY - We will work in partnership with others to achieve social and economic wellbeing in our communities and improve equity in health outcomes.			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓	✓	✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
Executive summary:	The Performance Assurance Framework (PAF) outlines how the Trust develops and maintains effective systems and processes for monitoring, managing and improving performance across the organisation. The PAF is reviewed and refreshed at least annually. Proposed updates to the PAF for 2026/27 are: • Confirmed that the IPR dashboard will include the			

	• NHS Oversight Framework Assessment • Corrected responsibility for recording the QPS actions		
Purpose: (please select as appropriate)	**Approval** ✓	**To note** ✓	**Decision**
Recommendation:	The Trust Board is asked to support the amendments to the PAF as part of the annual refresh.		
Previously considered by:	**Committee**	Finance + Sustainability Committee	
	Agenda Ref.	FSPCiC/26/03/230	
	Date of meeting	23/03/2026	
	Summary of Outcome	Supported by Committee to go to Trust Board.	
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***None***		
Freedom of information status (foia):	Whole FOIA Exemption		
Freedom of information exemptions applied: ***(if relevant)***	Section 22 – information intended for future publication		

1. Background/context

The Performance Assurance Framework (PAF) outlines how the Trust develops and maintains effective systems and processes for monitoring, managing, and improving performance across the organisation. The PAF is reviewed and refreshed at least annually.

The Executive Team has considered the effectiveness of the PAF and current accountability structure. A number of amendments have been proposed to the current PAF. These changes are laid out in section 2 of the report.

2. Key elements

The following amendments are being proposed to the PAF and have been incorporated as track changes into the draft updated PAF in **Appendix A**.

- The introduction has been updated to reference the NHSE National Performance Assessment Framework (PAF) and to align the Trust's PAF with national requirements, ensuring clear oversight of the metrics against which NHSE will hold the Trust to account.

- Confirmation that the IPR dashboard structure will include the NHS Oversight Framework Assessment slides to ensure consistency with national reporting requirements.

- The responsibility for recording Quality, Performance and Safety (QPS) actions has been corrected to reflect the appropriate accountable team.

3. Recommendations

The Trust Board is asked to approve the amendments to the PAF as part of the annual refresh.

North Cheshire and Mersey
NHS Foundation Trust

Appendix A

North Cheshire and Mersey NHS Foundation Trust

Performance Assurance Framework – Update for April 2026

Performance Assurance Framework

1. Introduction

1.1 Background

This Performance Assurance Framework (PAF) sets out principles of accountability and the commitment by Warrington & Halton Teaching Hospitals NHS Foundation Trust to establish, maintain and provide assurance of effective systems and processes for managing and improving performance across all levels of the Trust. The PAF was developed to provide clarity of accountability and subsequently assurance from 'Ward/Department to Board'. This is underpinned by a focus on health outcomes for patients and the community. The PAF supports the Trust's ambition of being "Outstanding".

In 2025, NHS England (NHSE) introduced a new national Performance Assessment Framework, defining the key metrics against which acute Trusts will be assessed in 2025/26. NHSE will use this framework to evaluate organisational delivery, identify areas requiring improvement, and determine each provider's national improvement segment. To support transparency, NHSE have published an interactive scorecard, showing delivery scores, segmentation outcomes, benchmarking data, and ICB and provider capability ratings. This information is updated quarterly.

It is therefore essential that our internal PAF provides clear oversight of the measures critical to delivering our operational and financial plans, as well as the metrics NHSE will use to hold providers to account.

1.2 What is Performance Measurement?

The Trust has many different processes for measuring performance at every level of the organisation. Measuring performance via dashboards, reports and systems is vital for ensuring our services are operating in line with National and Local standards. Measuring performance gives an early indicator of potential risks which can be resolved before they become an issue.

1.3 What is Performance Management/Improvement?

Performance management is about ensuring the delivery of timely, high quality, effective and safe patient care by using Trust resources in an efficient manner. This includes understanding how the Trust is performing, reasons for variation, and barriers to improvement. Once this is understood, actions can be planned and delivered in order to make improvement.

1.4 Scope

The PAF covers all performance requirements set out in the Trust's Operational Plan, NHSE System Oversight Framework, NHS Standard Contract, NHS Operational Planning Guidance, by the CQC and the Foundation Trust Licence. Whilst the framework describes the links to individual accountabilities and the contributions that all staff make to the delivery of Trust performance, it does not deal directly with individual performance management, which is covered in the agreed Trust performance management policy/incremental pay progression policy.

1.5 Dependencies

The successful implementation of the PAF is dependent upon the production of information dashboards and reports by the Trust's Digital Analytics Team as well as Operational services who managed their own reporting processes (e.g., Theatres, Pathology, Radiology) and the timely supply of data by the Trust's Finance, Quality and HR teams.

1.6 Associated Polices and Strategies

Whilst the PAF incorporates performance across the whole Trust, it is recognised that the Trust has policies and procedures in place that will contribute to the delivery of this Framework.

2. Role and Function of the Performance Assurance Framework

2.1 Main Purpose

This PAF sets out the approach the Trust undertakes in ensuring there are effective systems in place to monitor, manage and improve performance. Prompt reviews will be undertaken where performance is deteriorating, and appropriate actions will be implemented to bring performance back to an acceptable level. The PAF:

- Sets out clear lines of accountability and responsibility for delivery of performance from 'Ward/Department to Board'.
- Supports the principle that all staff have a responsibility to contribute towards improving performance of the organisation and everybody should take ownership.
- Creates clear understood accountabilities and oversight.
- Ensures performance objectives are agreed and transparent measurements are set to monitor performance against objectives.
- Ensures performance delivery is focused and is seen as a continual process which is embedded in all aspects of organisational activity.
- Provides assurance to the Board, Governors, Regulators, Stakeholders/Partners and the Public that the organisation has strong systems in place to deliver the highest standards of patient care.
- Supports the achievement of the Trust objectives.
- Supports the delivery of the requirements of the Trust Foundation Licence, NHSE System Oversight Framework and the NHS Standard Contract.
- Provides focus on and assurance of best value for money ensuring that services meet the needs of the local population and local health economy.
- Supports the delivery of an engaged and motivated workforce with the right skills and capacity to provide consistent, good quality care.
- Recognises good performance and improvement and share good practice.
- Set out the process for managing performance risks/issues with a balance between challenge and support.

3. Our approach to Performance Management

3.1 Ward to Board Accountability Structure

The accountability structure provides a line of sight from "Ward/Department to Board" and "Board to Ward/Department" as set out in **Appendix 1** and is detailed as follows:

3.1.1 Trust Board Level

The Trust Board meets bi-monthly and receives the Integrated Performance Report (IPR) which is presented with an explanation about performance issues from relevant Executive Directors. The Trust Board may subsequently request one or more performance improvement actions (see 3.3.2) where there is variation with any area of performance.

The Integrated Performance Report (IPR) and the Care Group/CBU IPR are produced by the Trust Contracts & Performance Team with support from Finance, Quality, Governance, Digital Analytics and HR. The format of the IPR and Care Group performance reports have been designed to ensure:

- That information is presented in a way which supports an informed discussion by the Board about achieving improvement. This will include the triangulation of data to identify trends and areas considered to be an outlier in terms of performance.
- That the commentary presented by the respective Executive, along quantitative performance data, both explains current performance and identifies the actions that are being taken to provide assurance of continual improvement in quality, safety and performance.

KPIs within the Board IPR are reviewed and agreed at least annually by Board Committees with final approval from the Trust Board. KPIs may be changed in year with the minuted support of the appropriate Board Committee and the approval of the Trust Board.

The IPR Dashboard contains the following elements which are designed to provide the Trust Board with assurance around the performance of the Trust against the KPIs and to highlight areas of improvement and good practice:

- NHS Oversight Framework Assessment – setting out the defined measures through which NHS England monitors performance and ensures accountability for the trust
- Exception Report – the front section of the document is an exception report which summarises all KPIs by both Assurance and Variation Category. This is followed by a report of KPIs consistently failing to meet set targets, and KPIs indicating special cause variation of a concerning nature. This section also contains additional information around the Trust's Financial Performance including the capital programme.
- Assurance and Variation Movements – this section details areas of special cause variation across all KPIs using Statistical Process Control (SPC) Assurance and Variation Icons (supported by NHSE as part of the "Making Data Count" initiative). Also detailed is whether KPIs are achieving their set Targets.
- Dashboard – The dashboard details current and historic levels of performance, reasons for underperformance and/or performance deterioration and detail of actions and investigations underway in order to improve performance against the KPI. Wherever possible KPIs are presented as Statistical Process Control charts which look at data over time to determine if a process is within control or not, or whether there is special cause variation which requires action.

There is an annual rolling programme of auditing of KPIs to ensure there is assurance around the quality of the data and reporting processes which is facilitated by the Mersey Internal Audit Agency (MIAA).

3.1.2 Board Committees (Finance & Sustainability, Quality Assurance, Strategic People)
Executive Directors and Senior Managers will present updates on performance relative to the Committee remit as appropriate and in addition to the bi-monthly IPR discussed at the Board. The Committee may request one or more performance improvement actions (see 3.3.2) where there is a variation with any KPI. The Committee will escalate any performance variation or highlights to the Trust Board as appropriate via the committee Chair's 'Issues' report.

Each Committee receives regular performance reports as part of its agenda. The KPIs contained in the Committee reports can be changed by approval of Committee members as there may be occasions where the Committee wants to report at a more granular level of detail. Any changes to KPIs need to triangulate to the Trust Board IPR. All changes must be minuted to include the rationale for the change.

3.1.3 QPS Quarterly Performance Review at Care Group Level

The Quality Performance and Sustainability (QPS) Executive Team Review is chaired by the Chief Executive where a Quarterly review of each Care Group's performance is undertaken.

The Care Group Triumvirate will be required to attend this forum four times per year and present their position alongside their CBU IPR Dashboard, which will highlight any declining variation and/or assurance by exception to the Executive Team. In addition, a summary of Quality, Access and Performance, Workforce and Financial Sustainability performance will be presented alongside relevant KPIs. Prior to the quarterly QPS review, the Care Group Triumvirate will review and update the IPR by exception report and in-year business plan progression in relation to Quality & Governance, Operational Performance, Strategy, Improvement, People, and Finance.

Discussions will take place to understand any barriers to performance improvement or reasons for variation against signed off Business Plans and will look at any additional support required to address barriers preventing strategic priorities from delivery. The Care Group will also address ongoing revenue requests and benefits realisation against historic revenue requests. . In addition, the Care Group Triumvirate will present on areas of improvement and good practice which can be shared across the Trust. This will form part of the Trust Learning Framework. Actions from the forum will be recorded by a member of the Performance and Commercial Development team. If urgent actions are required, the Care Group will provide an update to the next available Executive Team meeting and will not wait until their next quarterly review.

The Executive Team may request one or more performance improvement actions (see 3.3.2) where there are any areas of variance. The Executive Team will escalate to the appropriate Board Committee or the Trust Board if it feels necessary to do so.

The Executive Team may ask Care Groups to attend Executive Team meetings at any time outside of the review process where there is a potential performance issue.

3.1.4 Leadership Observational Rounds

Non-Executive & Executive Leadership Observational rounds have been in place since 2022/23, and focus on positive interactions, celebrating success, and utilising CQC Red Flags to guide key lines of enquiry with the goal of improvement. Leadership Observational Rounds may also utilise performance variation to guide key lines of enquiry. The Leadership Observational Rounds take place 6 times per year and feedback will be collated as evidence as part of the CQC well led domain.

3.1.5 Care Group/CBU Level

The Care Group & CBU Triumvirate is expected to manage the performance of their services and have appropriate structures/forums in place to do so. The Care Groups & CBUs will be able to access performance information to enable them to monitor and manage performance in real time. Care Groups & CBUs are required to take corrective action to improve areas of underperformance, working with corporate services and other Trust departments as appropriate. Care Groups & CBUs should escalate any areas of performance variance to the appropriate forum. The Care Groups & CBU Triumvirates may request one or more performance improvement actions (see 3.3.2) for an individual Ward, Department, Service or Team where there are any areas of variation.

3.1.6 Ward, Department, Service or Team Level

Ward/Department/Service/Team managers will be able to access appropriate performance reports at that level in order to ensure they are managing day to day performance. Wards/Departments/Services/Teams are accountable to the CBU Triumvirate, who will provide any support, along with corporate services as necessary.

The production of quality, meaningful and timely performance information is fundamental to the delivery of the PAF. Information must be timely, accurate and complete; and follow the principles set out in the Trust's Information Governance and Data Quality Policy.

3.2 Roles & Responsibilities

Specific roles and responsibilities in relation to the ongoing monitoring, management, and improvement for the performance of the Trust are as follows:

3.2.1 Chief Executive

The Chief Executive has overall corporate responsibility for performance across the Trust.

3.2.2 Executive Directors

Executive Directors have delegated authority, responsibility, and accountability for the areas within their portfolio for ensuring effective performance management structures, systems and processes are in place for reporting, managing and improving performance with robust arrangements in place for addressing performance concerns.

3.2.3 Chief Finance Officer

In addition to responsibilities outlined in 3.2.2, The Chief Finance Officer has delegated authority for ensuring the overarching Performance Assurance Framework is in place and Executive oversight of the Performance Team activities outlined in 3.2.4.

3.2.4 Contracts, Performance and Commercial Developments Team

The Contracts, Performance and Commercial Developments Team is responsible for the management, production and development of the Trust and Care Group/CBU IPR as well as the management of the QPS Executive Team Review process. The Performance Lead is the gatekeeper of the IPR and is responsible for ensuring any changes are approved via the appropriate governance process and once approved are actioned.

The Contracts, Performance and Commercial Developments Team will provide training to the Care Groups & CBUs so that all staff have sight and understanding of the performance KPIs they are accountable for and are aware of the associated consequences of not achieving the required standards.

3.2.5 Digital Analytics Team

The Digital Analytics Team will develop, generate and publish the necessary local reports and dashboards to enable the Care Group/CBU/Teams to monitor and manage performance and will provide data for the Trust and Care Group/CBU level IPRs.

3.2.6 Corporate Services

Corporate services (Finance, Governance, HR, IM&T, Strategy) has responsibility for the production and validation of data for Trust, Care Group & CBU IPR dashboards. Corporate services will provide the necessary support to Care Group/CBUs in order to improve performance in their area.

3.2.7 Care Group Triumvirates

The Care Group Triumvirates has responsibility and accountability for the management and improvement of performance for their CBUs and will implement appropriate performance improvement actions (see 3.3.2). Care Group Triumvirates will hold CBU Triumvirates accountable for the delivery of performance KPIs at CBU level.

3.2.8 CBU Triumvirates

The CBU Triumvirates has responsibility and accountability for the management and improvement of performance for their CBU and will implement appropriate performance

improvement actions (see 3.3.2). Each CBU triumvirate will, in turn, hold individual service managers, clinical matrons, specialty leads and, where applicable, Professional Heads of Service, accountable for the delivery of performance KPIs at specialty and service level.

3.2.9 Ward/Department/Service/Team Managers
The Ward/Department/Service/Team managers have responsibility for the management and improvement of performance for their Ward/Department/Service/Team and will implement any improvement actions requested by the CBU Triumvirate.

3.2.10 All Staff
All members of staff contribute to managing and improving performance and are encouraged to suggest areas for improvement and ideas on how improvement can be made. All staff should have an understanding of how their role contributes to performance of the Trust and the impact this has on patient care.

3.3 Performance Risks/Issues
Where there is a risk to the Trust achieving a standard or target or where performance has deteriorated or is an outlier against a benchmark , this should be highlighted as a performance risk/issue and must be detailed as necessary on relevant risk registers All actions and interventions relating to performance risk/issues will focus on ensuring patient safety is paramount, be delivery focussed and proportionate to the level of risk identified and there will be a balance between challenge and support, recognising any organisation wide resource needs.

3.3.1 Identification and Management
A performance risk/issue can be identified by any member of staff at any level of the organisation ("Ward/Department to Board").

Where a performance risk/issue has been identified, it is the responsibility of the Performance Oversight Group outlined below to oversee appropriate actions in order to resolve the issue as soon as possible.

Performance Issue/Risk Area	Performance oversight Group	Support
Ward, Department, Service or Team Level	CBU Triumvirate	Corporate Services
CBU Level	Care Group Triumvirate Quality, People & Sustainability Executive Team	
Trust Level	Executive Team Finance & Sustainability Committee Strategic People Committee Quality Assurance Committee Clinical Oversight Recovery Committee Trust Board	

3.3.2 Performance Improvement Actions

A. Informal

Some low/medium level performance issues/risks may be managed locally by reviewing processes and making the necessary operational changes. These performance risk/issues may be as a result of a temporary local issue such as a staff shortage or an unexpected increase in demand. In the first instance, these performance issues should be managed and resolved locally with the appropriate authority to do so.

B. Remedial Action Plan

Where a performance risk/issue cannot be resolved in the short term and it is likely to have a medium to long term impact on Trust performance, the Performance Oversight Group may request a Remedial Action Plan. The Remedial Action Plan will outline actions to be taken, impact, timescales and review timescales and will be reviewed at an appropriate forum each month. Once the performance oversight group is satisfied that the actions are complete and performance has returned to a satisfactory level, the Remedial Action Plan will be closed.

C. Deep Dive Review

The relevant Performance Oversight Group may request at any time a deep dive into areas where there is a continued performance concern. The Performance Oversight Group will set out terms of reference including timescales. Once the review has been concluded, the Performance Oversight Group will agree next steps this may include setting quality improvement metrics, trajectories for improvement, further investigations, the implementation of a Remedial Action Plan or the establishment of an Improvement Group.

D. Improvement Group

Where performance issues/risks need additional support in order to return to satisfactory levels, a time limited Improvement Group will be established. The Improvement Group will be made up of representatives from corporate and clinical services as appropriate and will be sponsored by an appropriate Executive Director or Senior Manager and will report progress to the Performance Oversight Group.

E. Intensive Support

Where performance has not returned to a satisfactory level after the required support has been provided, the Performance Oversight Group may place a Care Group, CBU or Team into Intensive Support. Intensive Support is a recovery planning and delivering procedure and is a mechanism to direct additional management focus. The performance oversight group will write to the Care Group/CBU/Team to inform them of the decision and will outline the reasons this action has been taken. The Care Group/CBU/Team will be expected to report weekly to the Performance Oversight Group actions taken to improve performance and the impact this has had. This effort will be supported by appropriate corporate resources. The Care Group/CBU/Team will remain in Intensive Support until the performance issue has been resolved. Once the performance oversight group is satisfied that the performance issue has been sufficiently addressed, the performance oversight group will write to the Care Group/CBU/Team to inform them of the decision to bring them out of Intensive Support.

The Intensive Support procedure may be deployed in the following circumstances:

- Where there are continued and persistent performance issue in one or more areas.
- Where there is an ongoing risk to patient safety which has not been addressed, effective delivery of services or any other reasons where it is judged that the level of support is justified by the performance oversight group.
- Where delivery levels against operational performance targets is inadequate as determined by the Performance Oversight Group, where no robust plan has been agreed.
- Failure to operate within the financial parameters outlined without a legitimate reason or evidence of lack of financial controls.

- Any other circumstances where it is assessed that a risk exists which cannot be resolved via normal line management actions or where less intensive recovery actions have failed.

A summary of improvement groups and intensive support provision will be reported to the relevant board committee.

4. Structure and Governance to ensure delivery

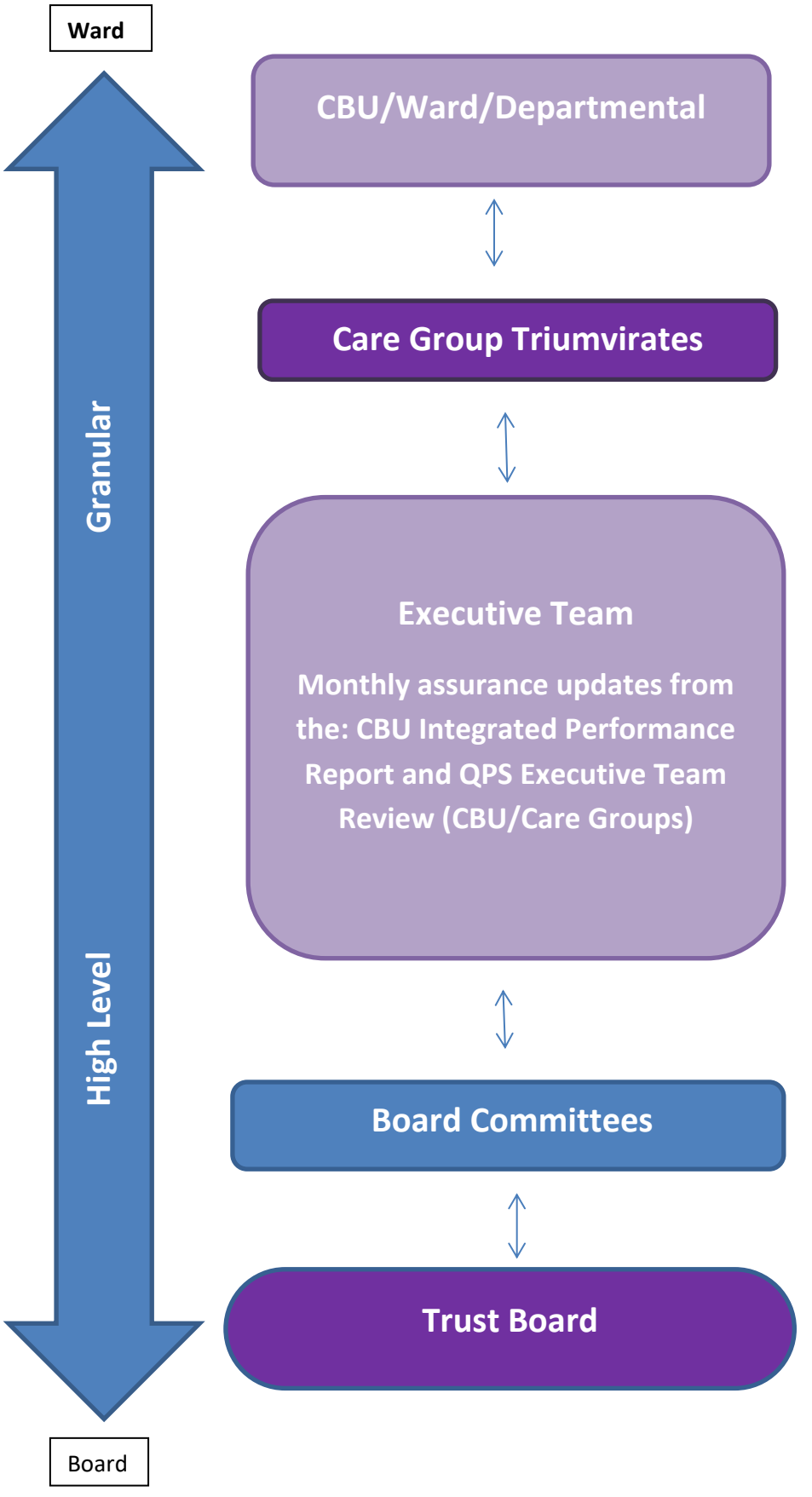
4.1 Accountability, Responsibility and Reporting Structure

Appendix 1 sets out the Trust's Accountability, Responsibility and Information reporting structure. Each meeting will have a Terms of Reference, setting out clear roles and responsibilities, objectives and membership and the devolved responsibilities from Board to Ward.

5. Next Steps

This Performance Assurance Framework will be reviewed in April 2026 as part of the annual planning cycle. The PAF will be reviewed and updated as appropriate as new guidance emerges in year.

Appendix 1 - Trust Accountability, Responsibility and Information Reporting Structure – "Ward/Department" to Board



CBU/Ward/Departmental	• CBUs/Wards/department leaders. • Review performance and identify risk at granular level weekly and take corrective action as appropriate. • CBU Triumvirates report up Care Group Triumvirates.
Care Group Triumvirates	• Full review of performance at CBU level. • Review, confirm and identify any risk/issues with agreement of remedial action plans. Risk to be reported through Risk Review Group. • Support CBUs to improve performance in identified areas. • Monitoring of remedial actions arising from QPS.
Executive Team Monthly assurance updates from the: CBU Integrated Performance Report and QPS Executive Team Review (CBU/Care Groups)	• Executive Committee holds Care Groups to account via the QPS. • Provide support to Care Groups to address identified performance issues.
Board Committees	• Executive Director/Senior Leaders attend committee meetings. • Board Committees review their performance reports/dashboards. • Deep dives requested by Committee where there is variation in performance. • Relevant committees assure Board through key issues reports and escalates any issues to Trust Board.
Trust Board	• Integrated Performance Report presented by Executive Directors. • Receiving concerns raised by Committee Chairs. • Board request additional actions and assurance where necessary. • Bi-Monthly meeting.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/04/010**			
Subject:	Integrated Performance Report			
Date of meeting:	1st April 2026			
Action required:	The KPIs that are underperforming are managed in line with the Trust's Performance Assurance Framework.			
Author(s):	Janet Parker – Deputy Chief Finance Officer Andrew Hatfield – Performance and Systems Development Lead			
Executive director sponsor:	Jane Hurst, Chief Finance Officer Paul Fitzsimmons – Executive Medical Director Alison Kennah – Chief Nurse Michelle Cloney – Chief People Officer Dan Moore – Chief Operating Officer and Deputy Chief Executive			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience 2. PEOPLE - We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future with staff developing, growing and thriving. 3. SUSTAINABILITY - We will work in partnership with others to achieve social and economic wellbeing in our communities and improve equity in health outcomes			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety BAF 2: Urgent and Emergency Care Flow BAF 3: Planned Care Access & Elective Recovery BAF 5: Workforce Capacity, Capability & Wellbeing BAF 6: Financial Sustainability			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓	✓	✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓

	Further Information / Comments:
Executive summary:	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: • **Open Incidents (over 40 days)** - Target 0% • **30. A&E Waiting Times** – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge. - Target 2% or less • **58. Capital Programme** – % delivered against plan • **59. Better Practice Payment Code** – % cumulative performance There is **one indicator that has special cause variation of a concerning nature and do not have a target**, this is: • **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 presented within the IPR exception slides at the February 2026 Trust Board meeting. Two indicators, VTE assessment and HSMR, have been removed because both now fall within the range of common variation. A new metric has been added, which is the A&E waiting time measure for the percentage of patients waiting longer than twelve hours. This has been included because seven or more recent data points are positioned above the mean, and because two of the most recent three data points are close to the upper control limits. Together these patterns demonstrate a shift in variation and indicate a deterioration in performance. **Financial Position** At Month 11 the Trust has recorded a deficit position of £38.4m (before deficit support) which is £0.6m worse than plan due to the impact of integration costs. The Trust is currently forecasting deficit of £40.7m compared

<table>
<tr><td></td><td colspan="3">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 £1.1m better than the extrapolated year to date run rate of £41.9m. The Trust underlying deficit is £45.5m which includes some risk regarding non recurrent CIP.</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:
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.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">Finance + Sustainability Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">FSPCiC/26/03/224 (vi)</td></tr>
<tr><td>Date of meeting</td><td colspan="2">23/03/2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Changes to the capital contingency supported and approved.</td></tr>
<tr><td>Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">None</td></tr>
<tr><td>Freedom of information status (foia):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>Freedom of information exemptions applied:
(if relevant)</td><td colspan="3">None</td></tr>
</table>

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 **Access & Performance** 29. A&E Wait Times – % patients waiting longer than 12 hours from arrival to admission, transfer, or discharge ↓ **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 **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) 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** **Quality** 26. MUST nutritional assessment completion ↑ **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** 8. VTE Assessment ⬆	**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 45. Elective Outpatient Activity 50. Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation		**Finance** 62. Agency Reduction
 **Consistently Passes the Target (based on the last 7 months)**	**CONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE**	**CONSISTENTLY PASSING TARGET & VARYING PERFORMANCE**	**CONSISTENTLY PASSING TARGET & MAINTAINING/IMPROVING PERFORMANCE**	**CONSISTENTLY PASSING TARGET & NO SPC**
		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. **Workforce** 54. Core/Mandatory Training **Finance** 60. Cost Improvement Programme – In year performance to date (£m)	**Access & Performance** 36. Diagnostic Waiting Times 6 Weeks ⬆ **Workforce** 53. Turnover	
	NO ASSURANCE SPC & DECLINING PERFORMANCE	**NO ASSURANCE SPC & VARYING PERFORMANCE**	**NO ASSURANCE SPC & IMPROVING PERFORMANCE**	**NO ASSURANCE SPC & NO SPC**

No SPC **No SPC/Not Enough Datapoints/Not Applicable**	**Quality** 14. Mortality ratio - SHMI	**Quality** 3. Healthcare Acquired Infections (MSSA) 13. Mortality ratio – HSMR ⬆ 25. Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT)) **Access & Performance** 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** 30. Average time in department ED 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 February 2026 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).
- 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 (£10.6m equating to 49% full year) also present a challenge to future sustainability if they are not addressed. The forecast non-recurrent CIP is currently £9.6m of which £7.1m is in the underlying deficit the balance is being reviewed.

The Trust is currently forecasting deficit of £40.7m 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 £1.1m better than the extrapolated year to date run rate of £41.9m.

The Trust underlying deficit is £45.5m 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.

The Trust has submitted a draft deficit plan for 2026/27 of £34.9m with a WTE reduction of 118. The deficit plan reduces to £17.5m in 2027/28 (WTE reduction of 304) and then to £3.3m deficit in 2028/29 (WTE reduction of 247). Years 2 and 3 of the plan will be reviewed and resubmitted each year and changed depending on new information guidance available.

Cash

The cash balance at the end of February is £17.2m of which £7.1m relates to capital creditors. Given the current cash position and the planned deficit for 2025/26 this has led to the Trust requiring external cash support and £8.037m was received in March.

Increased cash management measures continue in line with NHSE guidance. As a result, BPPC remains low (57% against a target of 95%, 88% cumulative position in

March 2025). Cash days are at 15 days which is an improvement from last month (11 days) due to drawing down capital PDC cash before the end of year deadline. This is also a reduction from April 2025 (18 days) due to the decreasing cash balance.

CIP

At 28 February 2026, the Trust has delivered a CIP of £19.4m which is £21k better than plan. However, it should be noted that year to date £10m 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 £10.5m 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. At month 11 the forecast for this has been assessed as £9.6m compared to the actual non recurrent CIP of £10.5m. The difference of the £0.9m is due to full year effect of recurrent schemes. The forecast non-recurrent CIP is currently £9.6m of which £7.1m is in the underlying deficit the balance £2.5m is being reviewed.

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.

Capital Programme

The Trust total capital funding consists of £12.44m Capital Departmental Expenditure Limit (CDEL) and £10.82m external funding, a total of £23.26m. The Trust also has £1.49m IFRS16 CDEL.

The Trust capital spend (excluding IFRS 16) for month 11 is £9.4m which is £14.2m below the plan of £23.6m. This is mainly driven by NHSE agreed EPR delays, the CDC scheme paused by the ICB and late confirmation of additional capital. A revised forecast of £19m has been agreed with the ICB and is expected to be fully delivered by year end.

Table 3 highlights the current contingency fund.

Table 3: Capital Contingency

DETAIL	£'000	£'000
Contingency balance start of month 11		**634**
Proposed changes in month		
VAT Recovered		
Returned to contingency fund		
Sentinal Gamma Probes - ringfence for 2026/27	45	
Sub Total		**45**
Requests supported by CPG Chair		
Interventional Radiology addendum	- 72	
Sub Total		**- 72**
Contingency as at end of month 11		**607**

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:

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

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

- Special Cause Variation of a improving nature.
- Common Cause (Normal Variation).
- Special Cause Variation of a concerning nature.
- Consistently passes the target
- Inconsistently passes and fail the target
- Consistently fails the target

		Latest				Previous		
	QUALITY	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	**Assurance**
1	Incidents	0	88	Feb-26		58	Jan-26	
2	Healthcare Acquired Infections (MRSA)	0 (for 2025/26)	0	Feb-26		0	Jan-26	
3	Healthcare Acquired Infections (MSSA)	no threshold set	2	Feb-26		5	Jan-26	No SPC
4	Healthcare Acquired Infections (CDI)	60 (for 2025/26)	7	Feb-26		10	Jan-26	
5	Healthcare Acquired Infections (Ecoli)	79 (for 2025/26)	2	Feb-26		5	Jan-26	
6	Healthcare Acquired Infections (Klebsiella)	28 (for 2025/26)	1	Feb-26		5	Jan-26	
7	Healthcare Acquired Infections (PA)	8 (for 2025/26)	0	Feb-26		1	Jan-26	
8	VTE Assessment	95.00%	95.28%	Feb-26		95.03%	Jan-26	
9	Inpatient Falls & harm levels	10% reduction from 2024/25	39	Feb-26		41	Jan-26	
10	Pressure Ulcers	20% reduction from 2024/25	8	Feb-26		13	Jan-26	
11	Medication Safety Reconciliation within 24 hours	80.00%	47.33%	Feb-26		41.39%	Jan-26	
12	Staffing - Average Fill Rate	97.77%	N/A - grouped indicator	Feb-26	No SPC	97.77%	Jan-26	No SPC
13	Mortality ratio - HSMR	No target set	92.74	Feb-26		93.33	Jan-26	No SPC

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

14	Mortality ratio - SHMI	No target set	102.04	Feb-26	H	102.03	Jan-26	No SPC
15	Complaints	Zero complaints open over 6 months old/in the backlog	1	Feb-26		1	Jan-26	F
16	Friends and Family (Inpatients & Day cases)	95.00%	97.77%	Feb-26		98.65%	Jan-26	P
17	Friends and Family (ED and UCC)	87.00%	72.50%	Feb-26		74.43%	Jan-26	F
18	Mixed Sex Accommodation Breaches (ITU)	0	15	Feb-26		11	Jan-26	F
19	Sepsis - % screening for all emergency patients.	90.00%	69.00%	Feb-26		70.00%	Jan-26	F
20	Sepsis - % screening for all inpatients	90.00%	86.00%	Feb-26		72.00%	Jan-26	F
21	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag	90.00%	55.00%	Feb-26		60.00%	Jan-26	F
22	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90.00%	79.00%	Feb-26		88.00%	Jan-26	F
23	Acute Kidney Injury	Less than previous month	131	Feb-26		145	Jan-26	?
24	Maternity Postpartum Haemorrhage	3.70%	4.60%	Feb-26		4.70%	Jan-26	?
25	Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	35%	Feb-26		15%	Jan-26	No SPC
26	MUST nutritional assessment completion	above > 85%	73.65%	Feb-26	H	72%	Jan-26	F

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

		Latest				Previous		Assurance
	ACCESS & PERFORMANCE	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
27	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (excluding WUTC).	78%	62.64%	Feb-26		63%	Jan-26	F
28	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (including WUTC).	78%	68.39%	Feb-26		68%	Jan-26	F
29	A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	25.07%	Feb-26	H	26.8%	Jan-26	F
30	Average time in department ED	No Target	415	Feb-26	L	470	Jan-26	No SPC
31	Ambulance Handovers within 15 minutes	65%	33.96%	Feb-26		22.37%	Jan-26	F
32	Ambulance Handovers within 30 minutes	95%	64.49%	Feb-26		50.27%	Jan-26	F
33	Ambulance Handovers within 45 minutes	100%	76.73%	Feb-26		61.45%	Jan-26	F
34	Type 5 attendances	No Target set	2025	Feb-26		2224	Jan-26	No SPC
35	Patients seen in the Fracture Clinic within 72 hours	95%	63.50%	Feb-26		80%	Jan-26	?
36	Diagnostic Waiting Times 6 Weeks	95.00%	98.38%	Feb-26	H	96.95%	Jan-26	P
37	Referral to treatment Open Pathways	92.00%	63.02%	Feb-26	H	61.48%	Jan-26	F
38	Referral to treatment - Number of patients waiting 52+ weeks	0	564	Feb-26	L	859	Jan-26	F
39	28 Day Faster Cancer Diagnosis Standard	75%	77.70%	Jan-26	H	77.60%	Dec-25	?

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

40	Cancer 31 Day Wait	96%	99.30%	Jan-26		98.20%	Dec-25	P
41	Cancer 62 Day Wait	85%	84.20%	Jan-26		80.40%	Dec-25	F
42	Reduction in Outpatient Follow Ups compared to 19/20 activity	No Target set	82%	Feb-26	L	78%	Jan-26	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%	99%	Feb-26		78%	Jan-26	?
46	Super Stranded Patients	Trajectory	153	Feb-26		150	Jan-26	No SPC
47	No Criteria to Reside (NCTR)	No Target set	230	Feb-26		190	Jan-26	No SPC
48	% Patients discharged to their usual place of residence	No Current Threshold	96%	Feb-26		96%	Jan-26	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%	1.47%	Feb-26		1.37%	Jan-26	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	5	Feb-26		3	Jan-26	?
51	Capped Theatre Utilisation	85%	79.00%	Feb-26		78%	Jan-26	F

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

		Latest				Previous		Assurance
	WORKFORCE	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
52	Supporting Attendance	5.00%	5.92%	Feb-26		6.70%	Jan-26	F
53	Turnover	Below 13%	11.20%	Feb-26	L	12%	Jan-26	P
54	Core/Mandatory Training	85.00%	89.82%	Feb-26		90.66%	Jan-26	P
55	PDR compliance	85.00%	81.49%	Feb-26	H	82.51%	Jan-26	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:

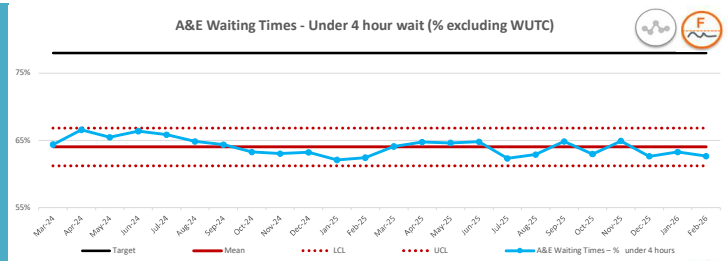
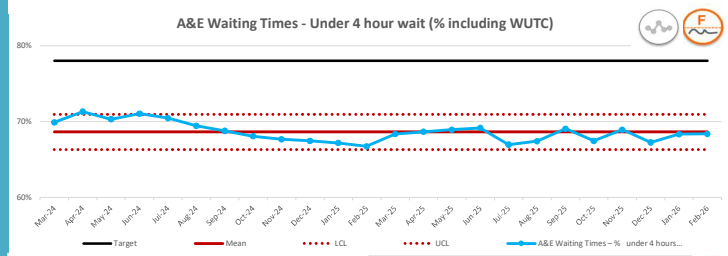
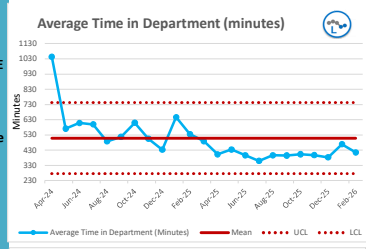
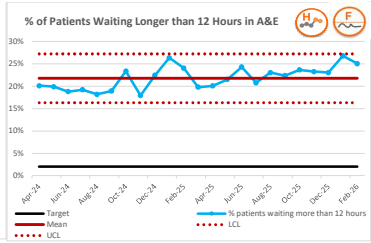
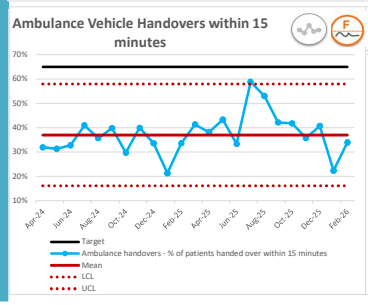
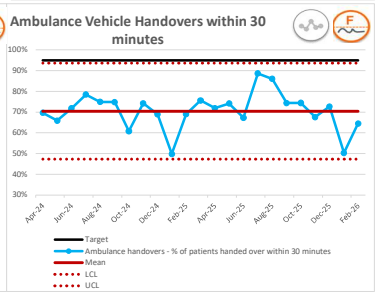
- Special Cause Variation of a improving nature.
- Common Cause (Normal Variation).
- Special Cause Variation of a concerning nature.
- Consistently passes the target
- Inconsistently passes and fail the target
- Consistently fails the target

		Latest				Previous		Assurance
	FINANCE & SUSTAINABILTY	**Target/Threshold**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
56	Trust Financial Position (£m)	-£3.20	-£3.55	Feb-26	No SPC	-£3.28	Jan-26	No SPC
57	Cash Balance (£m)	£3.70	£17.17	Feb-26	No SPC	£12.05	Jan-26	No SPC
58	Capital Programme (£m)	£21.28	£9.43	Feb-26	L	£6.45	Jan-26	F
59	Better Payment Practice Code	>95%	69%	Feb-26	L	57%	Jan-26	F
60	Cost Improvement Programme - In year (£m)	90% of plan	100%	Feb-26		100%	Jan-26	P
61	Cost Improvement Programme (recurrent) – In year (£m)	90% of plan	48%	Feb-26	No SPC	45%	Jan-26	F
62	Agency Reduction (£m)	£2.42	£2.67	Feb-26	No SPC	£2.42	Jan-26	?
63	Bank Reduction (£m)	£22.87	£28.50	Feb-26	No SPC	£26.17	Jan-26	F

Warrington and Halton Teaching Hospitals NHS Foundation Trust

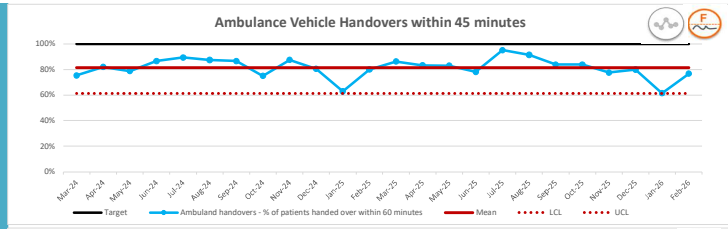
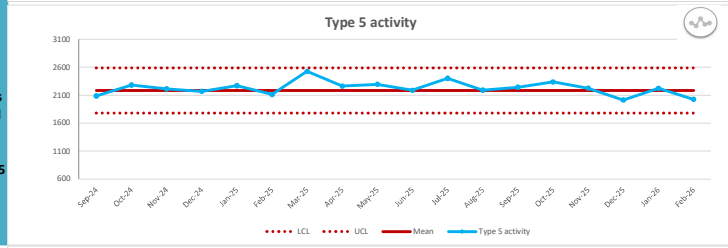
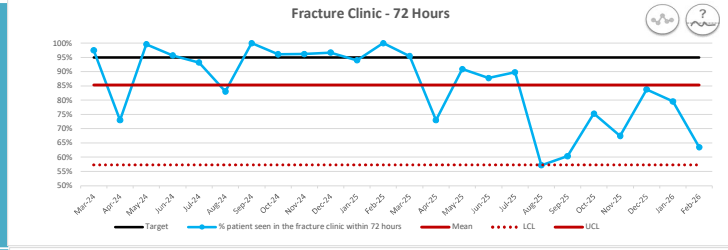
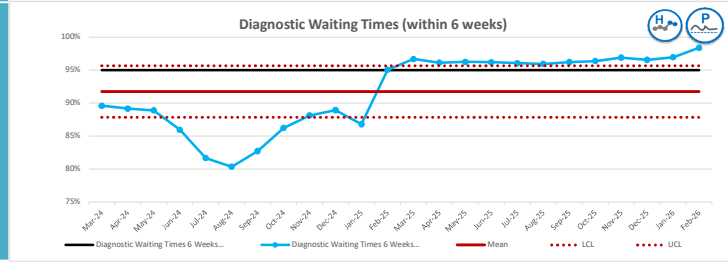
Access & Performance - Trust Position

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) Target: 78%	**The Trust achieved 62.64% 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** **• Increased capacity through SDEC has been created as a test of change to support deflection from ED this is due to be complete mid April**
28. A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Including WUTC) Target: 78%	**The Trust achieved 68.39% 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	**25.07% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 415 minutes.**	 	**Assurance: No Target set** **Variation: There is special cause of improving nature.** **Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a concerning nature.**	**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 Exec led service improvement group continues to support recovery** **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:** **- 34% Ambulance Handovers within 15 minutes (65% target)**	 	**(15) 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.**	
32. Ambulance Vehicle Handovers within 30 minutes Target: 95%	**- 64.5% Ambulance Handovers within 30**		**(30) Assurance: The Trust consistently fails the target.** **Variation: There is Common Cause (normal) Variation.**		

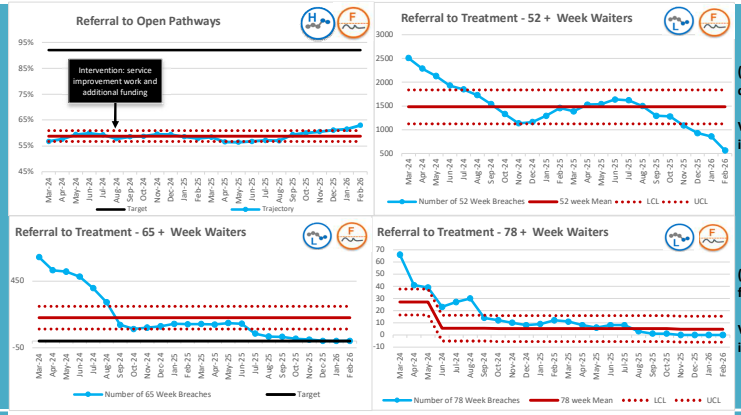
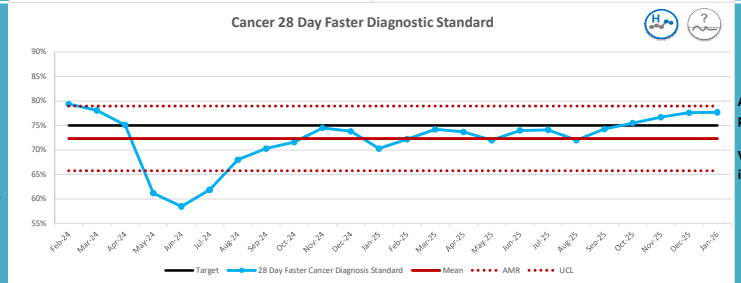
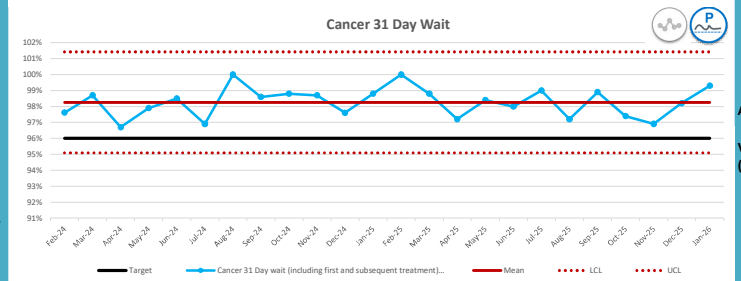
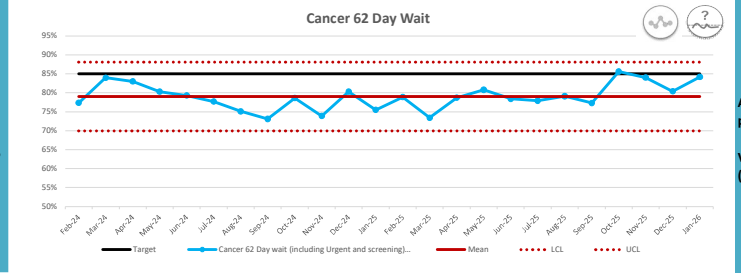
Access & Performance - Trust Position

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)** **- 76.7% 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 2025 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 83.8% 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 96.55% in month.**		**Assurance: The Trust consistently passes the target.** **Variation: Special Cause variation of improving nature.**	**The diagnostic target has been maintained for 13 consecutive months**	**This recovered position will continue to be monitored through Performance review group to ensure continued achievement.**

Access & Performance - Trust Position

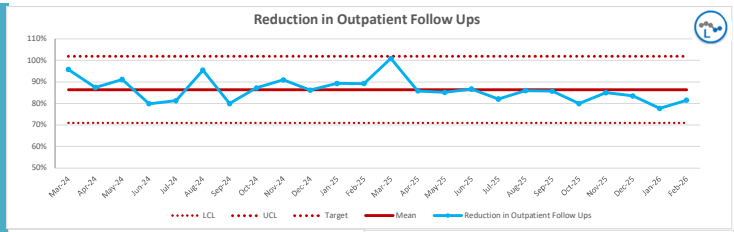
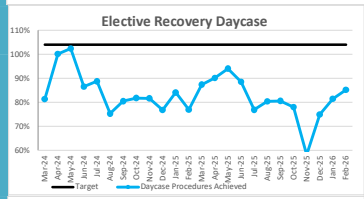
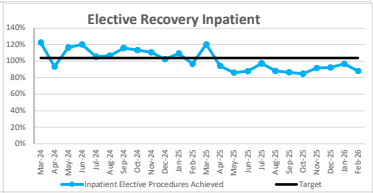
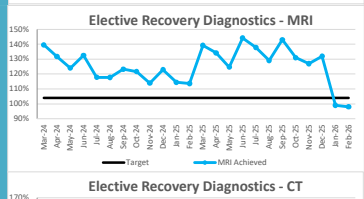
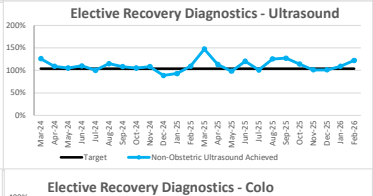
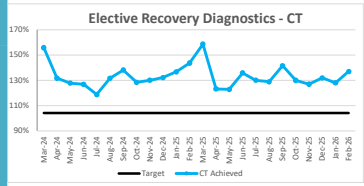
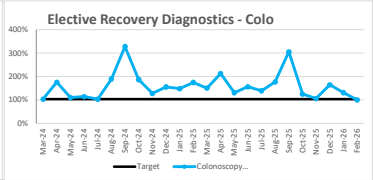
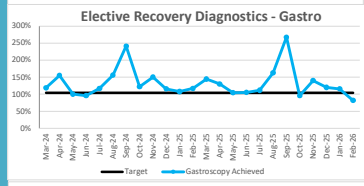
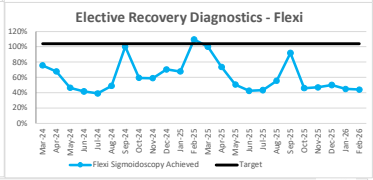
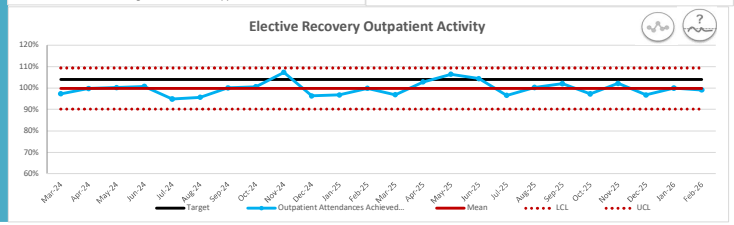
Appendix 2

	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 63.02% in month. There were 564, 52 week breaches, 0, 78 week breaches and 1, 65 week breaches.**		**(Open Pathways) Assurance: The Trust consistently fails the target.** **Variation: Special Cause variation of improving nature.** **(52+) Assurance: The Trust consistently fails the target.** **Variation: There is special cause of improving nature.**	**RTT performance - The Trust is on target to achieve the 1% 52 week target, 65 weeks continues track at low numbers with 1 declared for February**	**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 77.7% in month.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Special Cause variation of improving nature.**	**Performance for the Faster Diagnosis Standard is at 77.7%** **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 99.3% 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 84.2% in month for Cancer 62 Day Wait.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: There is Common Cause (normal) Variation.**	**62-day wait for first treatment performance is at 84.2%.** **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.**	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

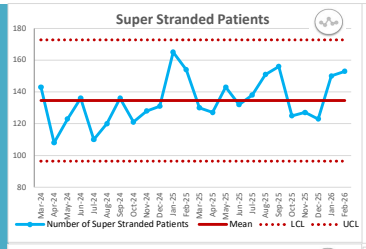
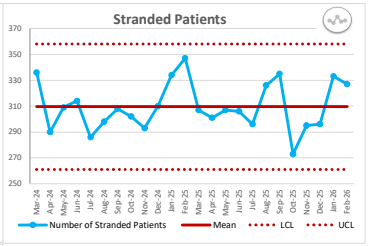
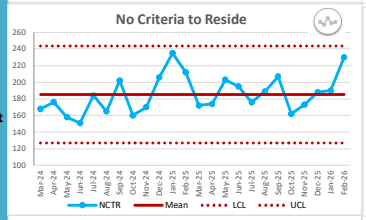
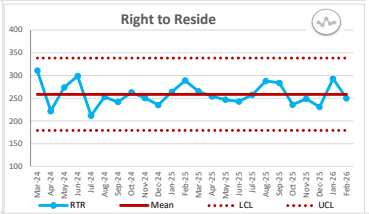
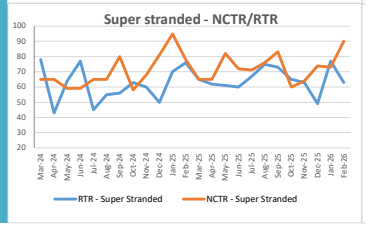
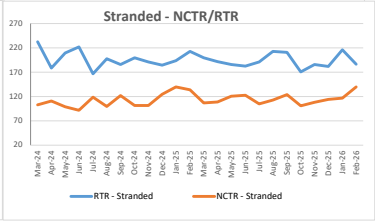
Appendix 2

	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)?
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 81.56% 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 85% of Daycase Procedures and 87.94% 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:** **98% of MRI** **137% of CT** **122% of Non-Obstetric Ultrasound** **44% of Flexi Sigmoidoscopy** **101% of Colonoscopy** **82% 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 99.13% of Outpatient activity.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: There is Common Cause (normal) Variation.**	**The Trust continues to deliver Outpatient activity in line with operational planning guidance**	**The Trust continues to restore clinical services in line with the national operating guidance.** **The position will improve following completion of coding of OPD procedures.** **New patients 98.99% of plan** **FU patients 89.98% of plan - impacted by IA** **OC Procs 78.33% - not finalised position**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

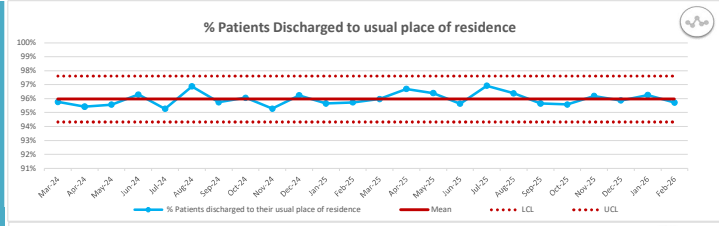
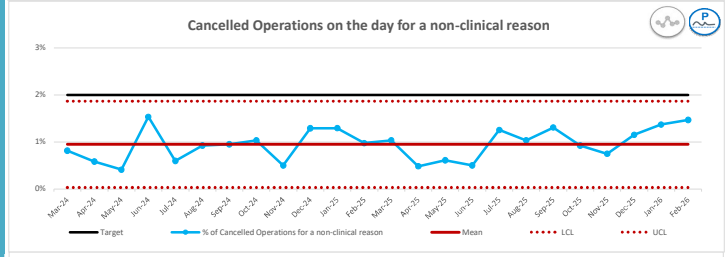
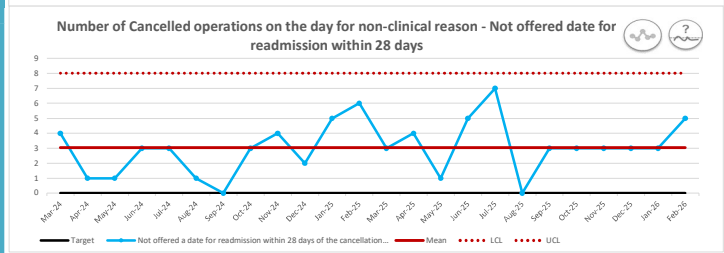
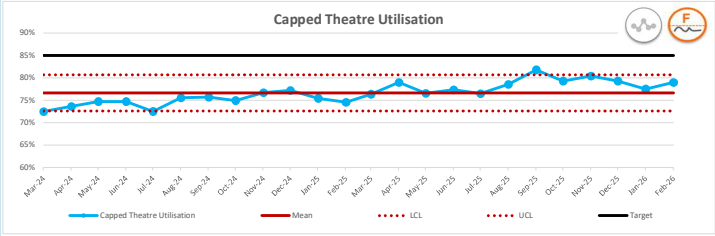
Appendix 2

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)?
46. Super Stranded Patients Target: Trajectory 47. No Criteria to Reside (NCTR) **There were 327 stranded and 153 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.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

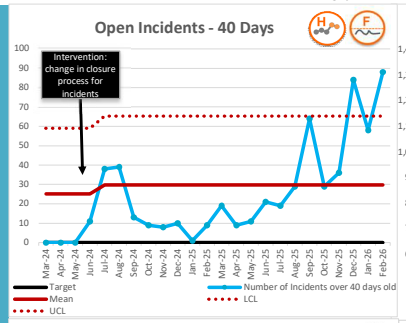
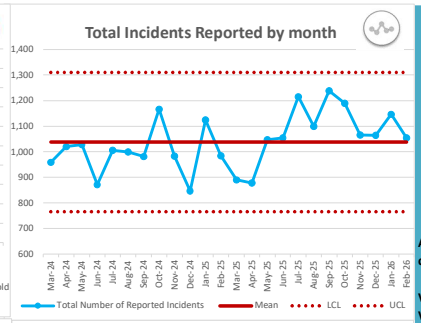
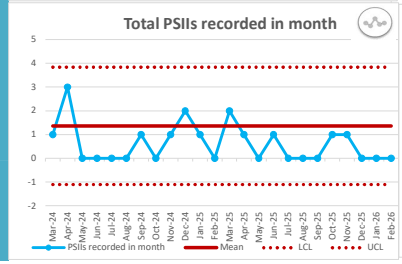
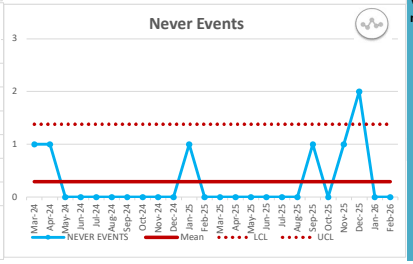
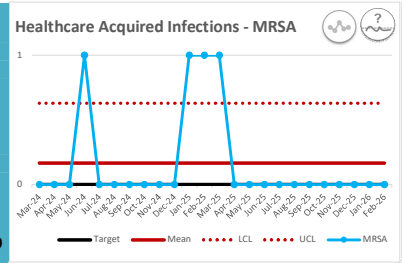
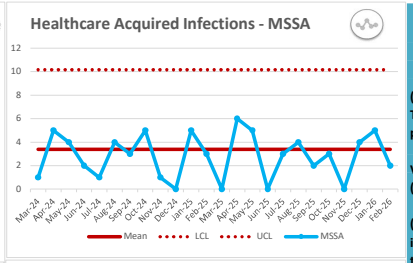
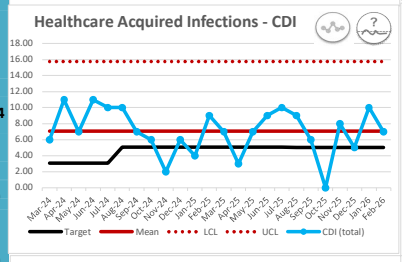
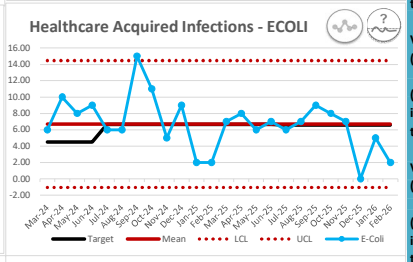
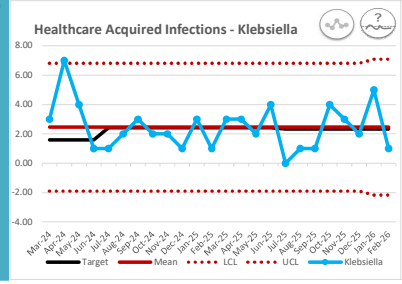
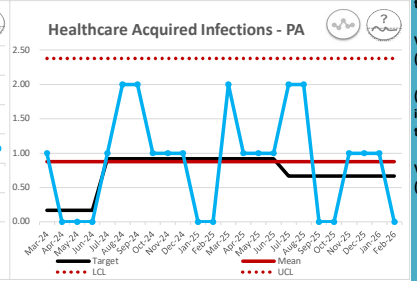
Appendix 2

	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)?
48. % Patients discharged to their usual place of residence Target: No Current Threshold	**95.72% 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 1.47% in month. 5 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 79% 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.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality Improvement - Trust Position

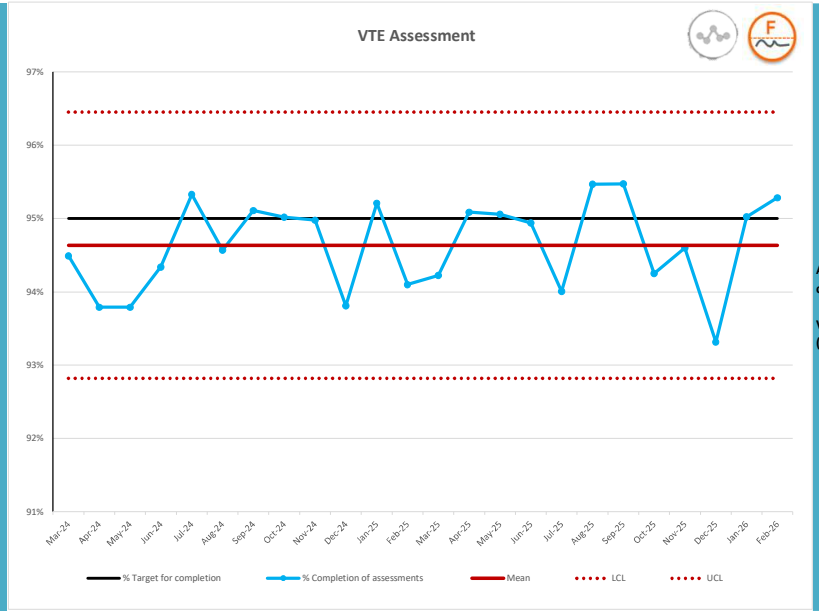
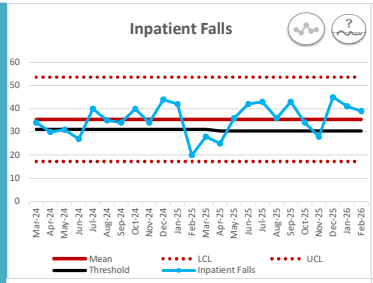
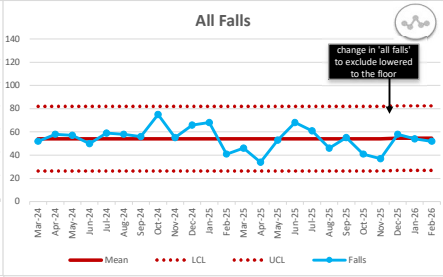
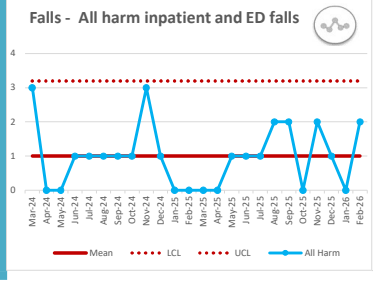
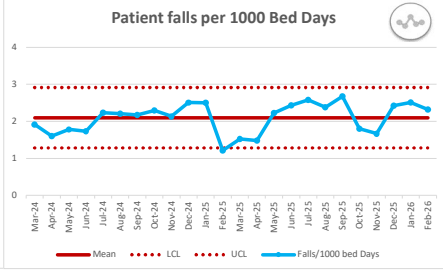
Appendix 2

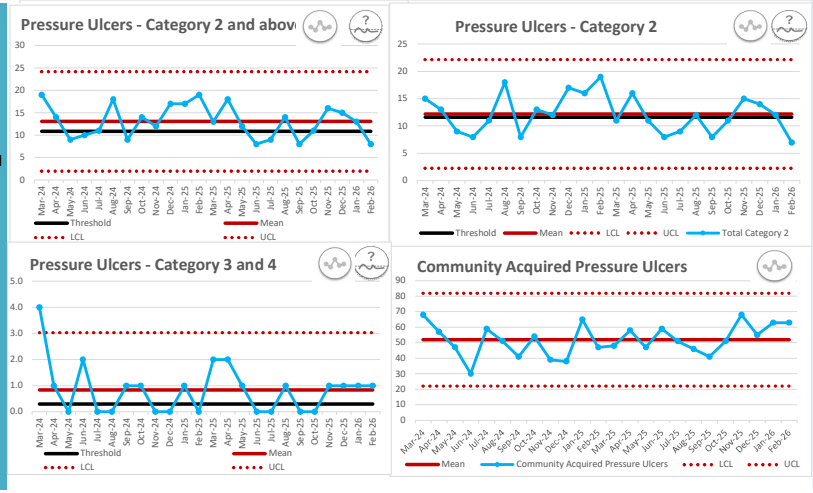
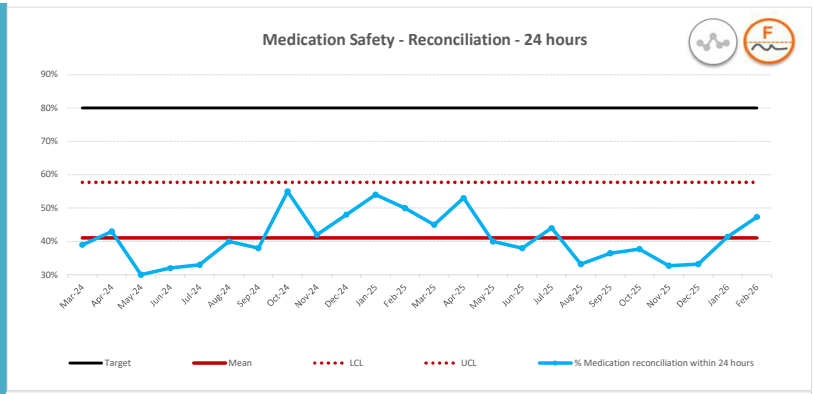
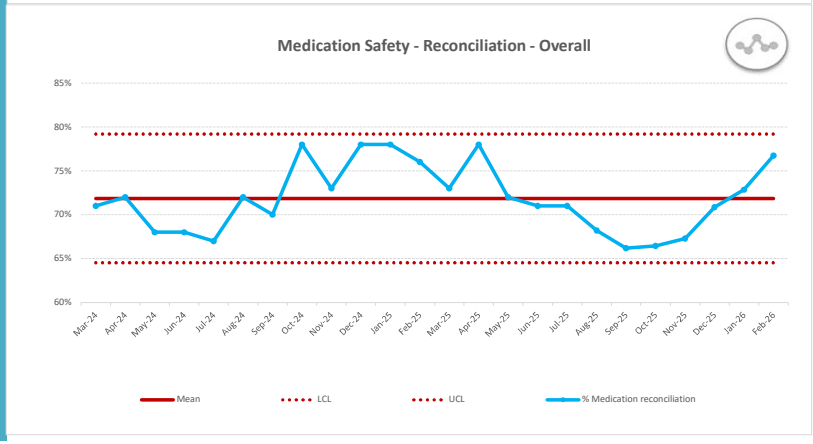
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
1. Incidents (over 40 days) **Target: ZERO Open incidents outside 40 day timeframe and** There was 88 incident over 40 days old.	   	**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a concerning nature.**	There were no PSII cases declared in February 2026. A total of 47 learning response reviews—including After-Action Reviews, MDT reviews, and swarm huddles—were in progress at the time of reporting. No incidents were reported to MNSI during February 2026. At the time of reporting on 02 March 2026, there were 88 incidents open for more than 40 days. These extended open cases were primarily due to delays in the completion of review actions, workforce capacity constraints within operational teams, and the need for additional information or verification before closure particularly relating to interface incidents.	A weekly Executive-led governance dashboard monitors reporting trends with triangulation of incidents, complaints, claims and inquests, supported by designated Governance Team members aligned to each Clinical Business Unit to ensure consistency. Incidents exceeding 40 days are escalated daily to triumvirates and prioritised, while Datix alerts at 30 days trigger early support. A daily learning-response and action report is provided for Care Group oversight, and PSII progress is reviewed through the weekly Executive-led Safety Oversight Meeting with escalation to Clinical Business Unit leads as required
2. Healthcare Acquired Infections (MRSA) **Target: 0** MRSA cases YTD annual threshold exceeded by 0	 	**(MRSA) Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.** **(CDI) Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.** **(ECOLI) Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.** **(K) Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.** **(PA) Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	Revised reporting rules since April 2024, where the decision-to-admit (rather than the admission date) is now used, have resulted in an increase in HCAI cases being apportioned to acute Trusts. There is a regional and national increase in C. difficile cases, and UKHSA has declared this rise a national standard incident; however, the Trust remains a low outlier for C. difficile cases compared with other NW Trusts to the end of December 2025. A national increase in MSSA cases has also been noted, and NHSE are reviewing this trend, with further information awaited. The Trust is not flagging as a high outlier for HCAI cases or rates, and many infections have multiple or deep-seated primary sources that are unlikely to be preventable. Changing population demographics, with increasing numbers of older adults, may be contributing to rising GNBSI cases. A reduction in E. coli, C. difficile and Klebsiella cases has been seen this month, likely reflecting the impact of strengthened infection-prevention measures, improved antimicrobial stewardship and enhanced environmental and clinical practices	**MRSA/MSSA:** A comprehensive Prevention Action Plan is actively being implemented. Peripheral cannula dwell times are under review to ensure full alignment with EPIC 3 guidance, and the Trust cannulation policy is being updated accordingly. A structured training programme for peer ANTT assessors is in place, and Clinical Business Units are progressing work to strengthen competency assessment for all ANTT-related procedures. The Quality Academy has been engaged to support identification of barriers to completing peripheral cannula documentation and to help define effective facilitators to improve compliance. **CDI:** A CDI Prevention Action Plan remains in place and enhanced IPC support is ongoing. Reviews of recurrent CDI cases are progressing. The Trust experienced significant operational impact from Norovirus in January 2026, which contributed to the increase in cases. Assurance is provided that mitigation and monitoring measures continue at pace. Antimicrobial stewardship activity has strengthened following the return to baseline Consultant Microbiology staffing, and associated reviews are underway. Antimicrobial Stewardship ward rounds have resumed to normal levels. The Gram-Negative Bloodstream Infection (GNBSI) Prevention Group has been revised and relaunched (August 2025) with confirmed medical staff membership. There is an increased focus on supporting wards reporting two Gram-Negative Bloodstream Infection cases per month. A quality improvement project is underway within the Surgical Services Clinical Business Unit to ensure timely removal of catheters after surgery, alongside work to reduce catheter use in elective joint replacement surgery.
3. Healthcare Acquired Infections (MSSA) **Threshold for 2025/26: no threshold set** MSSA 34 cases YTD no threshold set				
4. Healthcare Acquired Infections (CDI) **Threshold for 2025/26: 60** CDI 74 cases YTD annual threshold exceeded by 14 cases	 			
5. Healthcare Acquired Infections (Ecoli) **Threshold for 2025/26:79** E. coli 65 cases YTD annual threshold exceeded by 0				
6. Healthcare Acquired Infections (Klebsiella) **Threshold for 2025/26: 28** Klebsiella spp. 26 cases YTD annual threshold exceeded by 0	 			
7. Healthcare Acquired Infections (PA) **Threshold for 2025/26: 8** P. aeruginosa 10 cases YTD annual threshold exceeded by 2 cases				

Warrington and Halton Teaching Hospitals NHS Foundation Trust

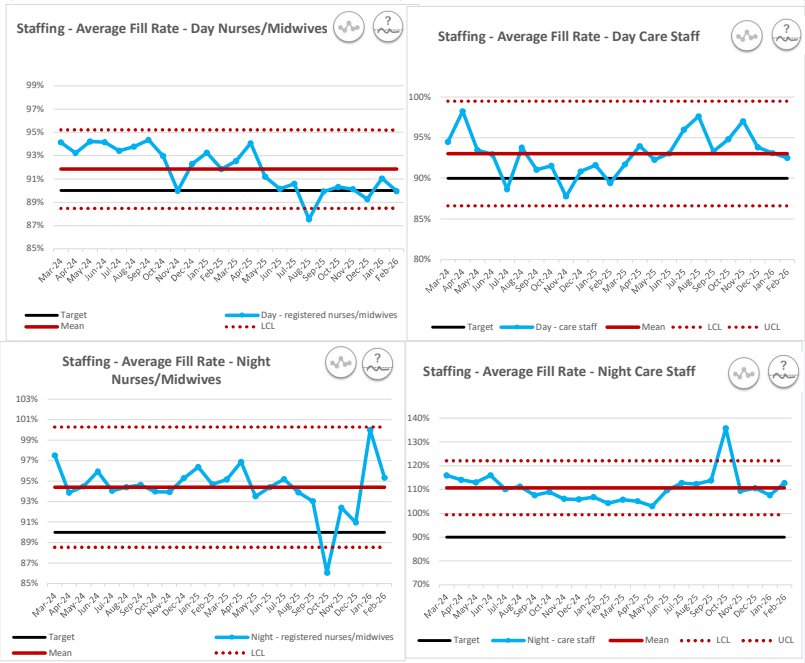
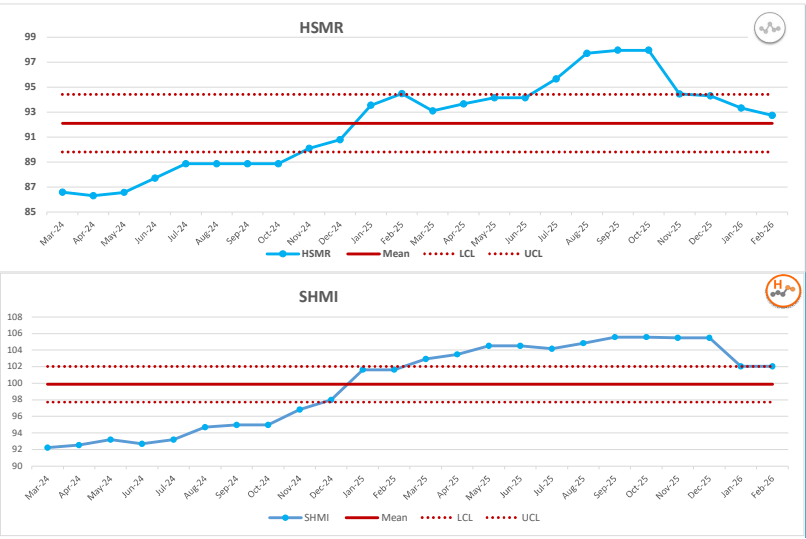
Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
8. VTE Assessment **Target: 95% (quarterly position)**	**The Trust did not achieve the required target at 95.28% for VTE assessments in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**The VTE risk assessment performance for February 2026 achieved the mandatory compliance threshold at 95.28%, marking the first time this standard has been met since September 2025**	**The Trust has already implemented several measures to strengthen VTE risk assessment (VTE RA) compliance, including encouraging ward teams to use real-time data from the GIRFT Inpatient Ward Productivity Dashboard to complete outstanding assessments, incorporating regular feedback from Clinical Business Units (CBUs) via the VTE RA dashboard into monthly Clinical Governance discussions, and providing monthly updates to clinical leaders to drive improvement within their areas.** **To sustain and further enhance compliance, Clinical Business Units are now being asked to work closely with ward managers and ward clerks to use real-time ward-level data to ensure all "VTE not completed" cases are addressed during daily morning board rounds, supported by a visual guide shared for dissemination. Positive engagement from the Women's and Children's Clinical Business Unit demonstrates the effectiveness of this approach at ward level.** **The Patient Safety Nursing Team will continue to reinforce the mandatory requirement for VTE Risk Assessments through the Nursing Forum and Trust-wide Safety Brief in January 2026, ensuring continued awareness and accountability. Meanwhile, the Thrombosis Group will maintain oversight of data trends to identify further opportunities for improvement and ensure ongoing, sustained compliance above the 95% target.**
9. Inpatient Falls & harm levels **Target: 10% reduction from 2024/25**	**52 total falls were reported in month. 39 of these were inpatient falls.** **There was 2 fall(s) in month with harm.** **There were 52 total falls in 2023/24. There have been 689 total falls YTD in 2024/25.** **We are expecting a 0% increase in falls from last year.** **There were 415 inpatient falls in 2023/24. There have been 405 inpatient falls YTD in 2024/25.** **We are expecting a 0% increase in falls from last year.**	   	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause Variation.**	**In February, there was a reduction in both inpatient falls and total falls across the organisation. There were 39 inpatient falls, of which 22 resulted in no harm, 15 in low harm, and 2 in moderate harm. The two moderate-harm incidents involved one patient sustaining a head injury and another sustaining a thoracic spinal fracture. Within the Emergency Department, there were 4 falls, with 2 categorised as no harm and 2 as low harm. Encouragingly, the falls rate per 1,000 bed days decreased to 2.32, which is below the national average, indicating continued improvement in fall-prevention measures and patient safety performance**	**During March, the Turun falls alarm representative is scheduled to undertake equipment checks across the Trust and provide targeted training within key clinical areas. The Patient Safety Improvement Nurses (PSIN) continue to actively support the Deconditioning Task and Finish Group, recognising that although increased mobilisation may heighten the risk of falls, the potential harm associated with deconditioning is far greater. A coordinated, multiprofessional approach therefore remains essential to reducing overall harm.** **The post fall SWARM process has now been digitalised and was piloted during February 2026. The PSIN Team will review the outputs from this trial and gather feedback from participating wards before progressing to a Trust wide rollout.** **In addition, the PSIN Team have scheduled a Patient Safety Study Days in Q4 2026, which include focused falls prevention teaching. These sessions also cover all elements of the falls risk assessment as recommended by the Royal College of Physicians.**

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
10. Pressure Ulcers (Category 2 and above) Target: 20% reduction from 2024/25	In month there were 7 hospital acquired category 2 pressure ulcers, 1 Category 3 pressure ulcers and 0 Category 4 ulcers in month. There were 63 community aquired pressure ulcers in month.		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (Normal) variation.	In February 2026, eight category 2 pressure ulcers were reported, reflecting a significant reduction on previous months One category 3 pressure ulcer was also reported. This positive trend follows the introduction of SWARM huddles, which have strengthened local learning and supported teams to implement timely actions, contributing to improved patient safety outcomes.	An After Action Review is completed by the ward manager, with learning shared across ward teams and through the Operational Patient Safety Group, and all Category 3 and above pressure ulcers now undergo a full MDT review. Improvement plans for both the Unplanned Care and Planned Care Groups are in place and monitored by the Associate Chief Nurses. Essential Healthcare has increased on-site technician capacity to ensure mattress pumps are checked and any faults rectified promptly, while film dressings are being applied to patients' heels in ED to reduce friction and shear injury. A Trust-Wide Safety Brief has been issued regarding TED stockings, supported by a Single Point Lesson, and staff are asked to retain any stockings linked to pressure damage so the Tissue Viability Team can audit the products involved
11. Medication Safety Reconciliation within 24 hours Target: 80%	Medicines reconciliation was completed within 24 hours of admission for 47.33% of patients. 76.75% of patients had MR completed during inpatient stay.	 	Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	Performance has improved over the past two months, with 47% of medicines reconciliations completed within 24 hours compared with 33% in November and December. Current pharmacy staffing levels do not allow full coverage of all inpatient areas, so workforce deployment is based on patient activity and acuity. As a result, variation in performance between CBUs reflects the prioritisation of higher-acuity and critical care areas (e.g. ED, AMU, ICU, ACCU), while lower-priority areas such as elective surgical and maternity services receive less pharmacy resource. Deployment decisions are supported by audit data and focus on patients receiving high-risk medicines. Of the patients who did not receive medicines reconciliation, 70% were within the W&C and SS CBUs, predominantly maternity patients in the birth suite and MLU. Previous analysis shows that 90% of these women take no regular medication and fewer than 5% are prescribed a critical medicine. In surgical specialties, analysis indicates that around 60–70% of patients without medicines reconciliation were discharged on day two of admission. Given limited pharmacy capacity, this would not represent an effective use of resource, and medicines reconciliation for these patients is instead completed by pharmacy as part of the TTO clinical check process.	Midwife recording of Medicines Reconciliation (MR) commenced in November 2025, and the number of MR entries being completed within maternity areas continues to rise. Ongoing training and support provided by the Medication Safety Nurse are strengthening midwives' confidence and consistency in documenting MR. The pharmacy prioritisation tool has now been deployed to all pharmacy teams, providing a systematic method for identifying and prioritising the highest-risk patients across the organisation. The tool is currently being piloted within the IMC pharmacy team, with continued collaboration between Pharmacy, IT, and Digital Analytics to support further development and full organisational rollout. The Lead Pharmacist for ED commenced in post from week commencing 19 January, restoring pharmacist staffing in ED to establishment. This has been associated with a noted improvement in UEC MR performance in February 2026

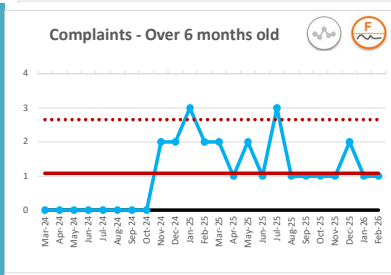
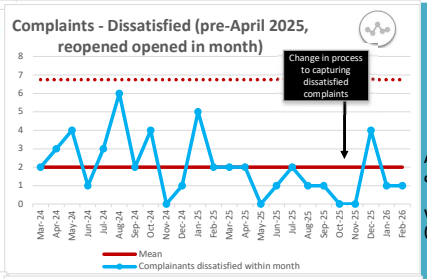
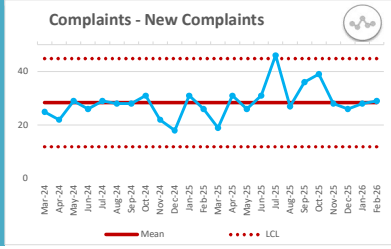
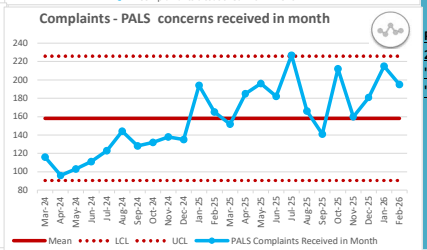
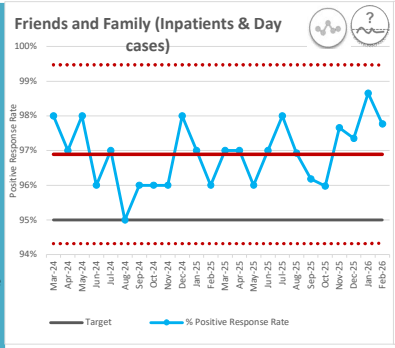
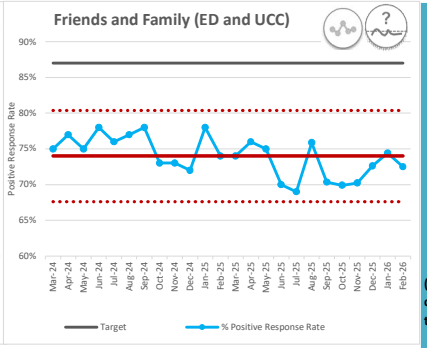
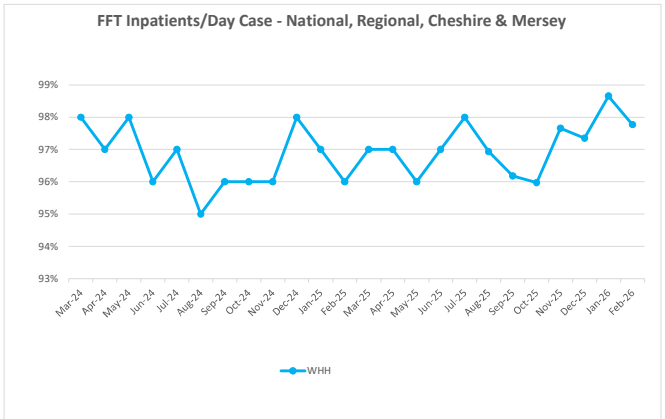
Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
12. Staffing - Average Fill Rate **Target: 90%**	**In month, the average staffing fill rates were:** **Day (Nurses/Midwife) 89.94%** **Day (Care Staff) 92.5%** **Night (Nurses/Midwife) 95.31%** **Night (Care Staff) 112.71%**		**Assurance: N/A Grouped Indicator** **Variation: N/A Grouped Indicator**	**Staffing fill rates experienced a slight decline this period, primarily due to the requirement to support newly established ward areas, including B3, Surgical Same Day Emergency Care (SDEC), and escalation areas. Additional contributing factors included increased sickness absence and short-notice cancellations by NHSP staff. At this stage, no specific cause has been identified for the NHSP cancelations but this is being explored.**	**Staffing levels are reviewed twice daily by the Senior Nursing Team, who monitor patient acuity, dependency, and activity to ensure safe staffing is maintained across all clinical areas. Variances from planned staffing are escalated in real time, and mitigation actions—such as redeployment and support from non-ward-based staff, alongside temporary staffing requests—are implemented promptly to protect patient safety. To improve staffing fill rates, the Trust has undertaken several actions: proactive roster reviews are completed to strengthen forward planning, targeted recruitment campaigns are delivered for hard-to-fill areas, temporary staffing utilisation is enhanced through optimised shift-release timings, and unavailability (including sickness and enhanced supervision requirements) is more closely monitored. Weekly oversight by the NHSP Review Meeting with the Deputy Chief Nurse and the monthly Workforce Review Group ensures trends are analysed, hotspots are identified, and corrective actions are tracked to completion. These measures collectively strengthen staffing resilience and support the delivery of safe, high-quality patient care.** **Daily oversight has now commenced through the daily staffing meeting, led by the Deputy Chief Nurse and Chief Nurse. This provides strengthened assurance by enabling real-time review of any staffing levels that are above establishment, ensuring that the underlying reasons are clearly understood, appropriately justified, and aligned to patient acuity, activity, and safety requirements. This enhanced scrutiny supports transparent decision-making, promotes consistent application of staffing principles, and ensures that workforce resources are deployed effectively across the organisation**
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 92.74. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 102.04.**		**(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.**	**Warrington's most recent mortality metrics remain within expected statistical limits. The HSMR has improved to 93, indicating mortality performance better than the national expected benchmark. The SHMI remains stable at 102 and is well within expected range when assessed using an over-dispersed funnel plot. There is no statistical evidence of excess mortality.**	**There are no SHMI diagnosis groups identified as outliers for the latest 12-month reporting period when assessed using an over-dispersed Poisson funnel plot with 95% control limits, providing assurance that mortality within individual diagnostic categories remains within expected statistical variation and does not indicate any areas of concern**

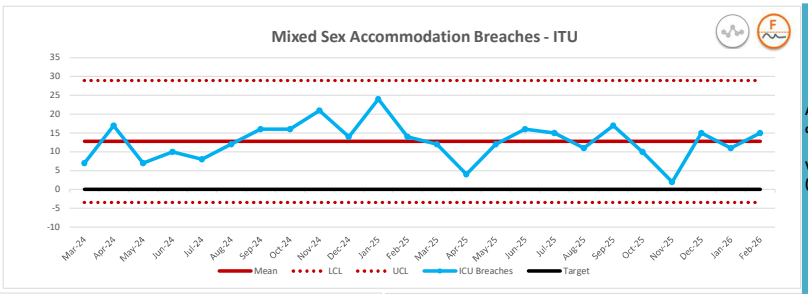
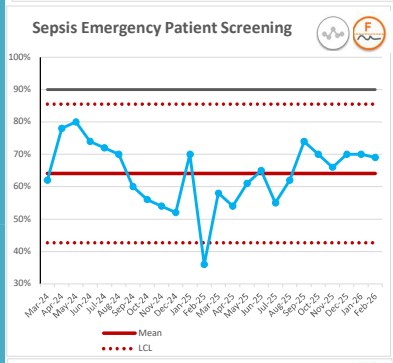
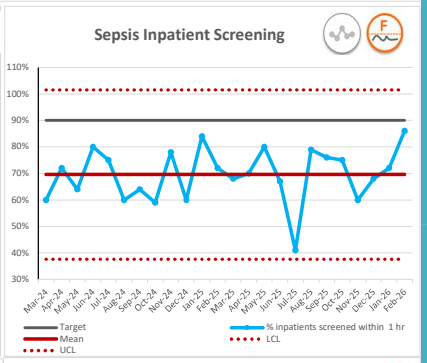
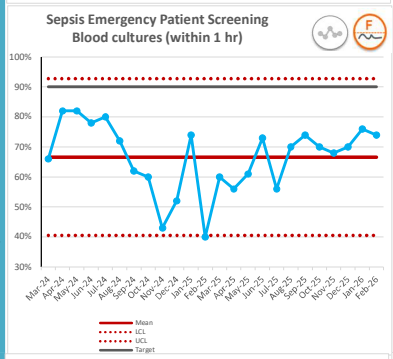
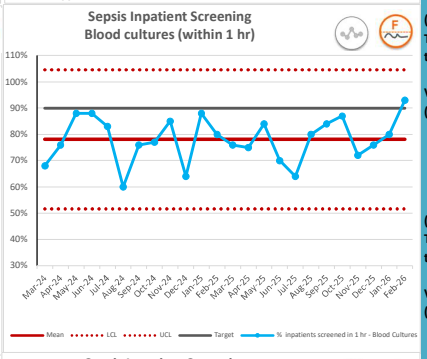
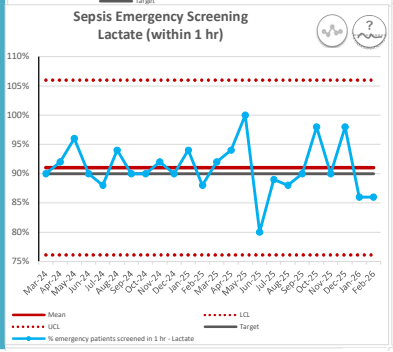
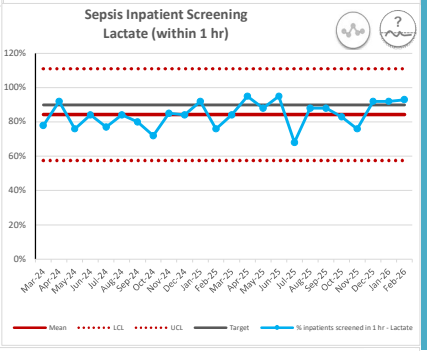
Warrington and Halton Teaching Hospitals NHS Foundation Trust

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)?
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 February 2026, one dissatisfied complaint was received, with the complainant expressing concerns that their questions had not been fully addressed and requesting additional information.** **There remains one complaint older than six months. The delay is due to a "stop the clock" being applied at the request of the patient and family, as the patient had been in hospital and unable to attend the planned meeting. This meeting has now taken place on 11 March 2026**	**At the time of reporting, the Trust has 90 open complaints, all of which continue to be closely monitored to ensure timely and robust responses. Where appropriate, concerns are redirected to PALS to facilitate prompt local resolution. All complainants are offered an initial meeting with the relevant clinical teams, with follow-up meetings arranged upon receipt of the formal response to support clarity and resolution.** **Each CBU has an identified complaints case handler in place to ensure consistency and quality in the management process. Weekly reviews of themes and actions from closed complaints are undertaken, enabling early identification of recurring issues and the implementation of targeted support and assurance actions across services**
16. Friends and Family (Inpatients & Day cases) **Target: 95%** **17. Friends and Family (ED and UCC)** **Target: 87%**	**The Trust achieved 97.77% in month for Inpatient & Day case FFT and 72.5% 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.**	**The Trust achieved a strong 98% positive response rate for Inpatient/Day Case services in February 2026, continuing to exceed the recommended target of 95% and remaining consistently higher than both regional and national averages for 2024 and 2025. In contrast, the Friends and Family Test results for ED/UCC reported a 73% positive feedback rate for February 2026, reflecting a slight decline compared with January and remaining below national and regional benchmarks for 2024 and 2025.** **The recurring themes within negative feedback continue to mirror previous months, focusing on staff attitude, waiting times, environment, communication, and implementation of care—issues likely influenced by ongoing operational pressures and increased waiting times**	**The Trust maintains strong governance and oversight of patient experience through systematic monitoring of FFT themes at Trust and Care Business Unit (CBU) level, with performance and improvement actions reviewed via the Patient Experience and Inclusion Sub-Committee and triangulated with wider observational feedback.** **Quality, access and equity are strengthened through the implementation of the new Accessible Information Standard policy, aligned training, and consistent FFT activity across services. In ED/UCC, assurance is provided through delivery of the UEC FFT action plan and targeted workstreams focused on reducing variation, improving communication, embedding reasonable adjustments, and enhancing patient flow.** **This is supported by the use of updated information screens, partnership working with Healthwatch on trauma-informed tools such as the About Me Card, strengthened safety alignment, expanded volunteer involvement for patient comfort and real-time feedback, and recruitment to grow the ED volunteer workforce.**

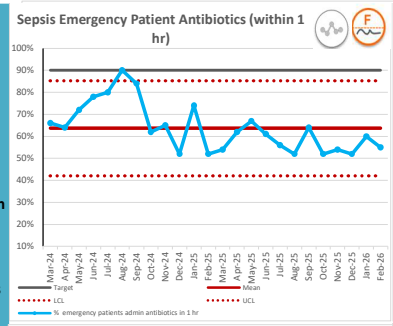
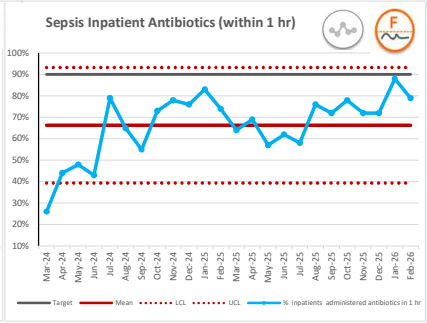
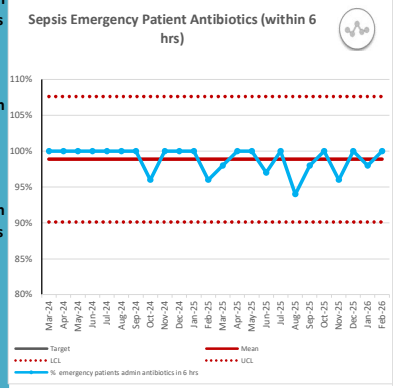
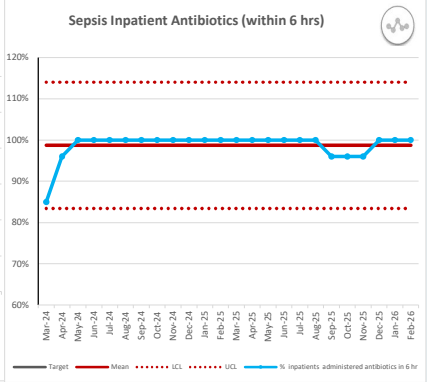
Appendix 2

	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)?
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	In January 2025, there were 11 mixed-sex breaches, representing a reduction of four compared with the December total of 15. All breaches occurred within the Intensive Care Unit. Any delays in discharge are escalated to the Patient Flow Team and the Tactical Manager on duty, and are reviewed at each bed meeting throughout the day. No breaches were reported in any other ward areas	Work is ongoing within the Care Group and Patient Flow teams to ensure that prioritisation is given to the Intensive Care Unit (ICU) for stepping down level 1 patients to appropriate ward areas. Several causes for delays have been identified, and action plans are being developed to address these issues. The high number of patients with no criteria to reside across the Trust continues to be a contributory factor. The Trust's Mixed Sex Accommodation Breach Policy is currently being updated and was ratified in Q4.
19. Sepsis - % screening for all emergency patients. Target: 90% 20. Sepsis - % screening for all inpatients Target: 90%	The Trust achieved: • 69% Sepsis screening for all emergency patients with suspected sepsis within 1 hour. • 86% screening for all inpatients with suspected sepsis within 1 hour. Blood Cultures: • 74% screening for Emergency patients with suspected sepsis within 1 hour. • 93% screening for Inpatients with suspected sepsis within 1 hour. Lactate: • 86% screening for Emergency patients with suspected sepsis within 1 hour. • 93% screening for Inpatients with suspected sepsis within 1 hour.	     	(Emergency) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation (Inpatient) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	In February 2026, performance in the Emergency Medicine department remained stable overall. Blood cultures were taken in 74% of patients, compared with 76% in the previous month. Lactate within one hour was achieved in 86% of patients, reflecting a similar rate to the prior month. Clinician review within 30 minutes was completed for 60% of patients, an improvement on 56% in January. Senior review within one hour was achieved in 62% of patients, also an increase from 56%. Within the inpatient wards, there has been notable improvement, with blood cultures completed in 93% of patients compared with 80% the previous month. Lactate testing improved to 93%, up from 92%. Clinician review within 30 minutes was completed for 93% of patients, an increase from 84% in January. There is no specific inpatient ward driving this improvement; however, the significant increases in both blood culture completion (93%) and inpatient lactate testing (93%) provide assurance of strengthened clinical processes and timely sepsis screening across inpatient areas	A series of assurance actions are in place to sustain and further improve performance across both Emergency Medicine and inpatient areas. Targeted education and refresher training continue to reinforce the importance of timely sepsis screening, including prompt blood cultures and lactate measurement. Escalation pathways have been strengthened to ensure timely clinician and senior reviews, with real-time monitoring and feedback provided through daily safety huddles. Ward-level oversight has been enhanced to maintain consistency across all areas, supported by senior leads who review compliance data and intervene where variation is identified. These actions collectively provide assurance that the Trust is actively embedding reliable processes to support early recognition and management of deteriorating patients

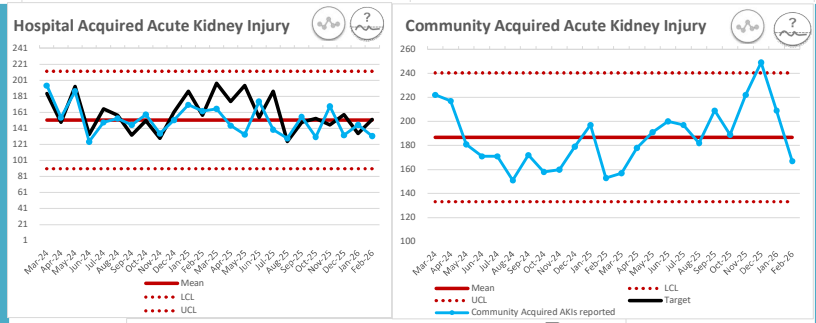
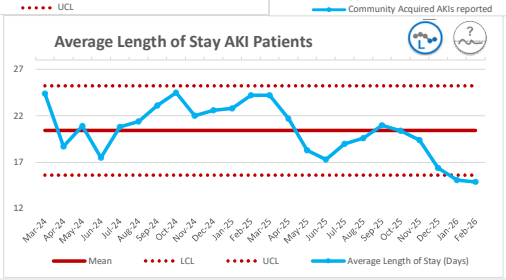
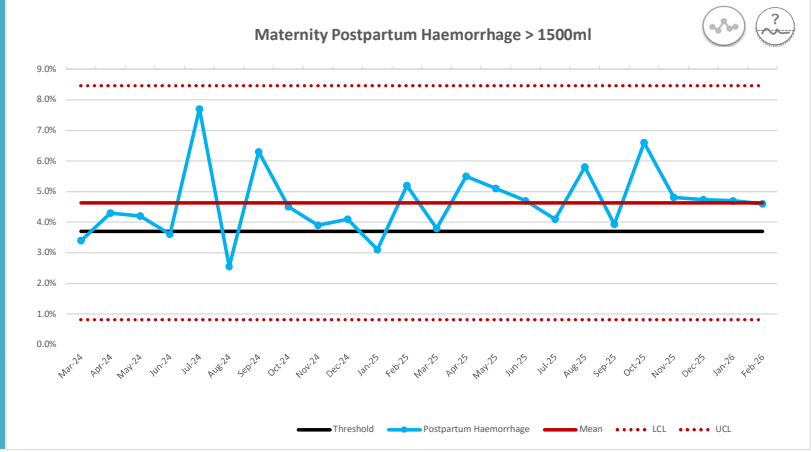
Warrington and Halton Teaching Hospitals NHS Foundation Trust

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)?
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:** **• 55% 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.**	 	**(Emergency 1hr) Assurance: The Trust consistently fails the target.** **Variation: Common cause (normal) cause variation.**	**There has been a slight deterioration in timely antibiotic administration, which appears to be multifactorial. Recent operational focus has centred heavily on improving compliance with blood cultures and lactate, with renewed training for HCSWs, the reintroduction of Sepsis Bags, and increased emphasis during handovers, and this may have unintentionally shifted attention away from the timely delivery of antibiotics. Ongoing skill-mix challenges, particularly in the Emergency Department where fewer staff are trained to take blood cultures or administer IV therapy, may also contribute to delays, alongside lower clinician and senior review rates within the required timeframes. Winter pressures across December and January have further affected flow and staff availability, causing potential delays in assessment, prescribing, and treatment. In addition, the introduction of the new NICE sepsis guidelines (NG254/255/256) has created a transition period in which teams are adapting to updated recommendations and awaiting revised Trust policies. Lower utilisation of the Sepsis Tool compared to screening actions suggests that clinicians may be completing some tasks without structured prompts, increasing the risk of delays in antibiotic administration. These issues are being addressed through Trust-wide improvement work, including targeted Tests of Change in both ED and inpatient areas, increased staff training, and strengthened oversight via the Sepsis Improvement Group.**	**The Trust continues to strengthen compliance with timely antibiotic prescription and administration through a coordinated programme of education, audit, and clinical leadership. The Medical Lead for Sepsis is reinforcing the importance of prompt prescribing and delivery of antibiotics—including the critical requirement for a STAT dose—during dedicated Sepsis Management teaching sessions for Resident Doctors, with plans to extend this training to Consultants and Registrars to ensure consistency across all senior clinical decision-makers. Audit findings from November and December 2025 have been presented to the Medical Cabinet, enabling clinical leads and Clinical Business Units to review performance, identify gaps, and initiate targeted local improvement actions. Doctors identified through the PSIRF audit as not prescribing STAT antibiotics have been individually contacted to raise awareness and reinforce expected standards of practice.** **Compliance data is shared monthly with Lead Nurses and scrutinised at both the Operational Patient Safety Group and the Sepsis Improvement Group to provide robust oversight. To support timely decision-making, services are being encouraged to launch the Sepsis Tool at the point of suspected sepsis, with ongoing promotion of the single-point lesson, laptop aids, and the new e-learning package to embed reliable use of the tool across the Trust. The Test of Change work is also reviewing communication processes between prescribers and nursing teams to minimise delays between prescription and administration. Together, these actions provide assurance that the Trust is actively addressing the factors affecting antibiotic timeliness and is continuing to drive improvement in compliance**
22. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis **Target: 90%**	**• 79% 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.**	 	**(Inpatient 1hr) Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of an improving nature.**		

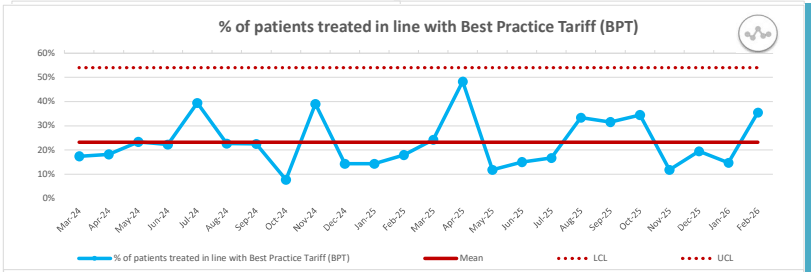
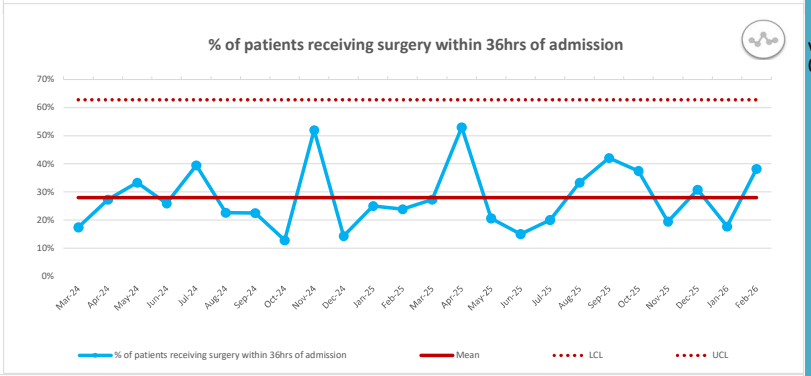
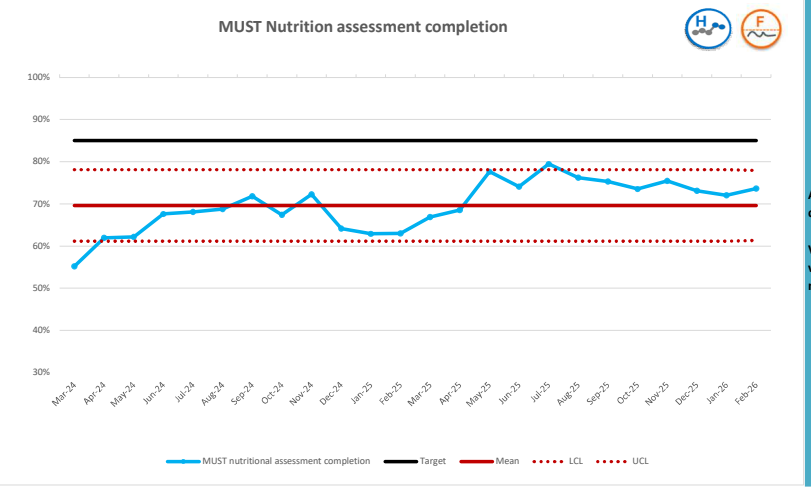
Appendix 2

	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 131 acute kidney injuries reported in month compared to 145 last month.**	 	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**Length of stay continues to improve, likely reflecting increased awareness and use of appropriate discharge pathways for patients with AKI. However, hospital-acquired AKI remains at 40%, which is above the target of 33%. This gap can only be reduced by implementing changes at the front door for unwell patients, ensuring that AKI risk factors are consistently identified and addressed early. Notably, length of stay for this group has significantly decreased**	**Hospital-acquired AKI remains higher than expected; however, the data we have demonstrates strong compliance with the AKI care bundles, providing assurance that core clinical processes are being reliably delivered. The area requiring focused improvement is the discharge summary, which currently lacks a mandatory AKI section. Addressing this will support safer transitions of care and ensure continuity of management in the community.** **Work is also underway to strengthen the deteriorating patient pathway. While early progress is encouraging, further development is required to ensure it fully supports timely recognition and escalation**
24. Maternity Postpartum Haemorrhage >1500ml **Threshold: < 3.7%**	**There were 4.6% Postpartum Haemorrhages >1500ml in month.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common cause variation.**	**Rates of PPH greater than 1500 ml continue to show fluctuation but remain within the expected range of common-cause variation. Comparator data received from the Cheshire and Mersey (C&M) LMNS indicates an average rate of 32 cases per 1000 births across the network, whereas the WHH rate is 66 cases per 1000 births.**	**PPH cases greater than 1500 ml continue to be reviewed individually through established governance processes, with enhanced oversight provided by the Intrapartum Incident Review Group, which meets regularly to identify patterns and emerging themes. In addition, a dedicated PPH Quality Improvement Group is actively reviewing and strengthening associated pathways. A new regional PPH guideline has recently been implemented, developed with contribution from WHH colleagues, and incorporates several change ideas proposed by the Trust. The Trust's position on PPH is reported monthly to the Quality Safety Assurance Committee, supported by an SPC chart that currently demonstrates common-cause variation with early signs of stabilisation. A full reaudit is planned for May 2026, six months after implementation of the new guideline, and findings will be presented to the Quality Safety Assurance Committee to provide further assurance on progress and impact.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

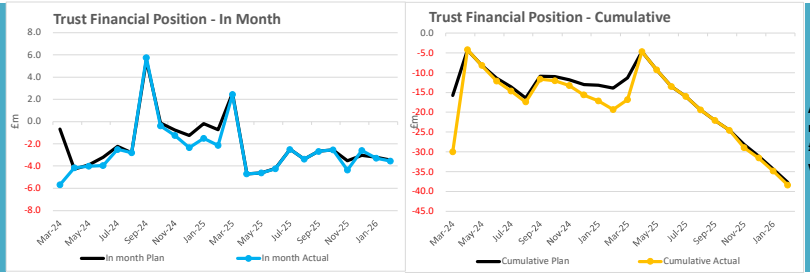
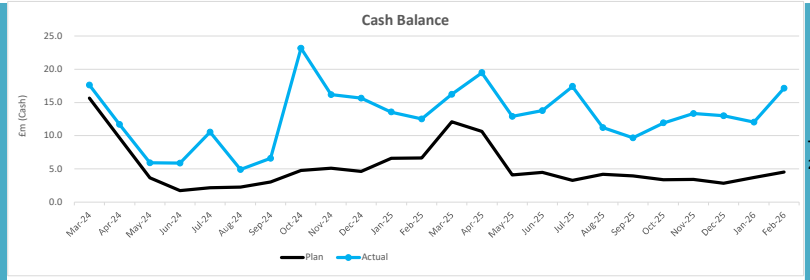
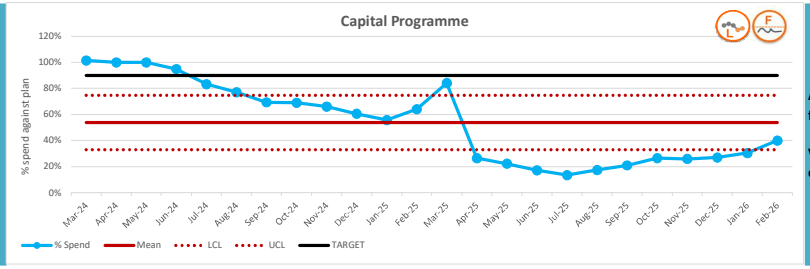
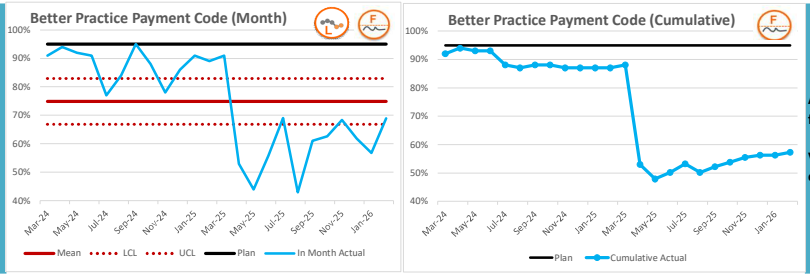
Quality Improvement - Trust Position

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**	**35.48% of patients were treated in line with Best Practice Tariff (BPT) in Feb-26.**	 	**Variation: Common Cause (Normal) variation.**	**February's NOF data shows improving pathway performance, with 35 patients submitted to NHFD and 31 meeting best practice tariff criteria. Direct admissions from A&E to the Orthopaedic ward increased to 94%, and 50% of outlying patients were transferred to A6. Timely surgery remains the main area requiring improvement at 42%, though this is better than previous months. Orthogeriatric input remains strong, with 100% of patients receiving senior review and 83% within 72 hours. Day-one mobilisation was 74% in January, and a multidisciplinary QI project is in place to address this. Overall, the position shows progress, with remaining gaps linked mainly to theatre access and early mobilisation**	**Performance against KPIs and best practice tariff is monitored regularly, with data submitted to both the NOF group and the Patient Safety and Clinical Effectiveness Group. A strengthened action plan has been presented to support improvement across the pathway. A new NOF escalation SOP is now live on the intranet to enhance compliance with the 36-hour surgery standard, and bed escalation is being incorporated to facilitate faster admission to the Orthopaedic ward.** **Additional actions include planning a hip fracture awareness day to improve staff understanding of the NOF pathway, as well as embedding learning from the recent Hip Fracture Summit, where the importance of direct admission to the Orthopaedic ward was strongly emphasised. The Hip Fracture Lead continues to work with the Planned Care Triumvirate and Trust Executives to identify opportunities to strengthen theatre capacity and ward flow. Ongoing assurance will focus on ensuring direct admission to the Orthopaedic ward and securing consistent, timely access to theatre to support improved clinical outcomes**
26. MUST nutritional assessment completion **Target: above 85%**	**MUST Nutrition assessment completion was 73.65% in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Special Cause variation of improving nature.**	**MUST compliance continues to demonstrate sustained improvement across the organisation, reflecting ongoing efforts to strengthen the quality and timeliness of nutritional assessments. Since the introduction of the LiON dashboard in 2023/24, targeted work with clinical teams has supported more consistent completion of mandatory assessments and enabled better oversight of performance.** **Analysis of compliance data shows a 5% improvement in 6-hour assessments, a 14% increase in 24-hour assessments, and a 29% improvement in 7-day reassessments since implementation of the dashboard. For November 2025, performance stands at 50.46% for 6-hour compliance, 75.38% for 24-hour compliance, and 86.52% for 7-day compliance**	**Several targeted actions are in place to further strengthen MUST compliance and provide assurance regarding ongoing improvement. The addition of MUST as a clinical indicator within Lorenzo now enables ward teams to easily identify patients requiring an assessment or reassessment. The automated 24-hour early-warning function, which turns the indicator orange ahead of the 7-day reassessment deadline, has been a key driver of the significant improvement seen in this metric.** **A multi-disciplinary approach continues to be led through the monthly Nutrition, Food & Hydration meeting, ensuring coordinated oversight and shared responsibility for nutritional care. Clinical Business Units and key stakeholders routinely produce high-level briefing papers, setting out local action plans and highlighting quality improvement initiatives that can be adopted Trust-wide. MUST remains a quality priority for 2025/26, with ward teams required to present compliance data and targeted actions for improvement at Quality Summits. Integration of MUST into the PSIRF approach—particularly in relation to harms such as falls and pressure ulcers—ensures that nutritional assessment is considered a core component of wider patient safety investigations and learning. To further strengthen workforce capability, a Trust-wide training programme focused on MUST and its relationship to broader aspects of patient care will be developed and implemented in 2026, with a particular focus on supporting the HCA workforce.**

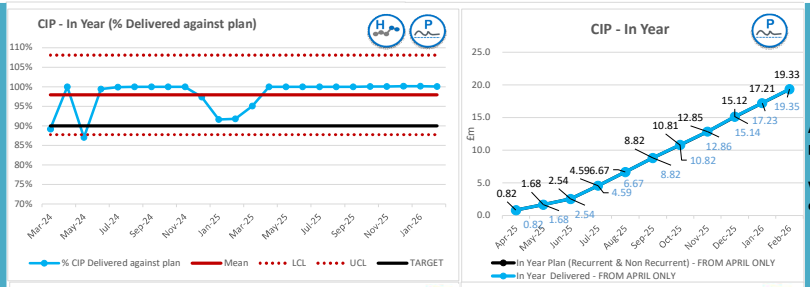
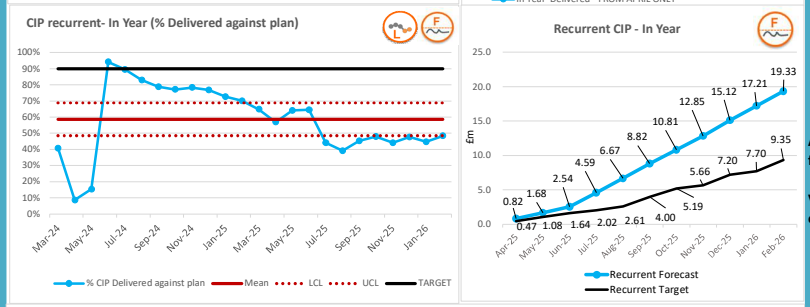
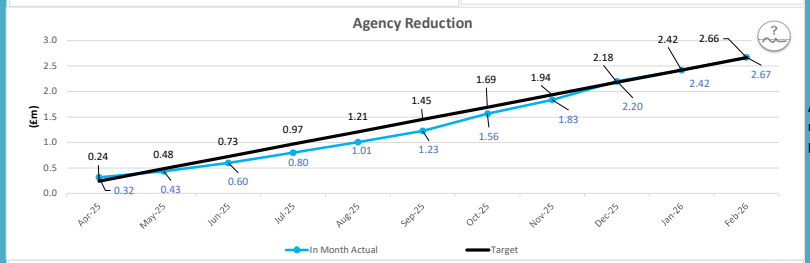
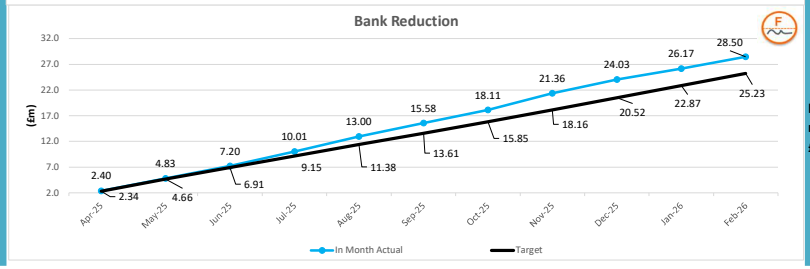
Warrington and Halton Teaching Hospitals NHS Foundation Trust

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 11 the Trust has recorded a deficit position of £38.4m (before deficit support) which is £0.6m worse than plan.	At month 11, the deficit position is £0.6m worse than plan due to the impact of unfunded integration costs.	The Trust has submitted a forecast deficit of £40.7m 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 unfunded integration of £0.8m.
57. Cash Balance **Target: On or better than plan**		The cash balance at 31 December 2025 is £17.2m.	The current cash balance is £17.2m which is £12.6m 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 £17.2m cash, £7.1m is related to capital creditors.	The deficit position has led to the Trust requiring external cash support and £8.037m was received in March. 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 11 is £9.4m against a plan of £23.6m. This is mainly driven by EPR delays, a scheme paused by the ICB and late confirmation of additional capital. A revised forecast of £19m has been agreed with the ICB and is expected to be fully delivered by year end.	The reason for the year to date variance is due to timing and the ICB agreed forecast of £19m 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 57% 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 one month remaining in the year.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

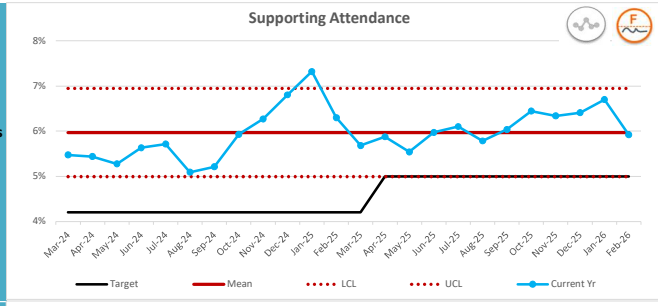
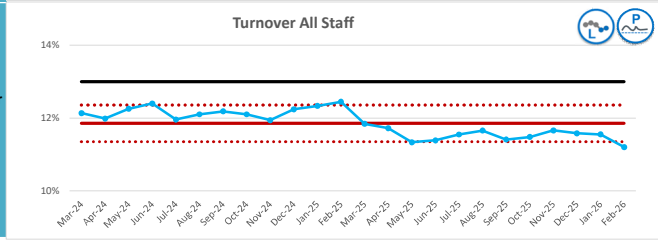
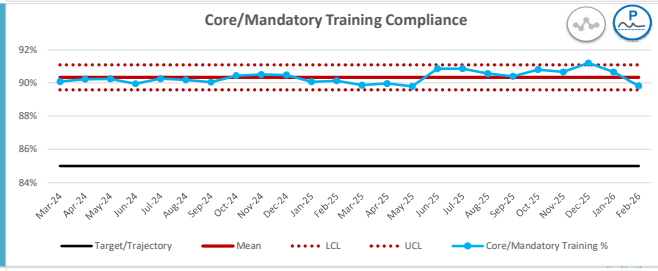
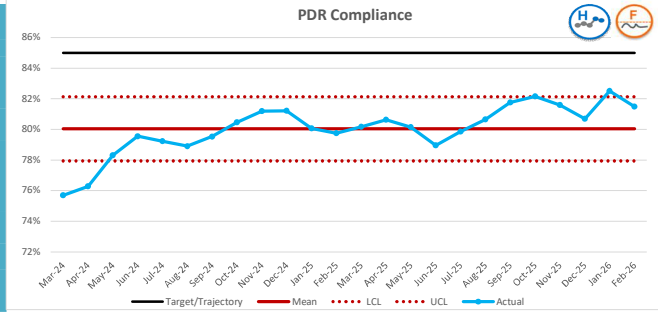
Finance and Sustainability - Trust Position

	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: Special Cause Variation of an improving nature.	At month 11, CIP is £21k 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. High risk schemes have all been mitigated and the Trust is forecasting to deliver the CIP plan of £21.5m.
61. Cost Improvement Programme (recurrent) – In year performance to date Target: >90% plan delivered YTD	 	Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a declining nature.	£9.4m CIP has been delivered recurrently against the target of £19.3m. The Trust aims to deliver CIP recurrently wherever possible and challenges if CIP is not recurrent. Where recurrent CIP has not been realised, efforts have been made to deliver the CIP on a non-recurrent basis rather than not achieving at all.	Work continues to identify recurrent CIP schemes 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 £2.7m at month 11 which is in line with plan.	There is no variation at month 11, agency expenditure is in line with plan.	Although agency expenditure remains in line with plan it 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 £28.5m at month 11 compared to a plan of £25.2m.	At month 11 bank expenditure is overspent by £3.3m. £2.3m 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 from 1 May 2025. Substantive recruitment into medical posts has taken place and is expected to continue which will reduce the medical bank spend.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
52. Supporting Attendance **Target: Below 5%**	**The Trust's sickness rate was 5.92% 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 and an MDT approach to LTS, reducing from 4.39% in April 2022 to 2.84% in February 2026.** **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 "Be Present, Be Here, Be WHH" campaign commenced in November to reinforce attendance and wellbeing, supported by a refreshed wellbeing offer on the intranet site.** **A new Supporting Attendance Policy is under development, and digital solutions such as PowerApp notifications have been introduced to strengthen compliance and reporting. A targeted approach is addressing the top 12 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.** **Absence is now being reported to the Executive team on a weekly basis.**
53. Turnover **Target: Below 13%**	**The Trust's turnover of all staff was 11.2% 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).** **To support the achievement of the 26/27 Workforce Plan, the Trust is exploring rostering for all areas, thus helping to support with temporary staffing controls. the Trust was unsuccessful in it's national charity bid to support the roll out of preference rostering and is reviewing a roll out plan following this.** **Leaver numbers continue to reduce. Work/life balance remains the main reason people leave WHH. The #MyFlex campaign continues to support this.**
54. Core/ Mandatory Training **Target: 85%**	**Core/Mandatory training compliance was 89.82% in month.**		**Assurance: The Trust consistently passes the target.** **Variation: Common cause (normal) variation.**	**CSTF Mandatory Training compliance is consistently above the Trust target and shows no significant change.**	**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 81.49% in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of an improving nature.**	**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.**	**A programme of actions have been taken to support managers and staff with achieving appraisal compliance and improve the quality of appraisals. Appraisal guides have been developed to support managers and staff, whilst the continued Appraisal Roadshow is actively engaging teams.** **Drop-in sessions for leaders have been put on to support with accessing workforce data to inform areas for focus for compliance.**

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?

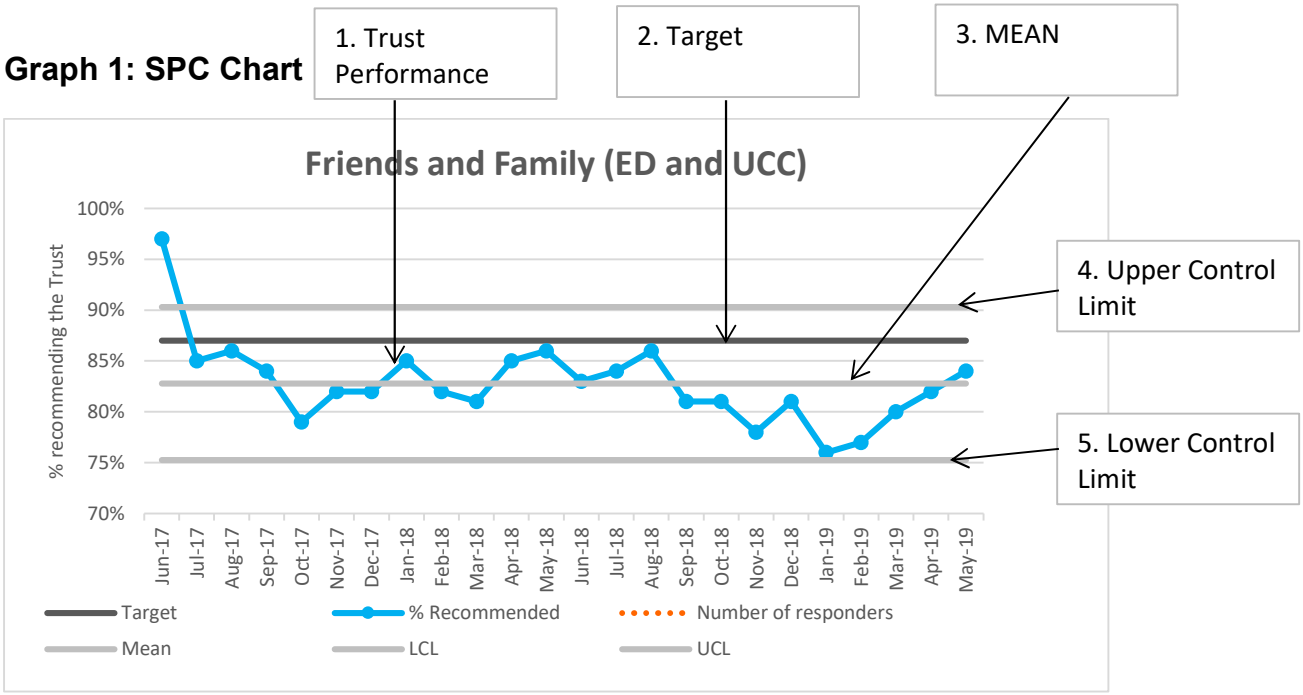
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

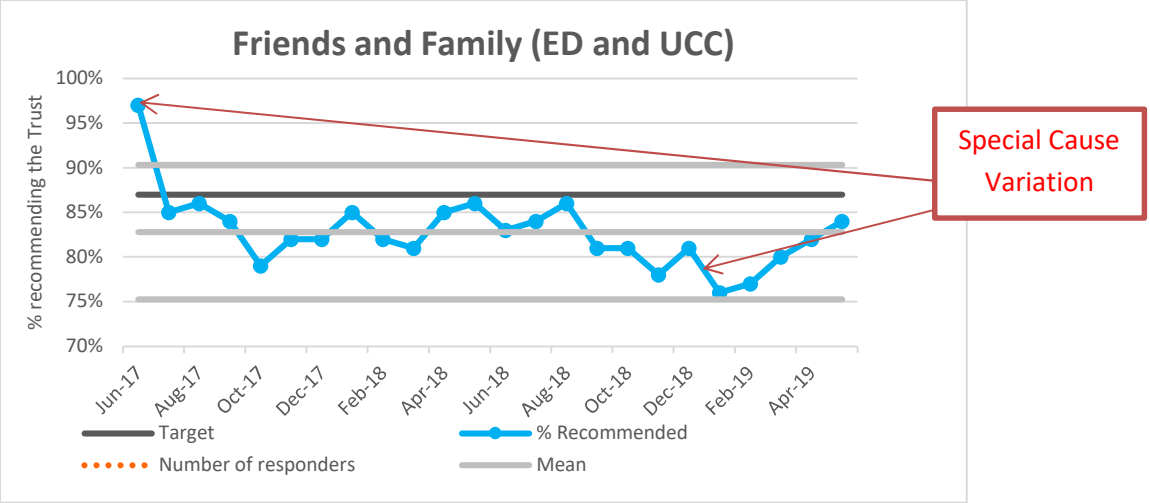


2.1 Interpreting a SPC Chart

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 28th February 2026

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	3,774	3,258	-516	41,049	36,051	-4,998
Outpatient Firsts & Procedures	34,256	2,713	2,789	76	31,271	30,405	-867
Other Variable Activity	30,406	2,481	2,000	-481	27,865	27,986	121
Deficit Support Funding	18,327	1,528	0	-1,528	16,799	4,582	-12,217
Other income (including fixed element of contract)	238,818	19,853	19,417	-436	218,965	218,147	-818
Sub total	**366,974**	**30,349**	**27,464**	**-2,885**	**335,950**	**317,170**	**-18,780**
Non NHS Clinical Income							
Private Patients	8	1	0	-1	7	5	-2
Non NHS Overseas Patients	70	6	16	10	64	169	105
Other non protected	750	62	51	-11	688	703	15
Notional Pension Income	0	0	0	0	0	0	0
Sub total	**828**	**69**	**68**	**-1**	**759**	**878**	**119**
Other Operating Income							
Training & Education	10,663	889	973	85	9,775	11,366	1,592
Donations and Grants	0	0	82	82	0	82	82
Miscellaneous Income	14,919	1,244	1,619	375	13,674	16,430	2,756
Sub total	**25,582**	**2,133**	**2,674**	**541**	**23,449**	**27,878**	**4,429**
Total Operating Income	**393,384**	**32,551**	**30,206**	**-2,345**	**360,158**	**345,925**	**-14,232**
Operating Expenses							
Employee Benefit Expenses	-284,113	-24,182	-24,466	-284	-268,931	-271,375	-2,444
Drugs	-23,121	-1,920	-1,550	370	-21,200	-20,284	916
Clinical Supplies and Services	-27,038	-2,486	-2,336	150	-26,710	-26,156	554
Non Clinical Supplies	-47,403	-4,044	-3,624	421	-44,033	-43,464	569
Depreciation and Amortisation	-17,659	-1,472	-1,384	88	-16,187	-15,037	1,150
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**	**-34,103**	**-33,359**	**744**	**-377,060**	**-376,316**	**745**
Operating Surplus / (Deficit)	**-5,950**	**-1,552**	**-3,153**	**-1,601**	**-16,902**	**-30,390**	**-13,488**
Non Operating Income and Expenses							
Profit / (Loss) on disposal of assets	0	0	4	4	0	43	43
Interest Income	520	43	98	55	477	1,187	710
Interest Expenses	-138	-11	-14	-2	-126	-126	0
PDC Dividends	-5,501	-458	-458	0	-5,043	-5,043	0
Total Non Operating Income and Expenses	**-5,119**	**-427**	**-370**	**57**	**-4,692**	**-3,939**	**754**
Surplus / (Deficit) - as per Accounts	**-11,068**	**-1,979**	**-3,523**	**-1,544**	**-21,595**	**-34,329**	**-12,734**
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	-82	-82	0	-82	-82
Add Depreciation on Donated & Granted Assets	669	56	56	0	614	614	1
Total Adjustments to Financial Performance	**669**	**56**	**-26**	**-82**	**614**	**533**	**-81**
Adjusted Surplus / (Deficit) as per NHSI Return	**-10,399**	**-1,923**	**-3,549**	**-1,626**	**-20,981**	**-33,796**	**-12,815**
Deficit Support Funding	-18,327	-1,528	0	1,528	-16,799	-4,582	12,217
Adjusted Surplus / (Deficit) - without deficit support funding	**-28,726**	**-3,451**	**-3,549**	**-98**	**-37,780**	**-38,378**	**-598**

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

IPR – December 2025 Detail
1st April 2026

Introduction

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

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

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

- **30. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge** – Target 2% or less
- **1. Open Incidents (over 40 days)** – Target 0%
- **58. Capital Programme** – % delivered against plan
- **59. Better Practice Payment Code** – % cumulative performance

There are **1 indicator that has a special cause variation of a concerning nature and do not have a target**, this is:

- **14. Mortality ratio** – SHMI

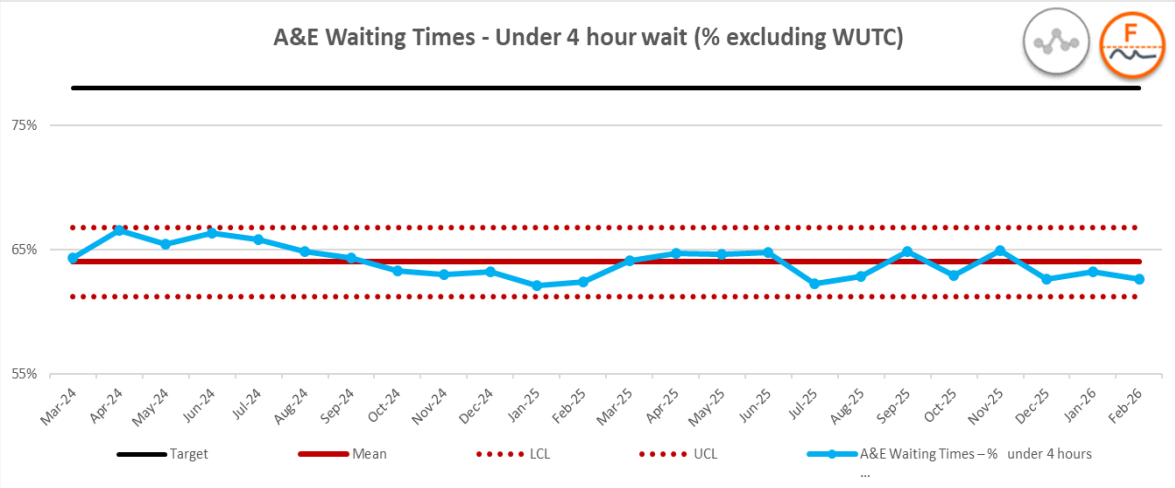
There are **2 indicators that consistently fails and cannot be measured for variation,** these are:

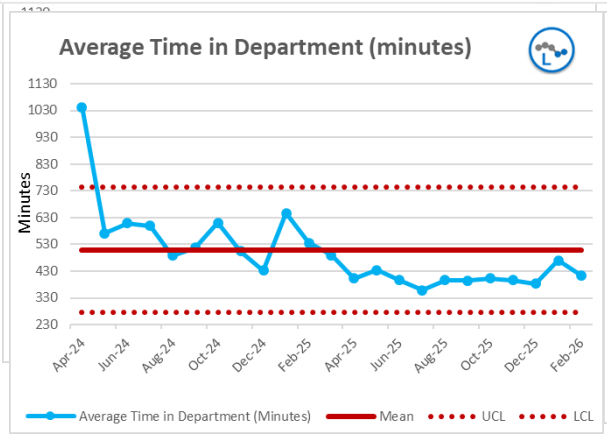
- **61. CIP (recurrent) –** delivered against plan
- **63. Bank Reduction** – delivery against 10% reduction of 2024/25 plan

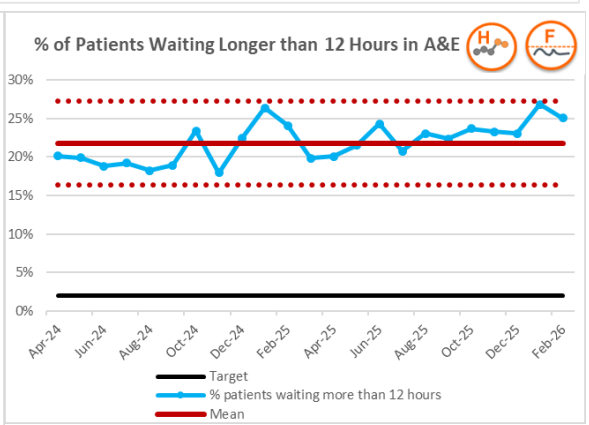
February 2026 IPR by Exception – A&E Waiting Times

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

27. A&E Waiting Times - Under 4 hour wait (% excluding WUTC) & 30. % patients waiting longer than 12 hours







Performance continues to be negatively impacted by wait to be seen in ED, long length of stay and an overall high bed occupancy. High levels of NCTR in February was a significant contributing factor during February, impact 4- and 12-hour performance.

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%.

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. A programme of improvement is ongoing to increase performance against these standards.

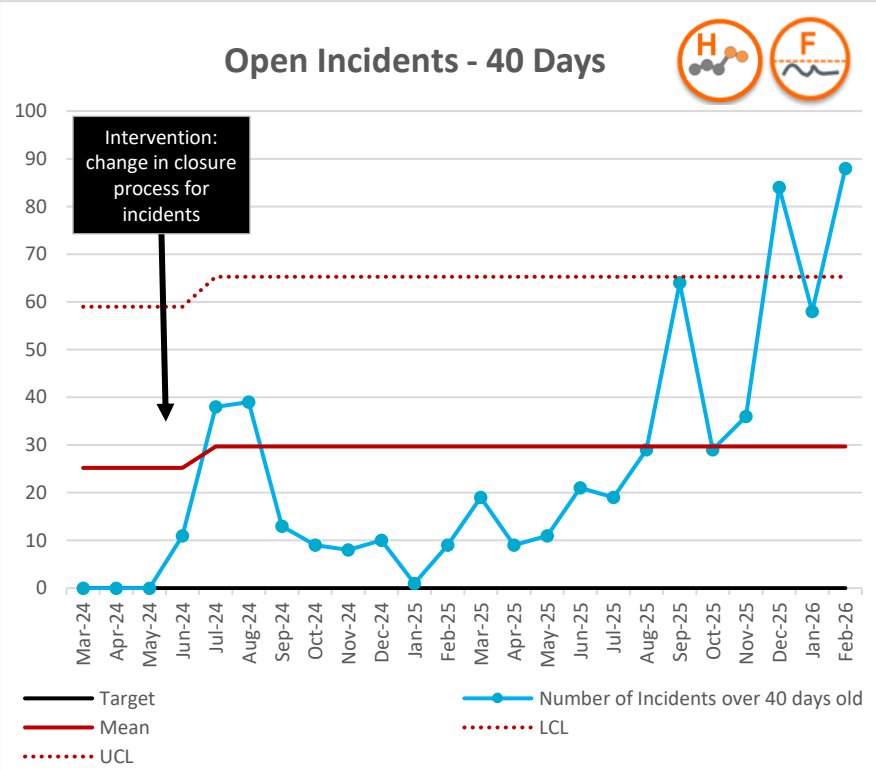
A&E 4-hour performance
Rank 104 out of 123
February 2026
Source:
NHS England Acute Provider Table
Accessed March2026

A&E 12-hour performance
Rank 115 out of 118
February 2026
Source:
NHS England Acute Provider Table
Accessed March2026

February 2026 IPR by Exception - Quality

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

1. Incidents (Over 40 days)



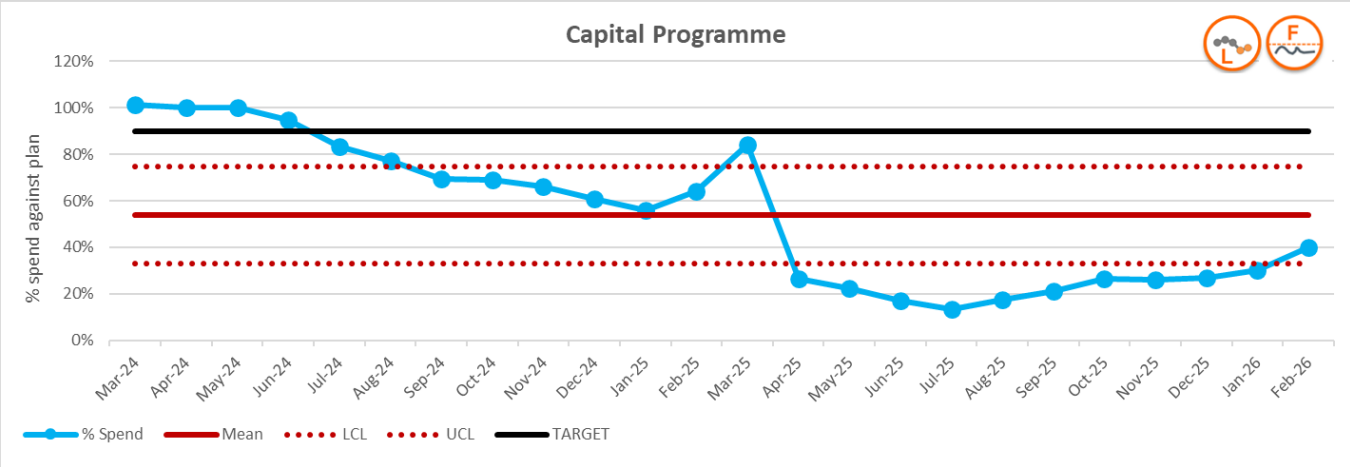
There were no PSII cases declared in February 2026. A total of 47 learning response reviews—including After-Action Reviews, MDT reviews, and swarm huddles—were in progress at the time of reporting. No incidents were reported to MNSI during February 2026. At the time of reporting on 02 March 2026, there were 88 incidents open for more than 40 days. These extended open cases were primarily due to delays in the completion of review actions, workforce capacity constraints within operational teams, and the need for additional information or verification before closure particularly relating to interface incidents.

A weekly Executive-led governance dashboard monitors reporting trends with triangulation of incidents, complaints, claims and inquests, supported by designated Governance Team members aligned to each Clinical Business Unit to ensure consistency. Incidents exceeding 40 days are escalated daily to triumvirates and prioritised, while Datix alerts at 30 days trigger early support. A daily learning-response and action report is provided for Care Group oversight, and PSII progress is reviewed through the weekly Executive-led Safety Oversight Meeting with escalation to Clinical Business Unit leads as required.

February 2026 IPR by Exception – Finance

58. Capital Programme – % delivered against plan

Warrington and Halton Teaching Hospitals
NHS Foundation Trust



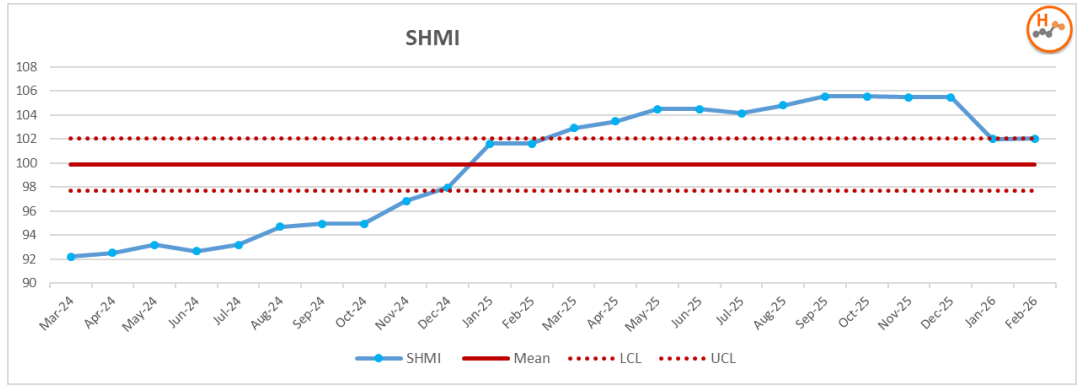
Capital expenditure at the end of month 11 is £9.4m against a plan of £23.6m. This is mainly driven by EPR delays, a scheme paused by the ICB and late confirmation of additional capital. A revised forecast of £19m has been agreed with the ICB and is expected to be fully delivered by year end.

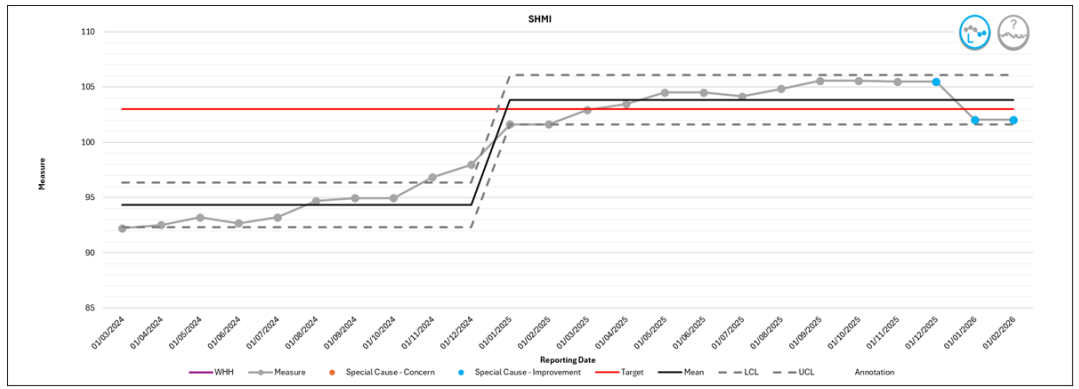
The reason for the year to date variance is due to timing and the ICB agreed forecast of £19m is expected to be fully delivered by year end. The risk associated with delivering the 2025/26 capital plan is being monitored at CPG and reported to FSPCiC.

February 2026 IPR by Exception - Quality

Warrington and Halton Teaching Hospitals NHS Foundation Trust

14. Mortality ratio – SHMI





The SHMI remains stable at 102 and is well within expected range when assessed using an over-dispersed funnel plot. There is no statistical evidence of excess mortality.

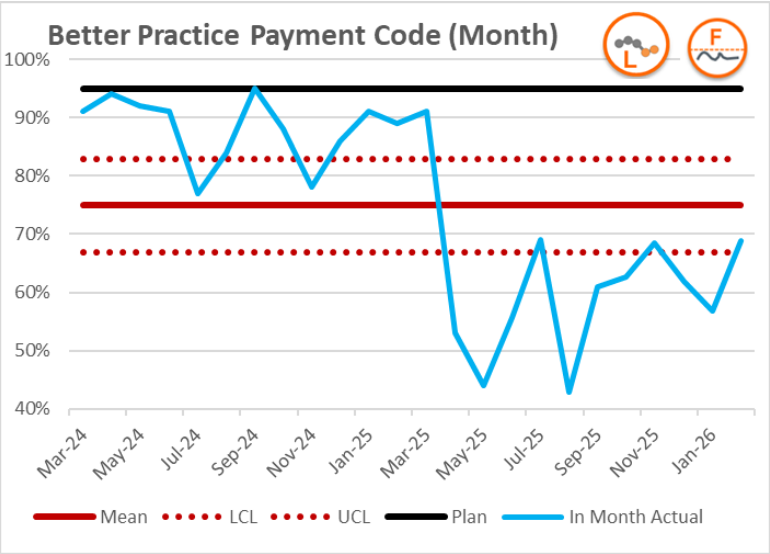
There are no SHMI diagnosis groups identified as outliers for the latest 12-month reporting period when assessed using an over-dispersed Poisson funnel plot with 95% control limits, providing assurance that mortality within individual diagnostic categories remains within expected statistical variation and does not indicate any areas of concern.

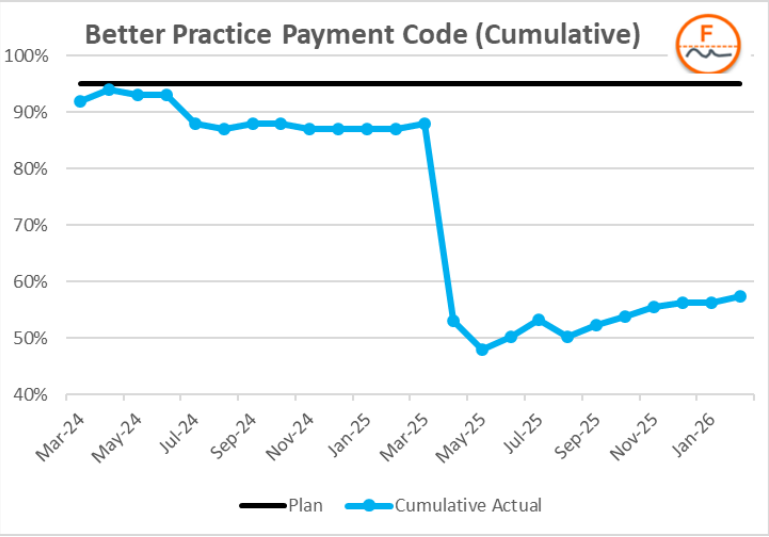
Since January 2025 there have been fourteen data points above the mean. This pattern indicates a potential shift in the underlying process. Therefore meets the criteria for considering a recalculation of the statistical process control chart, as the current limits may no longer reflect actual performance. A review will be taken to the next QSAC. This drafted in the second graph.

February 2026 IPR by Exception – Finance

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

59. Better Practice Payment Code –% cumulative performance





Cumulative BPPC performance is 57% which is below the national target of 95%.

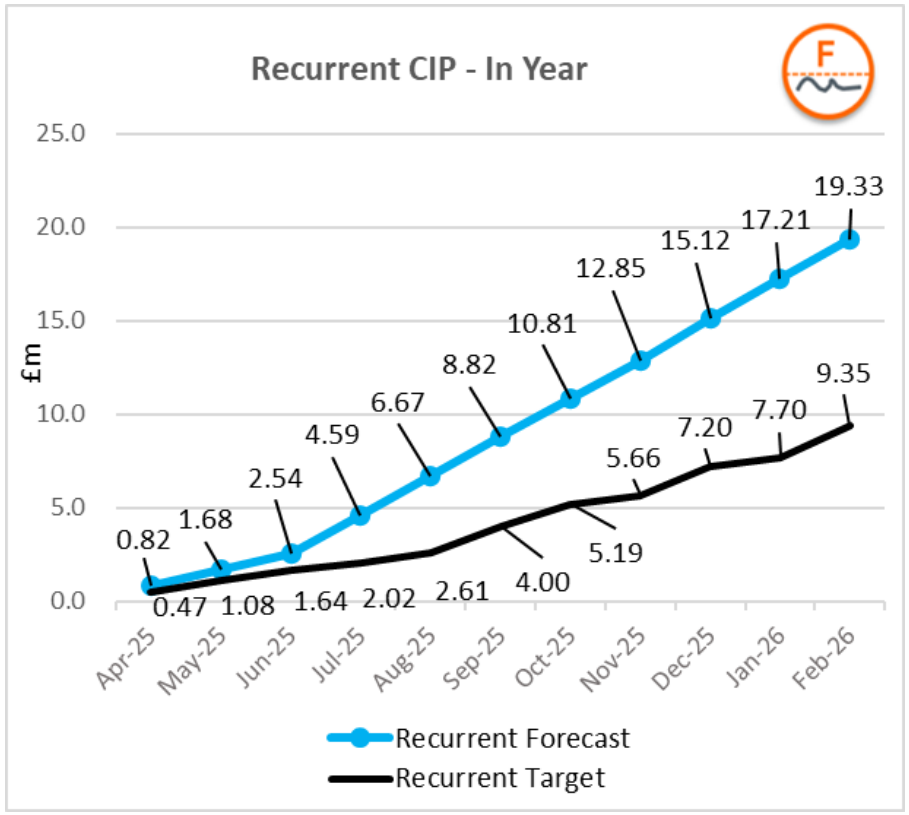
The main reason for this is due to cash management measures put in place to mitigate against the Trust's worsening cash position.

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 one month remaining in the year.

February 2026 IPR by Exception – Finance

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

61. CIP – % delivery against plan (recurrent)



£9.4m CIP has been delivered recurrently against the target of £19.3m.

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

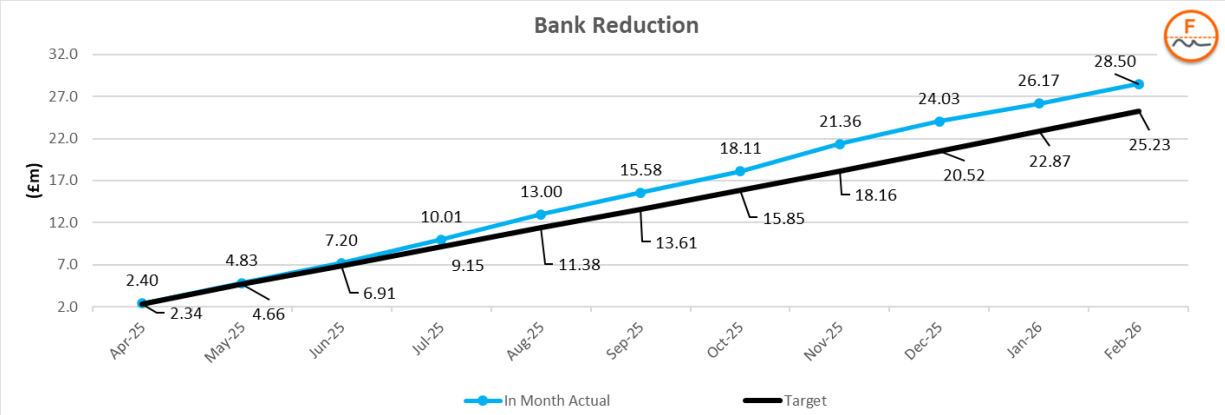
Where recurrent CIP has not been realised, efforts have been made to deliver the CIP on a non-recurrent basis rather than not achieving at all.

Work continues to identify recurrent CIP schemes 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.

February 2026 IPR by Exception – Finance

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

Warrington and Halton Teaching Hospitals
NHS Foundation Trust



Bank expenditure is £28.5m at month 11 compared to a plan of £25.2m.

At month 11 bank expenditure is overspent by £3.3m. £2.3m 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.

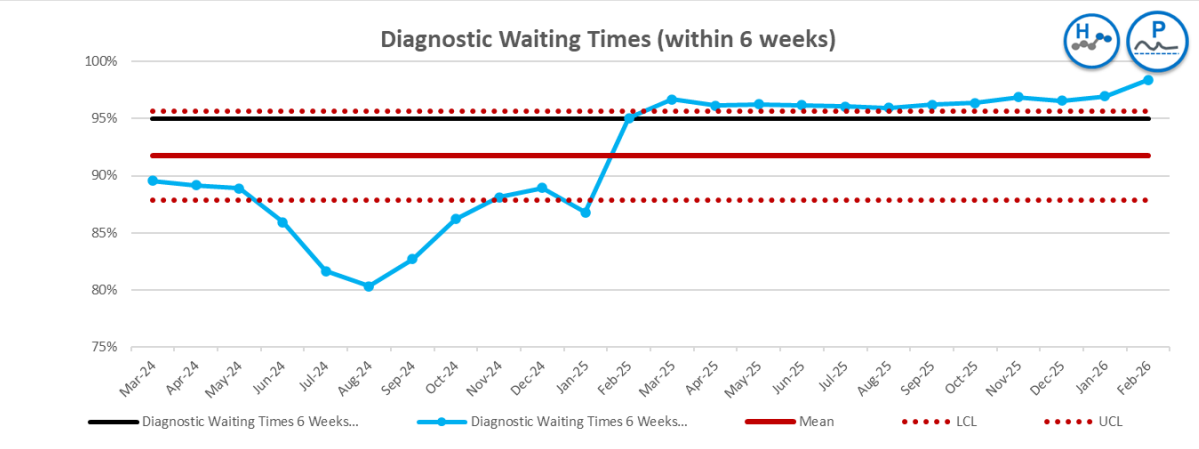
A number of additional controls have been put in place as a result of the PwC work including bank sign off by the Chief Nurse and Deputy Chief Nurse. The nurse bank rate was reduced during 2024/25 and has reduced from 1 May 2025. Substantive recruitment into medical posts has taken place and is expected to continue which will reduce the medical bank spend.

Improving metrics

Metrics consistently passing target & maintaining/improving performance

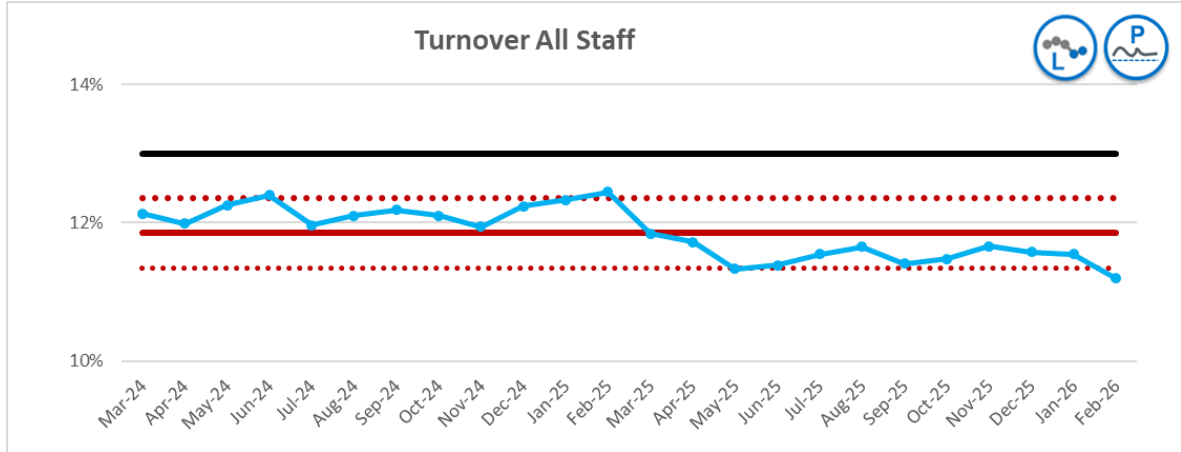
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

36. Diagnostic Waiting Times



- The diagnostic target has been maintained for 13 consecutive months
- This recovered position will continue to be monitored through Performance review group to ensure continued achievement.
- This is an indicator which will need a review to recalculate the upper and lower control limits at FSPC.

53. Turnover



- 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).
- Leaver numbers continue to reduce. Work/life balance remains the main reason people leave WHH. The #MyFlex campaign continues to support this.

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.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM2604010.7**
Subject:	**IQPR Month 11**
Date of meeting:	01 April 2026
Action required:	**To Note**
Author(s):	Melanie McLaughlin Acting Director of Operations/Deputy Chief Operating Officer
Executive director sponsor:	Dan Moore, Chief Operating Officer
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience 2. PEOPLE - We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future with staff developing, growing and thriving. 3. SUSTAINABILITY - We will work in partnership with others to achieve social and economic wellbeing in our communities and improve equity in health outcomes
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety BAF 2: Urgent and Emergency Care Flow BAF 3: Planned Care Access & Elective Recovery BAF 5: Workforce Capacity, Capability & Wellbeing BAF 6: Financial Sustainability

Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓	✓	✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
Executive summary:	The Month 11 Integrated Quality and Performance Report (February 2026) sets out the performance position across the Trust. While several indicators continue to demonstrate sustained compliance, several key operational, quality and people metrics remain below			

<table>
<tr><td></td><td colspan="3">target and continue to require focused management actions. Financial performance remains aligned with plan for the period.

There are 49 operational indicators, of which 23 are Green and 26 are Red. Performance pressures remain most pronounced within Dermatology cancer pathways, community waiting times, DNA/Child Not Brought and Warrington adult services. Notwithstanding this, several indicators have demonstrated in-month improvement, supported by targeted recovery actions, additional capacity and strengthened performance oversight.

Quality performance reports 22 Green and 9 Red indicators in Month 11. Deterioration has been noted in a small number of patient safety and governance indicators, including moderate and severe harm incidents, Duty of Candour timeliness, pressure ulcers and falls. These are being actively managed through established governance routes, including Directorate Incident Review and Learning Groups, Risk Management Council and Quality Council.

People performance remains challenging, with 2 Green and 2 Red indicators. Sickness absence continues to improve and is now within control limits, although it remains above target. Staff turnover remains above target, largely driven by organisational change and TUPE activity.

The Trust continues to report an adjusted deficit of £3.68m at Month 11, in line with plan. Savings delivery remains ahead of plan, and grip and control measures continue to be applied to maintain financial discipline through the remainder of the financial year.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The Trust Board is asked to note the content of this report.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">Not Applicable</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td>Date of meeting</td><td colspan="2"></td></tr>
<tr><td>Summary of Outcome</td><td colspan="2"></td></tr>
</table>

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
Freedom of information exemptions applied: ***(if relevant)***	None

1. Overview

Responsive (Operations)

There are 23 Green indicators and 26 Red indicators in month 11.

- Two Red to Green indicators
  - Warrington Dermatology Cancer – 2-week referrals (urgent GP)
  - Percentage of births receiving a face-to-face - New Birth Visit within 14 days by a Health Visitor (Warrington)
- Zero Green to Red indicators
- 27 indicators have shown an in-month deterioration
- 22 indicators have shown an in-month improvement
- 0 indicators have shown no in-month changes

Safe, High-Quality Care (Quality)

There are 22 green indicators and 9 red indicators in month 11.

- Four Green to Red indicator:
  - % of incidents causing severe/fatal harm (Score 4-5)
  - DOC (Duty of Candour) for moderate harms and above 10-day compliance
  - BCHFT patient safety Falls per 1,000 bed days - bed based
  - % of Category 4 pressure ulcers acquired in Bridgewater
- One Red to Green indicator:
  - % of BCHFT patient safety incidents that are medication incidents
- 4 indicators have shown an in-month improvement
- 16 indicators have shown an in-month deterioration
- 11 indicators have shown no in-month changes

People

There are 2 green indicator and 2 red indicators in month 11.

- One Red to Green indicator
- % of staff with a current PDR
- 0 Green to Red indicators
- 2 indicators have shown an in-month deterioration
- 2 indicators have shown an in-month Improvement

Making Good Use of Resources (Finance):

- The Trust is reporting an adjusted deficit at Month eleven of £3.68m, in line with plan.
- The Trust is reporting a savings achievement of £5.15m against a plan of £4.98m.

2. Operations highlights

Warrington Dermatology Cancer – 28 Day Faster Diagnosis Standard (January's performance reported in arrears)

- Current Target: 75%; Actual for Month 10 (month in arrears): 65.19%
- The service has historically met the 28-day Faster Diagnosis Standard; however, recent gains from additional capacity and temporary changes to the Skin Analytics model have stabilised.
- Focus in, Month 10 has therefore shifted to improving surgical and diagnostic throughput, supported by a further waiting list initiative to deliver recovery within agreed timeframes. This approach is being reinforced through a deep-dive review with WHH and working collaboratively with the Cancer Alliance.
- Previous reductions in capacity, increased referrals, and the introduction of Skin Analytics have cumulatively created significant pathway pressures. Breaches are expected to continue into Month 11 while recovery actions are implemented with close operational and clinical oversight.

Warrington Dermatology Cancer – 31-Day Standards

- Performance was 62.5%, with 3 of 8 patients breaching the standard. One breach related to patient choice and two breaches were due to limited face-to-face and surgical capacity. All patients have now been seen; one is awaiting histology results and two require further surgery for wider local excision via plastics.
- Reduced consultant sessions and the impact of Skin Analytics have constrained capacity in previous months.
- A recent waiting list initiative has increased throughput, and the service is working with Cancer Services colleagues at WHH to support recovery.

31-Day Subsequent Treatment Standard (old target 94%)

- Performance was 55.56%, with 4 of 9 patients breaching the standard. Three breaches were due to limited Skin Analytics, face-to-face and surgical capacity, compounded by elements of patient choice. Two patients have been discharged, and one remains on the follow-up pathway. One breach was solely due to limited appointment availability, with subsequent referral to plastics for excision of one lesion, while a second lesion was treated at Wolves.
- Previously reduced consultant sessions and the impact of Skin Analytics have continued to place pressure on capacity.
- A waiting list initiative to recover 31-day performance has increased throughput and has been replicated in Month 11, with further improvements expected.

Combined 31-day general standard - (Target 96%)

- Performance was 58.82%. Month 10 challenges were driven by Skin Analytics bottlenecks and reduced clinical capacity. While the backlog has been cleared,

lower achievement continues to be driven by the 31-day pathway. Breaches were anticipated and related to a combination of patient choice and capacity constraints.
- Previous reduced consultant sessions and the impact of Skin Analytics have continued to limit capacity; however, a recent waiting list initiative has increased throughput to support recovery of this standard.

62-Day 1sr treatment (Target 85%)

- Performance was 70.83%, with 3.5 of 12 patients breaching the standard. Two breaches were due to limited Skin Analytics, face-to-face and surgical capacity, and two were related to patient choice. All patients have now been seen; two have been discharged, three required referrals to plastics, and one patient has been listed for follow-up in four months.
  The service is working with the Cancer Alliance and the Cancer Team at WHH to improve compliance. Progress is currently gradual; however, a deep-dive review is underway, and an action plan will be developed. Capacity has been constrained by a previous reduction in consultant sessions and the impact of Skin Analytics; however, an increase in clinical sessions and delivery of deep-dive actions is expected to support improvement in Day-1 treatment performance.

Percentage referred onto A+E (UTC)

- Performance in Month 11 was 4.10% against the local target of 3%.
- This indicator relates to patients coded as ‘streamed to Emergency Department following initial assessment’; the 3% target remains achievable, and such occurrences should be rare.
- Performance has improved and remains within control limits. Coding cannot be amended once an attendance is closed; however, review has identified that a proportion of attendances were coded in error. The service lead has reviewed the data with UTC staff, reinforcing correct coding practice, and continued improvement is expected.

Percentage of DNAs - Warrington Adults

- This indicator is reported by exception due to performance of 2.46% against a target of 1.6%.
- DNA rates typically fluctuate between 2–3% and vary around the mean; however, a gradual upward trend has been observed over recent months, with the current target sitting just below the lower control limit. The Trust’s aspirational objective remains to reduce DNA rates and achieve sustained compliance with the 1.6% target.
- DNA rates fluctuate throughout the year, and work has been initiated across all teams to reduce non-attendance, with a focus on services reporting the highest DNA rates and identification of further improvement actions. Progress has been slower than anticipated and has been compounded by an increased volume of long-waiter appointments being booked, where in some cases patients no longer

require the appointment or their circumstances have changed but the service has not been notified in advance.
- The highest volumes of DNAs continue to relate to follow-up activity and therapy services. Targeted actions remain in place, with ongoing monitoring through routine performance oversight.

Percentage of DNAs/Was not brought – Children's

- Performance for Children's Services in February was 6.72% against the local target of 1.6%. An increase in children not brought to appointments was observed in Month 11; however, outside of school holidays, variation would typically be expected to range between 5% and 7%. The Trust's aspirational objective remains to reduce Child Not Brought rates and achieve sustained compliance with the 1.6% target.
- Children's Services reported a slight in-month increase, with variable performance across teams. While some teams have made significant progress in reducing non-attendance, others continue to experience challenges despite the implementation of agreed team action plans.
- Teams reporting the highest CNB rates are receiving targeted support, with ongoing work to explore and implement additional and more creative approaches to reducing unattended appointments. Performance continues to be monitored through routine performance oversight.

Warrington Audiology - Number of 6 weeks diagnostic breaches

- This indicator is reported by exception due to five breaches against a national target of zero, comprising of three breaches within the Halton team and two within the Warrington team. This performance is outside of control limits; however, normal variation would typically be expected to range between 30 and 100 breaches, and there have been several weeks reporting zero breaches.
- Weekly performance and allocation meetings are now in place with the Head of Service to review actual and potential breaches, ensuring robust oversight of the waiting list and its management. Additional training has been provided to ensure diagnostic clocks are stopped appropriately, and the team continues to review child not brought rates and internal waiting list processes to maximise efficient use of available capacity.
- There have been no reported incidents associated with harm and no complaints. Bridgewater continues to work with the regional diagnostic analytical team to monitor Audiology diagnostic pathways and support sustained improvement.

The Community Health Services (CHS) SitRep reports January 2026 data

- % Under 18 Weeks: 52.77%
- % Over 52 Weeks: 17.34%
- % Over 104 weeks: 0.54%
- The Community Health Services (CHS) SitRep collects monthly data on waiting lists and waiting times for Children and Young People's (CYP) and Adult's Community Health Services. Community Health Services Sitrep submission does not include Dental or Dermatology waiting times.

- CHS Sitrep performance has been deteriorating since Summer 2024. The variation can be expected to range between 59% and 69% for 18 week waits and 5% to 16% for over 52 weeks.
- Bridgewater is one of 15 trusts working with the national team to develop waits directly from daily Faster Data Flows submissions.
- Not all services are required to flow via CHS - Dermatology and Dental as an example are excluded from this submission.

- Bridgewater continues to report higher levels of patients waiting over 52 weeks when compared to peers, contributing to a lower NOF Access domain score.

- Focused actions remain underway to reduce long waits, with ongoing monitoring through routine performance oversight and continued engagement with national teams to support improvement.

All Bridgewater patients awaiting initial access to service – Including Dental and Dermatology Services.

- % Under 18 Weeks: 60.02%.
- % Over 52 Weeks: 10%
- % Over 65 weeks: 6.63%

Operational narrative - Services with over 65 week waits (*All Bridgewater Patients Awaiting Initial Access to Service – Including Dental and Dermatology Services*)

- Performance for patients waiting under 18 weeks improved again in Month 11, following a period of steady decline. In Month 11, 60.02% of patients were waiting under 18 weeks, 10% were waiting over 52 weeks, and 6.63% were waiting over 65 weeks. For waits under 18 weeks, normal variation would be expected to range between 55% and 65%, while waits over 52 weeks would typically be expected to range between 4% and 13%.
- If the Trust is to align with elective recovery ambitions, achievement of 65% of patients waiting less than 18 weeks by March 2026 would be required. Focused actions remain in place to support further improvement, with continued monitoring through routine performance oversight. Services with patients waiting over 65 weeks continue to be actively managed:

- **Community Paediatrics and Paediatric Neurodevelopment Services in Warrington and Halton** - continue to experience demand exceeding capacity. Appointments are prioritised for the highest-risk cohort using a stratified caseload approach, with trajectory modelling underway and engagement with commissioners in progress to address capacity constraints. Weekly performance and allocation meetings remain in place to ensure clinical risk is managed appropriately.

- **Dermatology** - continues to make progress in reducing long waits, supported by a waiting list initiative implemented from 28 November 2025, which has delivered positive reductions in high waiters. The initiative will continue through to the end of the financial year, and the service will achieve a below 52-week position.

- **Podiatry Services** – **Warrington:** All vacancies have been filled, and plans are in place to achieve a below 52-week position by the end of the financial year.

- **Podiatry Services** – **Halton:** Long waits have reduced following a change in service criteria, with continued focus on the remaining waiters to achieve a below 52-week position by year-end.

- **Dental - Greater Manchester** - reported no patients waiting over 65 weeks for initial assessment at the end of February. The remaining high waits relate to general anaesthetic pathways, where theatre capacity continues to constrain delivery, resulting in a small number of children waiting over 65 weeks. These patients continue to be prioritised based on clinical need, with system-level engagement ongoing to explore additional capacity.

Dental – Waiters by Time Band

Snapshot date	a) 0-17 wks	b) 18-25 wks	c) 26-51 wks	d) 52-78 wks	e) 79-103 wks	f) 104+ wks
2026-01-12	5293	1321	1558	116	51	13
2026-01-19	5316	1365	1476	106	52	6
2026-01-26	5305	1381	1403	107	51	8
2026-02-02	5368	1245	1428	102	48	7
2026-02-09	5305	1320	1397	87	51	6
2026-02-16	5175	1424	1373	86	61	7
2026-02-23	5088	1469	1370	75	61	7
2026-03-02	5098	1457	1324	64	58	7

Cheshire & Mersey:

- There are no patients waiting over 65 weeks across Cheshire & Mersey dental services at M11
- There are 0 waiters over 52 weeks across all pathways
- Patients are proactively managed through early opt-in processes, earliest possible assessment appointments, and minimum waits for treatment; however, this remains challenging in some pathways.
- Minor Oral Surgery (MOS) continues to create the greatest pressure, with absence, annual leave and maternity leave contributing to reduced capacity. Halton and St Helens have the largest volumes of waiters, with daily waitlist ‘huddles’ in place.
- Structured ‘golden’ appointments are now established across all sites to ensure contractual delivery is equitable and KPIs are achieved, with particular focus on special care new patients and children.

Performance improvement actions include:

- Weekly waitlist management meetings with Heads of Service, Dental Nurse Team Managers and Team Leaders, scrutinising discharges, cancellations and DNAs.
- Daily waitlist reviews for MOS in Halton and St Helens, with site- and pathway-specific targets.

- Weekly booking efficiency meetings, aiming for zero gaps in diaries for the week ahead.
- Operational flexibility, including booking staff and activity at alternative sites where demand is highest.
- Targeted movement of high waiters into cancellation slots to reduce breach risk.
- Review of dentist admin time, appointment lengths and long treatment plans to maximise clinical capacity.
- Ongoing focus on maximising clinical time, reducing non-essential time out of diaries and auditing diary utilisation.
- Agile working remains in place, with staff deployed to areas of highest demand. While Chester is an emerging risk due to workforce turnover, mitigation plans are in development.

Greater Manchester:

- Dental – Greater Manchester, At the end of February, 87 patients were waiting over 65 weeks within Greater Manchester, representing a reduction of two patients compared to the previous month. This improvement reflects the prioritisation of urgent referrals and limited gains in general anaesthetic (GA) theatre capacity. However, significant challenges remain, particularly for children with additional needs, where theatre capacity continues to be severely constrained. There remain seven children waiting in excess of 104 weeks, a position unchanged from the previous month.
- The highest volumes of long waits relate to the RBH neurodiverse pathway, where capacity remains limited to six patients every six weeks. The longest waiting patient remains at 125 weeks, and although the total number of patients on this list has reduced by 23 in-month, there continue to be 178 patients awaiting treatment, with 67 waiting over 65 weeks and 139 waiting over 52 weeks for GA. A paper exercise has been completed to identify patients who can be transferred to other Greater Manchester lists with greater capacity; however, without additional theatre access, clearance of the backlog will remain protracted.

A range of actions remain in place to support improvement:

- High-wait patients are being offered alternative clinics where capacity allows and where patients are willing to travel. Validation of GA pathways and open treatment plans continues, with ongoing reductions in waiting list volumes.
- Assessments are now being booked from 25 weeks, where possible, to support completion of treatment by 52 weeks, although this remains constrained by appointment availability.
- Monthly oversight meetings with managers, the Clinical Director and the BI team continue to review high waiters, cancellations, discharges and data quality.
- Additional pressures remain, including high levels of sickness absence, open treatment plans with multiple appointments, and limited appointment availability across some sites, all of which continue to impact on throughput and long waits.
- Notwithstanding this, overall waiting list volumes in Greater Manchester continue to reduce, with a decrease from over 5,171 patients in February 2025 to a lower position at the end of February 2026.
- Mitigation actions remain under close review, with system-level engagement ongoing to explore opportunities to increase GA theatre capacity

Percentage of births that receive a face-to-face NBV (New Birth Visit) within 14 days by a Health Visitor – Halton

- Performance for Quarter 3 was 91.67%, exceeding the local commissioner target of 90%, but remaining below the national target of 95%. Performance has shown a slight improvement during Quarter 3 2025/26, although it continues to sit below the Trust target (National target).
- The service monitors all New Birth Visits that occur outside of the 14-day timescale. During Quarter 3, the majority of contacts not meeting the target related to infants being admitted to neonatal units or instances where no-access visits occurred. On occasion, visits have been delayed due to staff sickness, although volumes remain low. The local authority commissioner target of 90% has been in place in Halton for over four years and continues to be achieved.

Percentage of children who received a 6–8-week review by the time they were 8 weeks – Halton

- Performance for Quarter 3 was 85.50% against the national target of 90%. While the service met the required target in 2024/25, performance has been below target during Quarters 1, 2 and 3 of 2025/26.
- New Birth and 6–8-week contacts are now reported via CSDS, which introduced new parameters that have impacted reported compliance figures since Quarter 1. The team continues to work closely with the Business Intelligence team to ensure robust recording and reporting of activity. All contacts taking place outside of the required timescales are exception reported. During Quarter 3, the majority of visits not completed by 8 weeks related to infants being admitted to neonatal units, parent-requested rescheduling or no-access visits, and families moving into the area. Performance continues to be monitored through routine operational oversight.

3. Quality highlights

% of incidents causing moderate harm (Score 3)

- Performance for this indicator remained above the 1% target in February, with compliance of 2.90%. Performance has remained above target for the last nine data points; however, for the most recent five data points it has remained slightly above the mean level of reporting, with minimal variation, indicating a stable but non-compliant position.
- All moderate harm incidents reported in February related to pressure ulcers**,** comprising of 5 category 3 pressure ulcers and 1 category 4 pressure ulcer. One of the category 3 pressure ulcers was identified as being related to a medical device**.** All moderate harm incidents are reviewed through the Directorate Incident Review and Learning Group**,** with monitoring of outcomes and learning through the Patient Safety Incident Review Framework and Learning Panel**.**

- The Trust continues to see fluctuation around the mean as incidents are reviewed and, where appropriate, re-graded. The target remains within control limits and is considered achievable**,** with ongoing quality improvement activity focused on pressure ulcer prevention and learning.

% of incidents causing severe/fatal harm (Score 4-5)

- Performance for February 2026 was 0.97%, compared to 0% in January 2026, and remains within the 1% target.
- The position reflects low incident volumes, with variation expected as incidents are reviewed and, where appropriate, re-graded.
- One incident related to a patient who became acutely unwell during a therapy visit, requiring CPR and hospitalisation; following review, this incident was downgraded to low harm.
- A second incident related to a patient who had missed multiple treatment room appointments and subsequently required hospital admission; this incident is subject to an after-action review, with the initial assessment indicating it met the criteria for severe harm.
- Performance has breached control limits twice in the last five months; however, the target remains within control limits overall and is considered achievable.
- All incidents are reviewed through established governance processes, with learning and actions overseen via the Directorate Incident Review and Learning Group and the Patient Safety Incident Review Framework.
- The corrected compliance for February – 0.48%

DOC (Duty of Candour) - 10-day compliance (part 1)

- This indicator is reported by exception due to performance compliance of 50% against a target of 100%.
- During February 2025, four of eight applicable incidents being completed within the Trust's timescale. Following review, the harm level for two incidents was downgraded, and Duty of Candour was no longer required. The remaining two incidents, which were non-compliant at day 10, and have since been completed.
- Future data will be refreshed to reflect the subsequent downgrading of incidents, resulting in a corrected compliance position of 67% for February. The application and recording of Duty of Candour continues to be reinforced through incident training. Compliance is monitored through Directorate Incident Review and Learning Group meetings, with assurance and learning oversight provided via the Patient Safety Incident Review Framework and Learning Panel.
- Performance continues to show variation due to low incident volumes, with the target remaining within control limits and achievable.

Information Governance Training

- Information Governance training compliance for February was 93.59%, below the national target of 95%. Although the target was achieved in December 2025, compliance has declined in January and February 2026.

- The overall trend remains within control limits and close to the target, indicating that the position is stable but not yet sustained. Recent slippage is likely reflective of staff turnover and refresher training cycles rather than a systemic failure.
- Targeted actions will be undertaken within Directorate Leadership Teams to reinforce compliance, including focused follow-up with non-compliant staff and local ownership of training completion.
- Compliance remains achievable and within control, with improvement actions in place. Performance will continue to be monitored through Performance Council to ensure recovery and sustained compliance.

Percentage of BCHFT risks identified as 12 or above

- The compliance for February 2025, was 16.34% against a target of 11%, remaining above target. This represents the third consecutive data point above the mean level of reporting for this indicator; however, performance remains within the upper control limit. The position reflects a minor increase of 1.13% compared to January 2026, when performance was 15.21%.
- The highest numbers of risks scoring 12 or above continue to be within Dermatology and Community Equipment Stores, each reporting four risks at this level. The Trust continues to take assurance regarding the identification, scoring and management of risks through the established risk review process, with oversight provided via the Risk Management Council. Performance remains under active review, with the target considered within control limits and achievable.

BCHFT patient safety Falls per 1,000 bed days - bed based

- This indicator is reported by exception due to a performance of 9.06 against a target of 8.
- A total of 8 falls were reported during the month; 7 were unwitnessed and 1 witnessed. All incidents resulted in no harm or low harm, with no moderate or severe harm reported.
- Incident reviews undertaken through the Directorate Incident Review and Learning Group confirmed that appropriate preventative and proactive measures were in place at the time of each incident.
- The majority of falls occurred when patients were attempting to mobilise independently, highlighting an ongoing risk inherent within the patient cohort.
- The Falls Priority Group continues to drive improvement through proactive assessment and prevention. Current actions include testing the use of carer insight within the falls checklist to further strengthen risk identification and personalised prevention measures.
- Despite breaching the local target in February, the absence of harm, evidence of effective controls, and continued improvement actions provide assurance that falls risk is being actively managed and remains under close review.

% of Category 4 Pressure Ulcers acquired in Bridgewater

- This indicator is reported by exception due to a performance of 13.33% against a target of 0%, reflecting two reported Category 4 pressure ulcers**.**

- As expected, performance demonstrates inconsistent variation due to the low numbers of Category 4 pressure ulcers, and figures may change as incidents are reviewed and, where appropriate and re-graded.
- The first incident related to a patient with complex health needs, requiring regular Tissue Viability Nurse monitoring and support. Despite all appropriate interventions, the patient's pressure ulcer deteriorated from a Category 3 to a Category 4.
- The second incident related to a patient who had not attended treatment room appointments; despite repeated interventions, including treatment room staff visiting the patient at home, a Category 4 pressure ulcer developed. An after-action review is being completed to identify any additional learning.
- All incidents have been reviewed through the Directorate Incident Review and Learning Group, with ongoing oversight and quality improvement activity led by the Pressure Ulcer Priority Group and monitored through the Patient Safety Incident Review Framework and Learning Panel. The target remains within control limits and is considered achievable.

% of Category 3 Pressure Ulcer acquired in Bridgewater

- This indicator is reported by exception due to performance of 33.33% against a target of 3%
- The trend in Category 3 pressure ulcer incidence remains inconsistent but within expected variation, reflecting the low numbers of incidents reported, although an increase was noted in-month. During February, five incidents were reported, with one incident in Halton and four incidents in Warrington across different teams. One incident was initially recorded as a Category 3 pressure ulcer but subsequently deteriorated to a Category 4 pressure ulcer, involving a medical device, and was therefore reported as a separate incident
- All incidents have been reviewed through the Directorate Incident Review and Learning Group, with no new learning identified. Quality improvement activity continues, led by the Pressure Ulcer Priority Group and monitored through the Patient Safety Incident Review Framework and Learning Panel. The Trust continues to expect variation around the mean as incidents are reviewed and, where appropriate, re-graded. The target remains within control limits and is considered achievable.

IPC Assurance Audit Compliance

- IPC assurance audit compliance for February was 86.4% against the local target of 90%. Overall compliance showed a slight improvement in-month, with Halton Adults and Halton Children's dashboards demonstrating progress. However, compliance remains below target.
- A small number of teams did not submit audit data during the month, which has notably lowered compliance rates both at Directorate level and overall.
- The IPC team is working closely with senior leaders within each Directorate to strengthen internal processes and improve submission compliance. These actions are being monitored on a weekly basis and progress is reported through Quality Council.

4. People highlights

Sickness absence rate (Actual)

- This indicator is reported by exception due to performance of 8.10% against a target of 5.50% in February.
- The indicator has reduced for two consecutive months and, from February 2026, is now within control limits**,** demonstrating a downward trajectory since December 2025**.** Despite this improvement, absence levels remain above target and continue to require active management.
- The highest contributors to sickness absence continue to be Anxiety, Stress and Depression**,** Cold/Flu, and Gastrointestinal conditions**,** consistent with seasonal trends and national patterns.
- Weekly monitoring via e-Roster is supporting earlier intervention and clearer management action, with monthly monitoring meetings in place. A revised sickness absence policy is currently under consultation. The top three services**,** as part of a wider top-12 cohort, receive targeted support and regular reporting to EMT**.** These actions have contributed to a 1.21% reduction from the peak absence rate recorded in December.
- Improvement actions are in place and are beginning to have impact. Performance will continue to be closely monitored, with further reductions expected as targeted interventions are embedded.

Staff turnover (rolling)

- This indicator is reported by exception due to performance of 13.54% against a target of 12.0%.
- The increase in turnover reflects a known and planned organisational change, specifically the TUPE transfer of the Warrington and Halton School Aged Immunisation teams in August 2025, alongside the delivery of the organisational headcount reduction programme. These factors have directly contributed to higher recorded turnover and explain the sustained position above target.
- Following recent adjustments, the latest data point shows that the process is now within control limits, indicating that turnover levels are stabilising post-change, albeit remaining above the target.
- The People Operational Delivery Council (POD) continues to monitor people metrics and drive improvement actions through the NHS People Plan, People Promises and People Strategy. Whilst staff retention remains a priority, the current focus on planned headcount reduction is expected to continue to influence turnover levels in the short term.
- The variance is planned and understood, with appropriate oversight and monitoring in place. Continued scrutiny through POD provides assurance that workforce impacts are being actively managed.

5. Finance highlights

- The Trust is reporting an adjusted deficit at Month eleven of £3.68m, in line with plan.
- The Trust has a Level 1 and 2 savings requirements excluding system savings, of £5.48m (5.02%). The Trust has an additional system stretch savings target of £2.90m (Level 3). The Level 3 savings will not be delivered.
- The Trust is reporting a savings achievement of £5.15m against a plan of £4.98m.
- Income is £91.89m against a plan of £91.92m.
- Expenditure is £95.57m against a plan of £95.60m.
- Pay is £66.05m against a plan of £66.41m.
- Agency spend is £0.24m against a plan of £1.03m.
- Non pay expenditure is £28.76m against a plan of £27.80m.
- Capital charges are above plan by £0.17m.
- Capital expenditure is £0.93m at month eleven, planned spend is £2.12m.
- Cash is £5.56m.

6. Recommendations

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

Communities Matter

Creating stronger, healthier, happier communities.

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Integrated Quality and Performance Report

Information Team

Reporting Period: February 2026 (Month 11)

Contents

Introduction

The monthly Integrated Quality and Performance Report (IQPR) provides an overview of the Trust's performance against the balanced scorecard Key Performance Indicators (KPIs).

KPIs are grouped by Domain and Executive leads are tasked with ensuring the KPIs are relevant, achievable, measurable, monitored, and managed.

Indicators have been reviewed and refreshed to ensure that they are relevant and are in line with the System Oversight Framework metrics and the new service lines which are delivered.

This month's report describes activity in February 2026.

Within this Report

1. KPI Amendments:

No amendments within Month 11.

2. Recommendations:

The Finance & Performance committee are asked to:

Accept this paper as assurance that indicators of performance in relation to operations, quality, people, and finance are being reviewed and appropriate actions taken to rectify any indicators which are reported as red.

Trust Overview

Executive Summary

Responsive (Operations)

There are 23 Green indicators and 26 Red indicators in month 11.

- Two Red to Green indicators:
  - Warrington Dermatology Cancer 2 week referrals (urgent GP)
  - Percentage of births that receive a face to face NBV within 14 days by a Health Visitor - Warrington
- Zero Green to Red indicators
- 27 indicators have shown an in-month deterioration
- 22 indicators have shown an in-month improvement
- 0 indicators have shown no in-month changes

Trust Overview

Executive Summary

Safe, High-Quality Care (Quality)

There are 22 green indicators and 9 red indicators in month 11.

- Four Green to Red indicators:
  - % of incidents causing severe/fatal harm (Score 4-5)
  - DOC (Duty of Candour) for moderate harms and above 10-day compliance
  - BCHFT patient safety Falls per 1,000 bed days - bed based
  - % of Category 4 Pressure Ulcers acquired in Bridgewater
- One Red to Green indicator:
  - % of BCHFT patient safety incidents that are medication incidents
- 4 indicators have shown an in-month improvement
- 16 indicators have shown an in-month deterioration
- 11 indicators have shown no in-month changes

Trust Overview

Executive Summary

People

There are 2 green indicators and 2 red indicators in Month 11.

- One Red to Green indicator:
  - % of staff with a current PDR
- Zero Green to Red indicators
- 2 indicators have shown an in-month deterioration
- 2 indicators have shown an in-month improvement

Making Good Use of Resources (Finance)

- The Trust is reporting an adjusted deficit at Month eleven of £3.68m, in line with plan.
- The Trust is reporting a savings achievement of £5.15m against a plan of £4.98m.

Operations

Executive Summary

Of the 49 Operations indicators which are reported; 26 are red and 23 are green.

The 26 indicators which were red in February are as follows:

- Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery – Improvement in Month
- Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment – Deterioration in Month
- Warrington Dermatology Cancer Combined 31 day General Standard – Deterioration in Month
- Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral) – Deterioration in Month
- 28 day Faster Diagnosis Standard – Improvement in Month
- Percentage referred onto A+E (UTC) – Deterioration in Month
- Data Quality Maturity Index (DQMI) (monthly internal reporting) – Deterioration in Month
- Data Quality Maturity index (DQMI) Monthly published score (3 months in arrears) – Deterioration in Month
- Percentage of was not brought – Childrens – Deterioration in Month
- Percentage of DNAs/Was not brought - Warrington Adults – Improvement in Month
- Audiology - Number of 6 weeks diagnostic breaches – Deterioration in Month
- Referrals to plan - Childrens – Deterioration in Month
- Referrals to plan - Warrington Adults – Improvement in Month
- Referrals to plan - Halton Adults – Deterioration in Month

Operations

Executive Summary – Continued

Red indicators (continued):

- Community Health Services Sitrep - % of waiters under 18 weeks (one month in arrears) – Improvement in Month
- Community Health Services Sitrep - % of waiters over 52 weeks (one month in arrears) – Deterioration in Month
- Community Health Services Sitrep - % of waiters over 104 weeks (one month in arrears) – Deterioration in Month
- All waiters - % waiting over 65 weeks (awaiting initial access) – Deterioration in Month
- All waiters - % waiting over 52 weeks (awaiting initial access) – Improvement in Month
- All waiters - % waiting under 18 weeks (awaiting initial access) – Improvement in Month
- Warrington Adults Activity Variance – Improvement in Month
- Warrington Children's Activity Variance – Deterioration in Month
- Halton Adults Activity Variance – Deterioration in Month
- Halton Children's Activity Variance – Improvement in Month
- Percentage of births that receive a face to face NBV within 14 days by a Health Visitor – Halton – Improvement in Month
- Percentage of children who received a 6-8 week review by the time they were 8 weeks – Halton – Improvement in Month

Operations

Trust Scorecard

Operations														
KPI Name	Target	Trend Line	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Warrington Dermatology Cancer 2 week referrals (urgent GP)	93%		98.92% (▲)	95% (▼)	95.61% (▲)	95.32% (▼)	88.32% (▼)	57.37% (▼)	5.87% (▼)	7% (▲)	11.56% (▲)	72.75% (▲)	89.67% (▲)	96.41% (▲)	
Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery	94%		100% (►)	66.67% (▼)	50% (▼)	85.71% (▲)	75% (▼)	28.57% (▼)	100% (▲)	0% (▼)	0% (►)	0% (►)	37.5% (▲)	55.56% (▲)	
Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment	96%		100% (▲)	94.74% (▼)	100% (▲)	56.25% (▼)	89.47% (▲)	95.45% (▲)	86.67% (▼)	33.33% (▼)	25% (▼)	40% (▲)	71.43% (▲)	62.5% (▼)	
Warrington Dermatology Cancer Combined 31 day General Standard	96%		100% (▲)	88% (▼)	87.5% (▼)	65.22% (▼)	86.96% (▲)	79.31% (▼)	88.24% (▲)	23.08% (▼)	12.5% (▼)	26.67% (▲)	62.07% (▲)	58.82% (▼)	
Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral)	85%		90.91% (▲)	93.75% (▲)	91.18% (▼)	90.48% (▼)	94.74% (▲)	66.67% (▼)	86.36% (▲)	79.17% (▼)	71.43% (▼)	53.85% (▼)	72.5% (▲)	70.83% (▼)	
28 day Faster Diagnosis Standard	75%		91.89% (▲)	84.26% (▼)	89.53% (▲)	85.94% (▼)	83.19% (▼)	79.88% (▼)	75.6% (▼)	65.14% (▼)	49.34% (▼)	66.87% (▲)	65.19% (▼)	67.16% (▲)	
A&E: Total time in A&E (% of pts who have waited <= 4hrs)	95%		94.5% (▼)	96.88% (▲)	94.49% (▼)	98.5% (▲)	98.97% (▲)	98.08% (▼)	98.62% (▲)	98.2% (▼)	98.36% (▲)	96.01% (▼)	95.95% (▼)	99.12% (▲)	98.56% (▼)
Total time in A&E - 95th Percentile (Mins)	4 Hrs		04:11 (▼)	03:54 (▲)	04:11 (▼)	03:49 (▲)	03:38 (▲)	03:46 (▼)	03:42 (▲)	03:39 (▲)	03:46 (▼)	03:57 (▼)	03:59 (▼)	03:27 (▲)	03:30 (▼)
Total time in A&E - Median (Mins)	4 Hrs		01:37 (▼)	01:19 (▲)	01:38 (▼)	01:27 (▲)	01:27 (▲)	01:18 (▲)	01:27 (▼)	01:17 (▲)	01:29 (▼)	01:33 (▼)	01:28 (▲)	01:22 (▲)	01:17 (▲)
A&E Time to treatment decision (median) <=60 mins (Mins)	60 Mins		00:07 (▼)	00:09 (▼)	00:07 (▲)	00:07 (▲)	00:07 (▼)	00:07 (▼)	00:07 (▲)	00:07 (▼)	00:07 (▲)	00:07 (▼)	00:08 (▼)	00:06 (▲)	00:07 (▼)
A&E Time to treatment decision 95th percentile <=60 mins (Mins)	60 Mins		00:16 (▼)	00:23 (▼)	00:18 (▲)	00:14 (▲)	00:14 (▲)	00:15 (▼)	00:16 (▼)	00:14 (▲)	00:18 (▼)	00:21 (▼)	00:22 (▼)	00:14 (▲)	00:15 (▼)
A&E Unplanned re-attendance rate <=5%	5%		4.79% (▼)	5.38% (▼)	5.24% (▲)	3.92% (▲)	4.1% (▼)	4.73% (▼)	3.69% (▲)	4.39% (▼)	4.24% (▲)	5.3% (▼)	4.58% (▲)	4.23% (▲)	3.69% (▲)
A&E left without being seen <=5% (left before trx completed)	5%		0.04% (▲)	0.22% (▼)	0.16% (▲)	3.63% (▼)	2.87% (▲)	2.87% (►)	4.61% (▼)	5.7% (▼)	4.8% (▲)	5.46% (▼)	5.68% (▼)	4.31% (▲)	4.6% (▼)
Percentage referred onto A+E (UTC)	3%		12.41% (▲)	10.33% (▲)	11.17% (▼)	6.13% (▲)	5.61% (▲)	5.98% (▼)	5.08% (▲)	5.19% (▼)	4.02% (▲)	5.96% (▼)	5.84% (▲)	4.04% (▲)	4.1% (▼)
Data Quality Maturity Index (DQMI) (monthly internal reporting)	95%		91.46% (▼)	90.42% (▼)	92.03% (▲)	91.46% (▼)	91.65% (▲)	91.31% (▼)	91.95% (▲)	92.21% (▲)	92.66% (▲)	92.8% (▲)	92.11% (▼)	92.67% (▲)	89.42% (▼)
Data Quality Maturity index (DQMI) Monthly published score (3 months in arears)	95%		90.2% (▼)	89.1% (▼)	88.1% (▼)	87.6% (▼)	88.3% (▲)	87.5% (▼)	87.6% (▲)	88.9% (▲)	89.2% (▲)	18.9% (▼)			

Operations

Trust Scorecard

Operations														
KPI Name	Target	Trend Line	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Percentage of was not brought - Childrens	1.6%		6.46% (▲)	5.87% (▲)	6.8% (▼)	6.45% (▲)	6.85% (▼)	8.67% (▼)	10.05% (▼)	7.07% (▲)	7.33% (▼)	5.83% (▲)	6.71% (▼)	5.81% (▲)	6.72% (▼)
Percentage of DNAs/Was not brought - Warrington Adults	1.6%		1.95% (▲)	2.07% (▼)	2.1% (▼)	2.13% (▼)	2.36% (▼)	2.09% (▲)	1.91% (▲)	2.13% (▼)	2.36% (▼)	2.29% (▲)	2.46% (▼)	2.72% (▼)	2.46% (▲)
Percentage of DNAs/Was not brought - Halton Adults	1.6%		0.89% (▲)	0.91% (▼)	1.02% (▼)	1.06% (▼)	0.86% (▲)	1.01% (▼)	0.85% (▲)	0.91% (▼)	0.92% (▼)	0.75% (▲)	0.87% (▼)	0.86% (▲)	0.88% (▼)
Proportion of Urgent Community Response referrals reached within two hours	70%		77% (▼)	81.1% (▲)	87% (▲)	91.5% (▲)	91.1% (▼)	93.9% (▲)	96.7% (▲)	92.6% (▼)	92.2% (▼)	98.2% (▲)	99.3% (▲)	96% (▼)	96.2% (▲)
Audiology - Number of 6 weeks diagnostic breaches	0		43 (▲)	32 (▲)	57 (▼)	63 (▼)	98 (▼)	93 (▲)	71 (▲)	50 (▲)	16 (▲)	41 (▼)	50 (▼)	2 (▲)	5 (▼)
Referrals to plan - Childrens	95%		107.77% (▼)	107.6% (▲)	105.12% (▲)	104.07% (▲)	107.45% (▼)	109.6% (▼)	103.67% (▲)	105.16% (▼)	105.53% (▼)	105.34% (▲)	104.95% (▲)	106.53% (▼)	107.43% (▼)
Referrals to plan - Warrington Adults	95%		79.91% (▼)	78.36% (▼)	74.33% (▼)	74.02% (▼)	74.53% (▲)	75.33% (▲)	73.24% (▼)	72.83% (▼)	73.18% (▲)	72.41% (▼)	72.63% (▲)	72.77% (▲)	72.87% (▲)
Referrals to plan - Halton Adults	95%		85.08% (▲)	84.62% (▼)	91.54% (▲)	89.6% (▼)	88.92% (▼)	88.9% (▼)	88.62% (▼)	87.25% (▼)	86.61% (▼)	85.36% (▼)	84.31% (▼)	84.46% (▲)	84.3% (▼)
Community Health Services Sitrep - % of waiters under 18 weeks (one month in arrears)	92%		61.39% (▼)	63.53% (▲)	59.56% (▼)	60.62% (▲)	58.99% (▼)	60.08% (▲)	58.36% (▼)	55.62% (▼)	54.74% (▼)	50.79% (▼)	50.49% (▼)	52.77% (▲)	
Community Health Services Sitrep - % of waiters over 52 weeks (one month in arrears)	0%		10.51% (▼)	10.87% (▼)	12.31% (▼)	12.36% (▼)	16.3% (▼)	13.74% (▲)	13.83% (▼)	14.55% (▼)	14.57% (▼)	15.68% (▼)	17.1% (▼)	17.34% (▼)	
Community Health Services Sitrep - % of waiters over 104 weeks (one month in arrears)	0%		0.03% (▼)	0.03% (▲)	0% (▲)	0% (►)	1.13% (▼)	0.16% (▲)	0.1% (▲)	0.22% (▼)	0.16% (▲)	0.16% (▲)	0.31% (▼)	0.54% (▼)	
All waiters - % waiting over 65 weeks (awaiting initial access)	0%		2.22% (▼)	2.81% (▼)	4.45% (▼)	2.7% (▲)	6.42% (▼)	7.48% (▼)	8.73% (▼)	9.66% (▼)	7.54% (▲)	7.95% (▼)	7.32% (▲)	6.43% (▲)	6.63% (▼)
All waiters - % waiting over 52 weeks (awaiting initial access)	0%		6.51% (▼)	7.42% (▼)	9.7% (▼)	10.61% (▼)	12.01% (▼)	13.04% (▼)	13.95% (▼)	14.62% (▼)	11.64% (▲)	12.35% (▼)	11.97% (▲)	10.44% (▲)	10% (▲)
All waiters - % waiting under 18 weeks (awaiting initial access)	92%		58.19% (▲)	59.56% (▲)	56.75% (▼)	57.69% (▲)	56.95% (▼)	55.77% (▼)	55.25% (▼)	54.49% (▼)	56.41% (▲)	55.94% (▼)	55.86% (▼)	59.59% (▲)	60.02% (▲)
Warrington Adults Activity Variance	3%		-20.09% (▼)	-21.64% (▼)	-25.67% (▼)	-25.98% (▼)	-25.47% (▲)	-24.67% (▲)	-26.76% (▼)	-27.17% (▼)	-26.82% (▲)	-27.59% (▼)	-27.37% (▲)	-27.23% (▲)	-27.13% (▲)
Warrington Childrens Activity Variance	3%		24.43% (▼)	24.38% (▲)	26.94% (▼)	23.24% (▲)	26.87% (▼)	26.52% (▲)	15.6% (▲)	16.47% (▼)	18.43% (▼)	19.37% (▼)	18.03% (▲)	19.78% (▼)	20.18% (▼)
Halton Adults Activity Variance	3%		-14.92% (▲)	-15.38% (▼)	-8.46% (▲)	-10.4% (▼)	-11.08% (▼)	-11.1% (▼)	-11.38% (▼)	-12.75% (▼)	-13.39% (▼)	-14.64% (▼)	-15.69% (▼)	-15.54% (▲)	-15.7% (▼)
Halton Childrens Activity Variance	3%		-23.69% (▲)	-24.14% (▼)	-30.06% (▼)	-28.63% (▲)	-26.17% (▲)	-20.94% (▲)	-18.94% (▲)	-16.56% (▲)	-18.55% (▼)	-20.19% (▼)	-19.48% (▲)	-18.29% (▲)	-16.63% (▲)

Operations

Trust Scorecard

Operations															
KPI Name	Target	Trend Line	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above - Halton			101 (▼)			112 (▲)			114 (▲)			139 (▲)			106 (▼)
Percentage of births that receive a face to face NBV within 14 days by a Health Visitor - Halton	95%		92.2% (▲)			92.16% (▼)			89.3% (▼)			90.07% (▲)			91.67% (▲)
Percentage of children who received a 6-8 week review by the time they were 8 weeks - Halton	90%		92.23% (▲)			90.51% (▼)			84.23% (▼)			83.33% (▼)			85.5% (▲)
Percentage of children who turned 12 months in the quarter, who received a 12 month review, by the age of 12 months - Halton	85%		85.99% (▼)			88.7% (▲)			84.67% (▼)			87.15% (▲)			90.73% (▲)
Percentage of children who turned 15 months in the quarter, who received a 12 month review, by the age of 15 months - Halton	85%		90.94% (▼)			91.42% (▲)			94.77% (▲)			95.39% (▲)			93.42% (▼)
Percentage of children who received a 2-2½ year review, by the age of 2½ years - Halton	90%		90.78% (▲)			89.07% (▼)			91.18% (▲)			91.78% (▲)			90.64% (▼)
Percentage of children who received a 2-2½ year review in the quarter, using ASQ 3 - Halton	90%		90.71% (▲)			82.52% (▼)			94.28% (▲)			90.55% (▼)			91.03% (▲)
Number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above - Warrington			319 (▼)			333 (▲)			338 (▲)			365 (▲)			299 (▼)
Percentage of births that receive a face to face NBV within 14 days by a Health Visitor - Warrington	95%		91.81% (▼)			93.68% (▲)			90.82% (▼)			93.16% (▲)			95.1% (▲)
Percentage of children who received a 6-8 week review by the time they were 8 weeks - Warrington	90%		95.47% (▼)			96.33% (▲)			91.69% (▼)			91.01% (▼)			94.21% (▲)
Percentage of children who turned 12 months in the quarter, who received a 12 month review, by the age of 12 months - Warrington	85%		96.16% (▲)			93.72% (▼)			93.11% (▼)			91.3% (▼)			92.12% (▲)
Percentage of children who turned 15 months in the quarter, who received a 12 month review, by the age of 15 months - Warrington	85%		97.37% (▼)			98.45% (▲)			97.1% (▼)			97.76% (▲)			96.96% (▼)
Percentage of children who received a 2-2½ year review, by the age of 2½ years - Warrington	90%		97.07% (▲)			96.58% (▼)			92.9% (▼)			93.75% (▲)			94.78% (▲)
Percentage of children who received a 2-2½ year review in the quarter, using ASQ 3 - Warrington	90%		100% (▲)			94.15% (▼)			96.77% (▲)			95.48% (▼)			97.57% (▲)
Available Virtual Ward Capacity per 100,000 head of population			4.18 (▲)	2.67 (▼)	3.85 (▲)	3.95 (▲)	5.66 (▲)	3.4 (▼)	4.51 (▲)	4.36 (▼)	4.31 (▼)	0.04 (▼)	2.32 (▲)	1.96 (▼)	0.36 (▼)

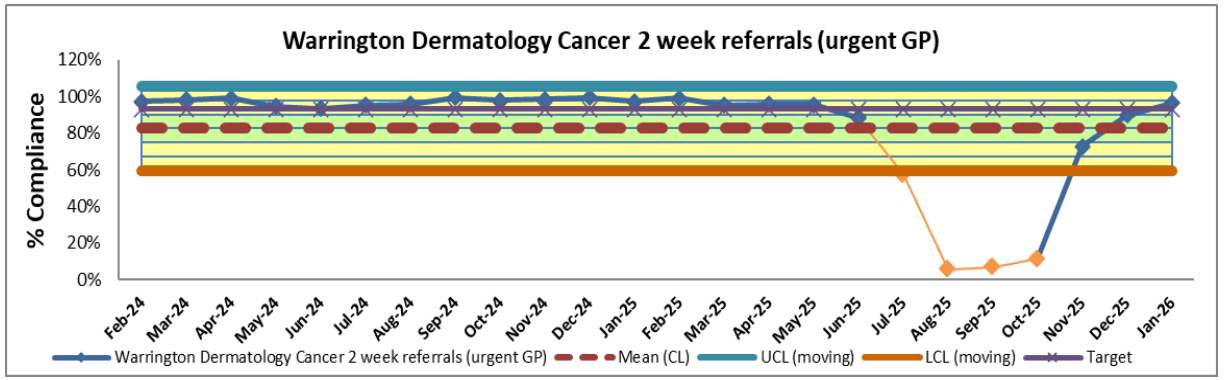
Operations: Exception Reporting

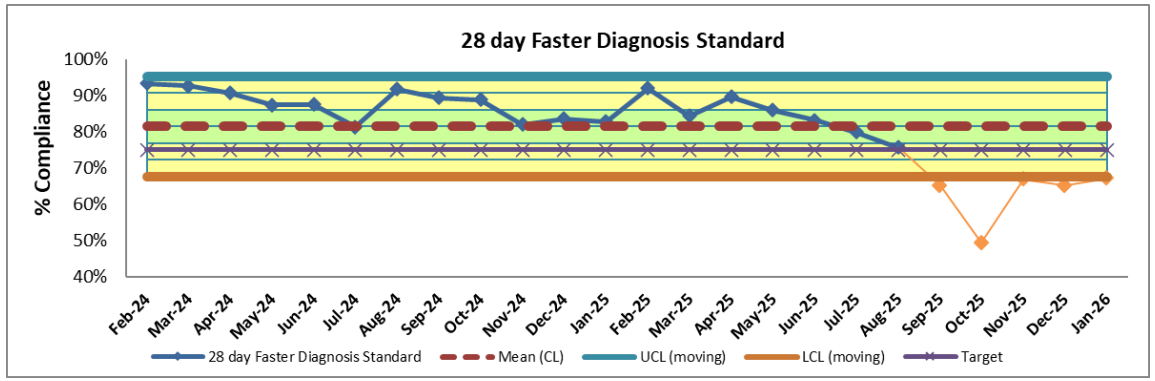
Flagged Indicators

28 day faster diagnosis		Points below lower control limit
Data Quality Maturity index (DQMI) Monthly published score (3 months in arears)		Points below lower control limit
Audiology - Number of 6 weeks diagnostic breaches		Points below lower control limit
Referrals to plan - Warrington Adults		Points below lower control limit
Community Health Services Sitrep - % of waiters under 18 weeks (one month in arrears)		Points below lower control limit
Community Health Services Sitrep - % of waiters over 52 weeks (one month in arrears)		Points above upper control limit
Community Health Services Sitrep - % of waiters over 104 weeks (one month in arrears)		Points above upper control limit
Warrington Adults Activity Variance		Points below lower control limit
Halton Childrens Activity Variance		Points above upper control limit

Operations: Exception Reporting

Warrington Dermatology Cancer – (January performance reported in arrears)



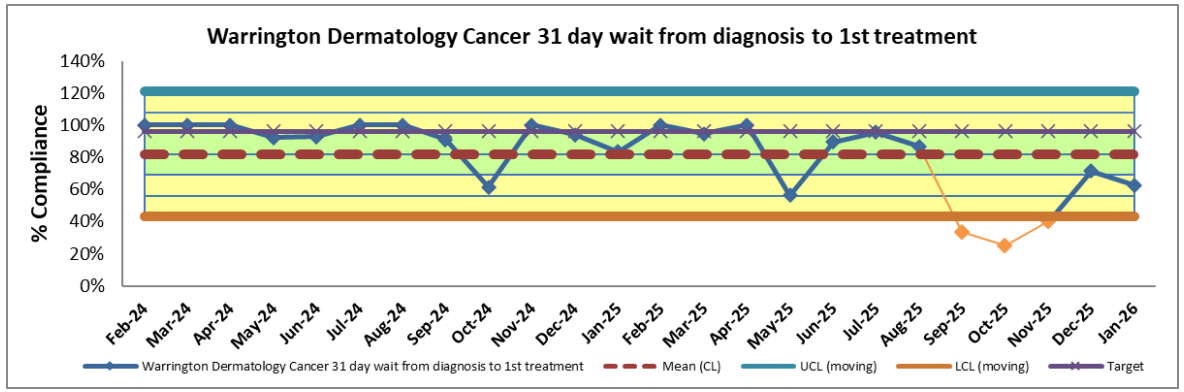


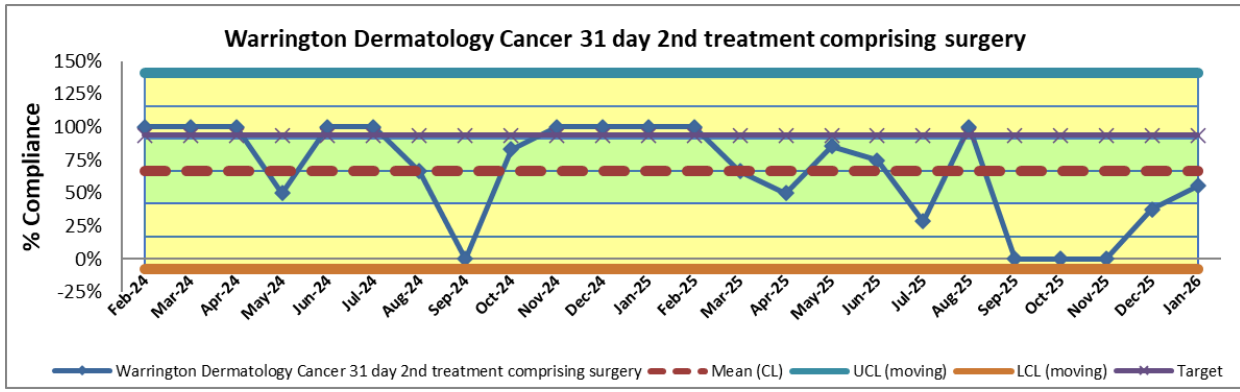
2 Week wait for first appointment – (Old target 93%) Within the month of January Bridgewater saw 212 patients for a first appointment with an urgent referral of suspected cancer. We would normally expect to see variation between 88% and 99%. We have seen an improvement with performance remaining within control limits in January with a compliance of 89.67% this was as a result of adding additional clinic capacity and adapting the one stop clinic model for skin analytics to provide more face to face slots (While no longer a formal cancer standard, this metric provides an early indicator of likely performance against the 28-day Faster Diagnosis Standard).

28 day Faster Diagnosis Standard - Target 75% (65.19% Month 9) The service has historically met the 28-day Faster Diagnosis Standard; however, improvements achieved through additional capacity and temporary changes to the Skin Analytics model have now plateaued. As a result, the focus has shifted to increasing surgical and diagnostic throughput, supported by a further waiting list initiative and reinforced through a deep-dive review with WHH and the Cancer Alliance. Previous capacity reductions, increased referrals and the introduction of Skin Analytics have collectively created sustained pressure within the skin cancer pathway, and breaches are therefore expected to continue into Month 11.

Operations: Exception Reporting

Warrington Dermatology Cancer – (January performance reported in arrears)





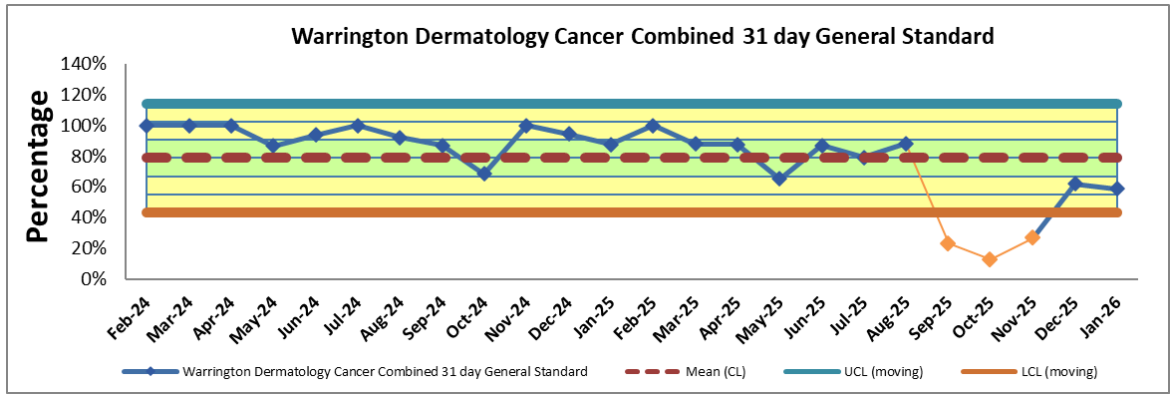
The two 31 day standards are now reported as a combined metric on the next slide. (As per national cancer standards)

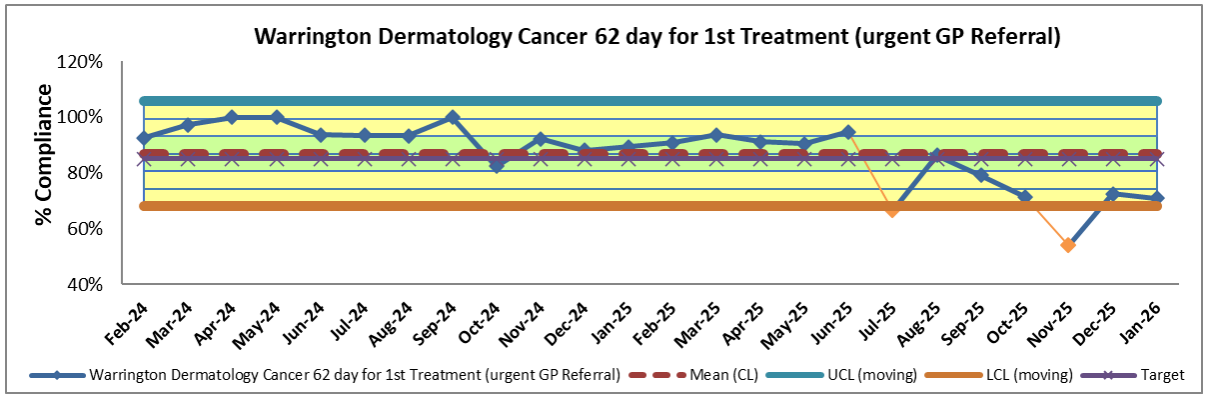
31 Day 1st treatment (old target 96%) - 31-day 1st treatment performance was 62.5% (3/8 breaches). One breach was due to patient choice and 2 were due to limited face to face and surgery slots. All patients have now been seen; 1 is awaiting histology results to be received, 2 are requiring further surgery for a wider local excision at plastics. Reduced consultant sessions and the impact of Skin Analytics have constrained capacity, although a recent waiting list initiative to recovery the 31 day performance has increased throughput. The service are engaging with our counterparts at WHH within the Cancer Services for support.

31 Day 2nd treatment (old target 94%) - Four out of nine patients breached the 31-day subsequent treatment standard (55.56%), 3 were due to limited SA, face to face and surgery capacity mixed with elements of patient choice. 2 have been discharged and 1 remains on the follow up list. 1 breach was due to limited appointment availability, resulting in referral to plastics for excision of one lesion, while the second lesion was treated at BCH.
Reduced consultant sessions and the impact of Skin Analytics have contributed to capacity pressures. A recent waiting list initiative to recover the 31 day performance has increased throughput, this has been duplicated for M11 so further improvements are expected.

Operations: Exception Reporting

Warrington Dermatology Cancer – (January performance reported in arrears)

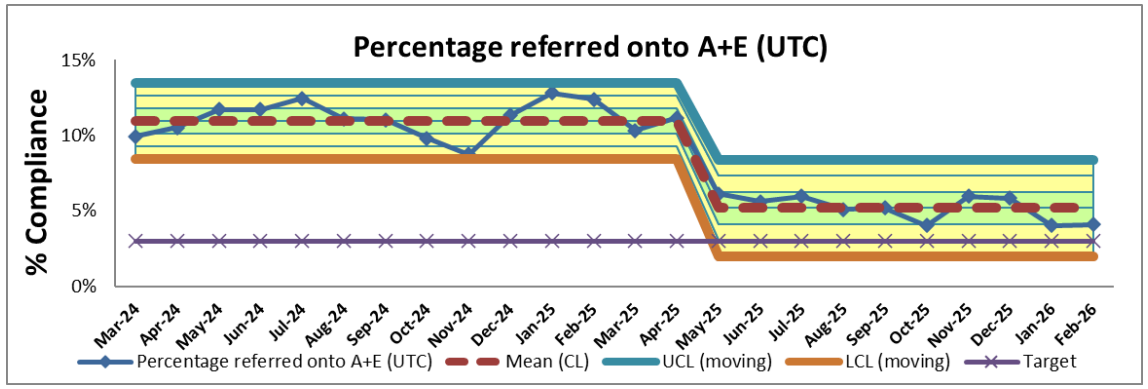




Combined 31-day general standard - (Target 96%) – Bridgewater's compliance with the combined standard is 58.82%. Month 10 challenges were driven by Skin Analytics bottlenecks and reduced clinical capacity, the backlog has been cleared. However, the service is exploring ways to see patients sooner in the 31 day pathway as this is what is driving the lower achievement. Breaches related to both patient choice and limited capacity were expected. Reduced consultant sessions and the impact of Skin Analytics have constrained capacity, although a recent waiting list initiative to recovery the 31 day performance has increased throughout.

62 Day 1st treatment (Target 85%) 3.5 of 12 patients breached the 62-day standard (70.83%).
2 breaches were due to limited Skin Analytics, face to face and surgery slots, 2 were related to patient choice. All patients have now been seen, 2 have been discharged. 3 patients required referral to plastics, 1 patient has been added to the follow up list for review in 4 months.
The service is working with the Cancer Alliance and the Cancer Team in WHH to improve compliance, this is gradual at present but a deep dive is taking place and an action plan will be developed. Capacity has been constrained by reduced consultant sessions and the impact of Skin Analytics; however, an increase in clinical sessions and the deep dive outcomes is expected to see an improvement to this standard.

Operations: Exception Reporting



Percentage referred onto A+E (UTC)

Local target is 3%

Performance in February – 4.10%.

Analytical Narrative

Work to align local and ICB calculation is visible from the significant change in variation from the month of May 25. The target is within control limits and is achievable.

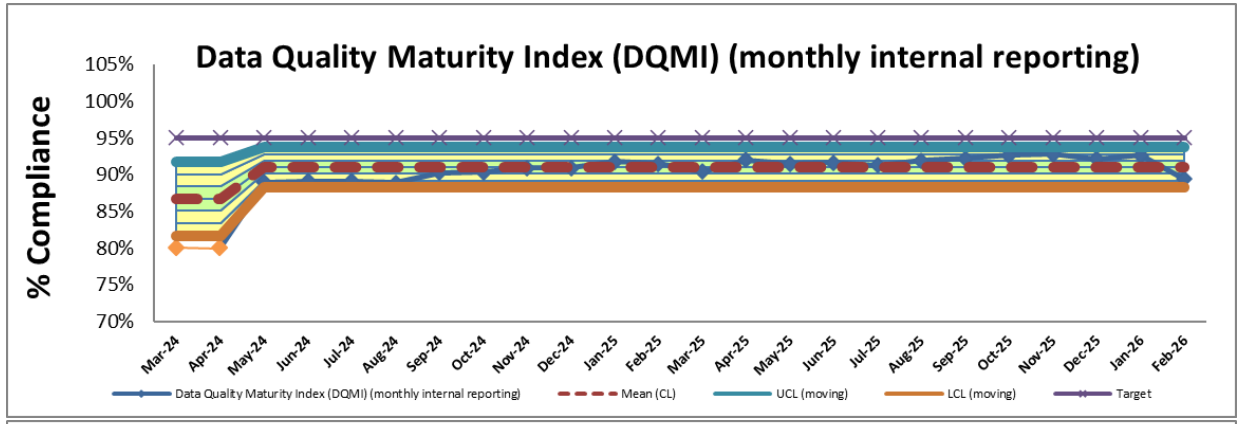
Operational Narrative

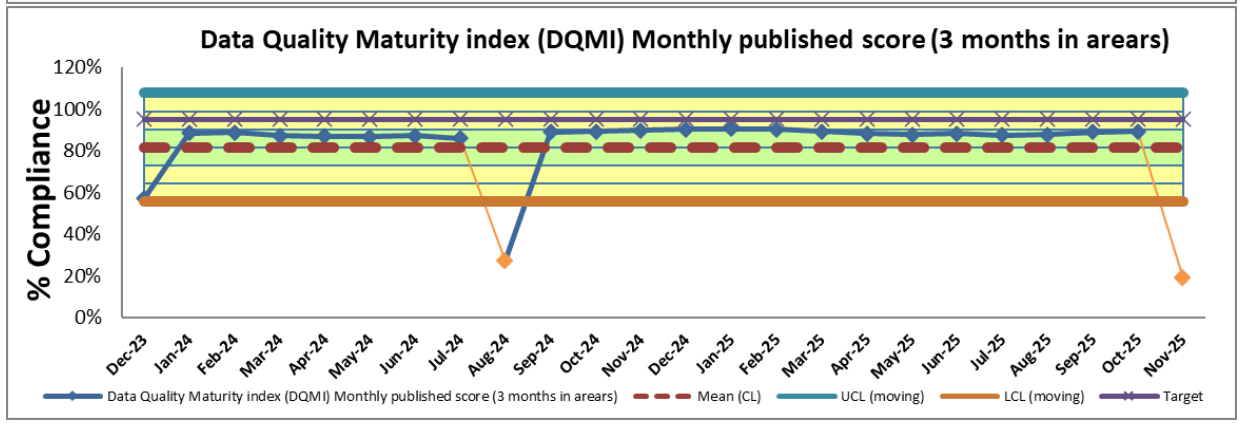
This indicator relates to patients coded as ‘streamed to emergency department following initial assessment (situation)’. The 3% target is achievable; these situations should be a rare occurrence.

Performance has improved and the target is within the control limits. The service lead is working closely with the information team to regularly analyse the data. There is no ability to correct this code in a patient record once the UTC attendance has been completed. UTC staff continue to be reminded as to the correct use of the code and the service are confident that improvement will continue to be made.

Operations: Exception Reporting

Data Quality Maturity Index (DQMI) monthly internal reporting and monthly published score (3 months in arears)
National Target: 95%





The National Data Set score of all Data Sets and providers in England across all Data Items is displayed in the card below. The table visual on the right is a break down of each Data Set's contribution to the overall National Data Set Score.

National DQMI Score

68.7

Experimental National DQMI Score

62.4

Data set	National Data Set Score	National Data Set Score Experimental
APC	90.0	90.0
CSDS	75.0	70.4
ECDS	77.6	77.6
IAPT	96.7	87.6
MHSDS	41.5	37.1
MSDS	97.6	97.6
OP	86.4	86.4

Operations: Exception Reporting

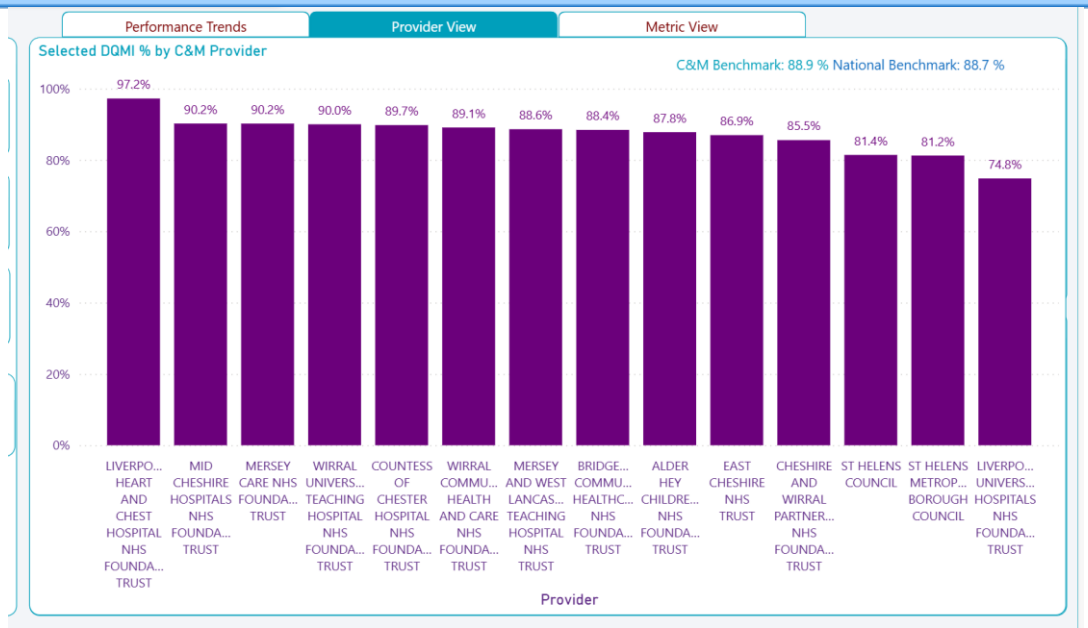
Data Quality Maturity Index (DQMI) monthly internal reporting and monthly published score (3 months in arears)
National Target: 95%

Standard	APC (%)	CSDS (%)	DID (%)	ECDS (%)	IAPT (%)	MHSDS (%)	MSDS (%)	OP (%)	DQMI Score (%)
		91.2		0.0		92.8			18.9

Analytical Narrative / Operational Narrative
The drop to 18.9% performance in the published score is directly related to Bridgewaters ECDS submission being inadvertently overwritten. This resulted from of a change of process. The error was identified and data resubmitted. Unfortunately, the DQMI dashboard is updated once per month via automation and there is no opportunity to reflect the resubmission in this dashboard.

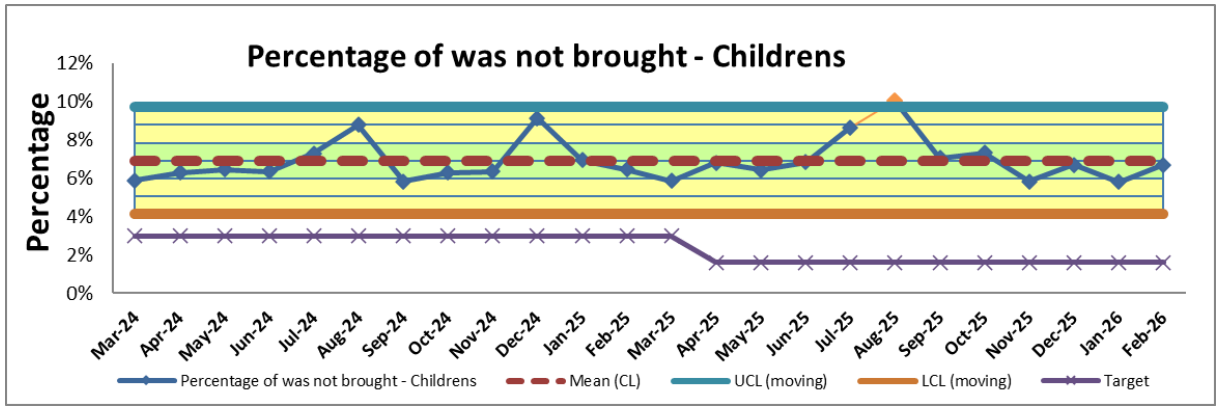
The national ECDS digital team have however, confirmed that they received our resubmission and that data will be reflected in the national ECDS data dashboards.

The slight decline in 'in month' performance is related to ceasing submission of MHSDS data. (following guidance from NHSE)



C+M comparison taken from ICB BIP dashboard (CSDS). Data in arrears (latest BIP published month Nov 2025)

Operations: Exception Reporting



Percentage of "Child Not Brought " Children's Services

Local Target: 1.6% February compliance – 6.72%

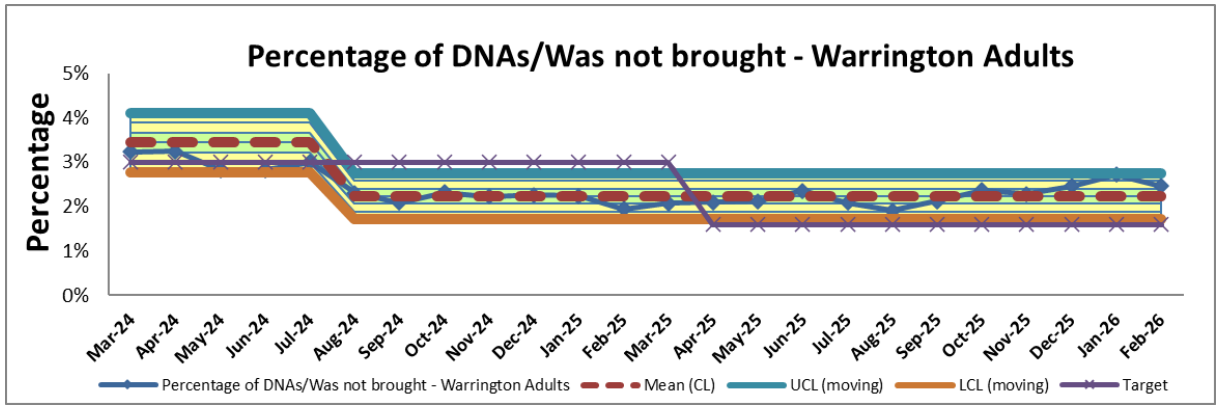
Analytical Narrative

The number of children not brought to their appointment has increased in February to 6.72%. Outside of school holidays we would expect variation to be between 5% and 7%.
The trusts aspirational target is to achieve 1.6% DNA / Child Not Brought.

Operational Narrative / Actions / Risks

Children's Services reported a slight increase in the percentage of children not brought to their appointments in Month 11 Whilst some teams have made significant progress in reducing numbers, others, despite implementation of team actions plans, have found this area more challenging. Teams reporting the highest CNB rates are continuing to be supported to explore and identify new and more creative approaches to reducing unattended appointments.

Operations: Exception Reporting



Percentage of DNAs/Was not brought - Warrington Adults

Local Target: 1.6% February compliance – 2.46%

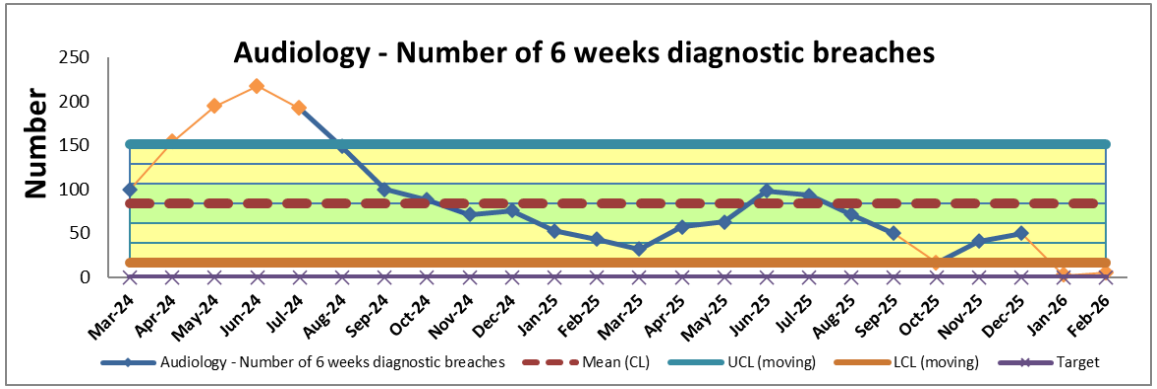
Analytical Narrative

DNA rates for Warrington Adults typically range between 2–3% and fluctuate around the mean, however the past six months has seen a steady increase. The current target sits just below the lower control limit. The Trust's aspirational goal is to reduce DNA rates further and achieve 1.6%.

Operational Narrative / Actions / Risks

DNA rates fluctuate throughout the year. Work has been initiated across all teams to reduce these rates, with a target of achieving 1.6% by the end of the financial year. Additional efforts are ongoing to address areas with the highest DNA rates and identify further actions to drive improvement.. This hasn't progressed at the pace first expected and has been compounded by a higher number of long waiter appointments being booked in. The highest numbers of DNA's predominantly relate to follow up activity and therapy services.

Operations: Exception Reporting



Audiology - Number of 6 weeks diagnostic breaches
National Target: 0 February compliance - 5

Operational Narrative / Actions / Risks
Weekly performance/allocation meetings are now in place with Head of Service to review actual and potential breeches, ensuring robust oversight of the waiting list and its management.

Although February reports 2 breaches in Warrington and 3 breaches in Halton there have been weeks reporting zero breaches. Additional training has been provided to ensure "clock stops" are applied appropriately.

The team are reviewing child not brought rates and internal processes relating to waiting list management to ensure the most efficient use of resources
There have been no incidents reported with any level of harm. There have been no complaints.

Analytical Narrative

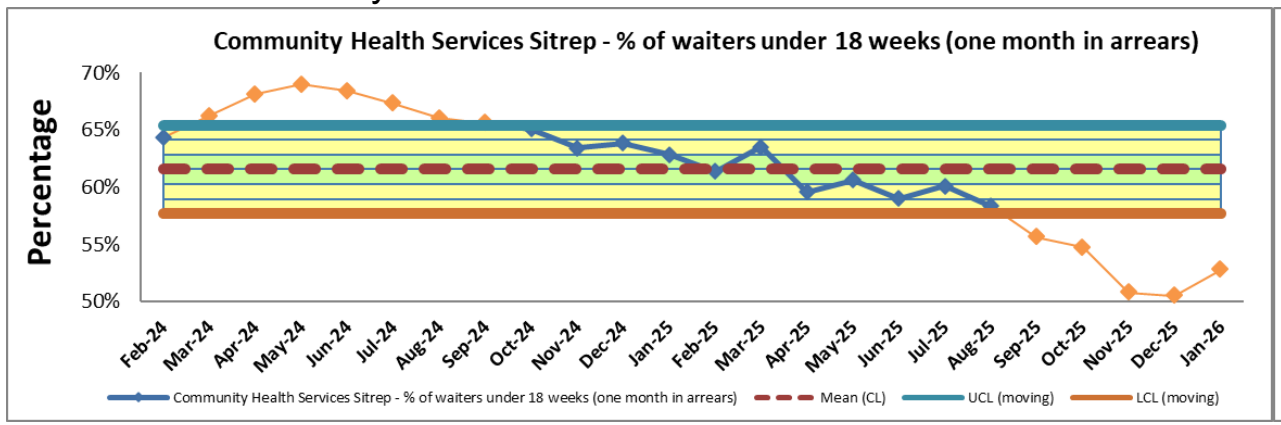
Performance deteriorated slightly in M11 with 5 reported breaches (3 within the Halton team and 2 within the Warrington team) which is outside of control limits. We would expect normal variation to range between 30 and 100 breaches.

Bridgewater are working with the regional diagnostic analytical team to monitor Audiology diagnostic pathways.

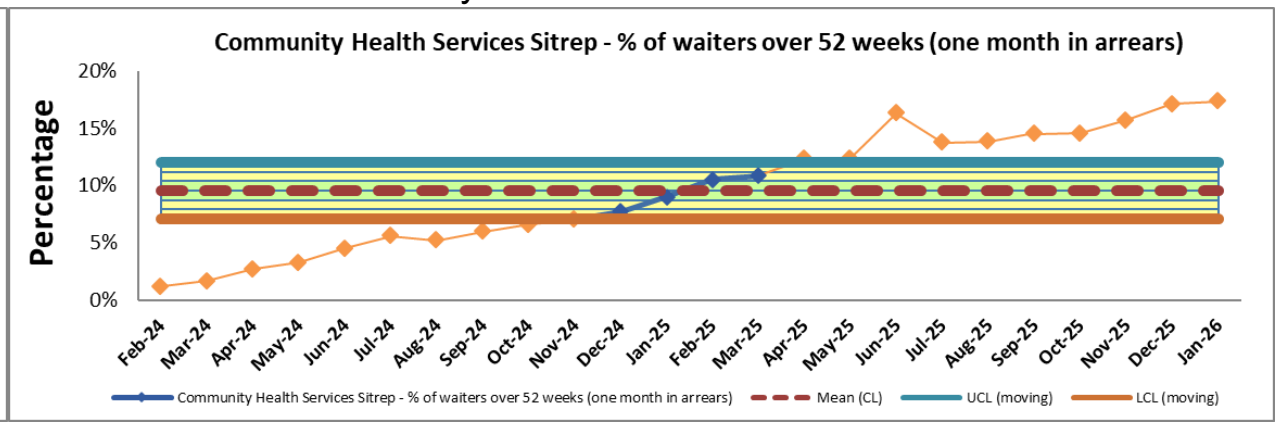
Operations: Exception Reporting

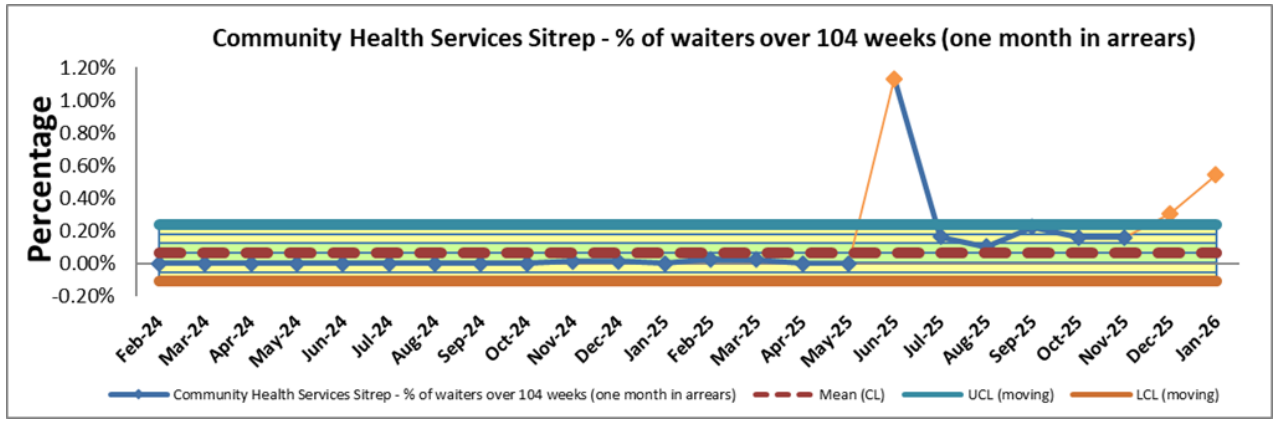
Community Health Services Sitrep – Published data (one month in arrears)

January % under 18 weeks – 52.77%



January % over 52 weeks –17.34%





The Community Health Services (CHS) SitRep collects monthly aggregate data on waiting lists and waiting times for community health services. The SitRep does not cover all services in some systems. This publication contains management data which is collected on a rapid turnaround basis, allowing only minimal validation to be undertaken.

Note: Community Health Services Sitrep submission does not include Dental or Dermatology waiting times.

Operations: Exception Reporting

Community Health Services Sitrep – Published data (one month in arrears) – Adults waiting / Cheshire & Mersey Comparison

		Number of patients waiting:							
Organisation Name	Total waiting list	0-1 weeks	>1-2 weeks	>2-4 weeks	>4-12 weeks	>12-18 weeks	>18-52 weeks	>52-104 weeks	Over 104 weeks
HCRG CARE SERVICES LTD	16,532	2,666	1,887	2,726	5,189	1,999	1,985	74	6
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	493	9	68	50	330	16	20	0	0
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	225	44	54	41	38	28	10	0	0
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	140	45	31	16	44	4	0	0	0
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST									
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	6,328	766	783	1,151	2,386	1,104	136	1	1
EAST CHESHIRE NHS TRUST	4,204	573	414	647	1,266	532	765	7	0
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST									
MERSEY CARE NHS FOUNDATION TRUST	17,998	3,085	2,209	3,219	5,638	1,972	1,875	0	0
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST									
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	3,814	352	335	465	1,064	586	925	87	0
WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST	5,495	650	420	839	1,796	932	858	0	0

Analytical Narrative for January 2026 data:

- Total adults reported on Bridgewater waiting lists in January 2026: **3814** (increase of **3.11%** on December 2025)
- Long waits for adults on Bridgewater waiting lists in January 2026: **586** waiting **>12-18 weeks**, **925** waiting **>18-52 weeks**, **87** waiting **>52-104 weeks**, and **0** waiting over **104 weeks**.
- Adults waiting over **52 weeks on** Bridgewater waiting lists has decreased by 19 to **87** from last month.

Operations: Exception Reporting

Community Health Services Sitrep – Published data (one month in arrears) – Children & Young People waiting / Cheshire & Mersey Comparison

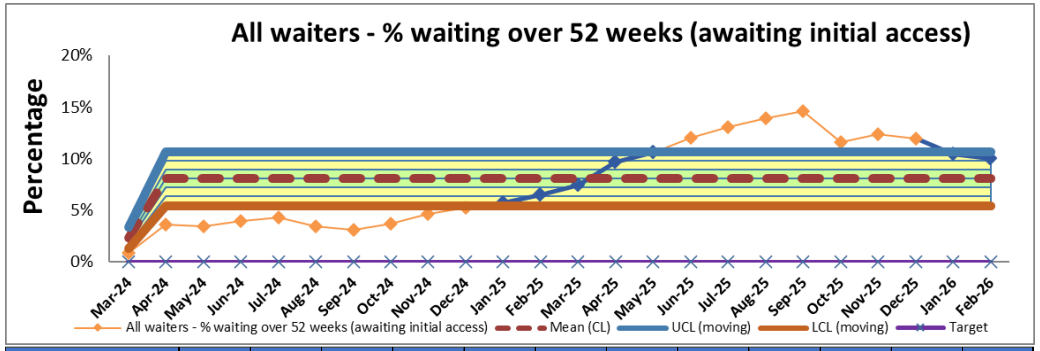
		Number of patients waiting:							
Organisation Name	Total waiting list	0-1 weeks	>1-2 weeks	>2-4 weeks	>4-12 weeks	>12-18 weeks	>18-52 weeks	>52-104 weeks	Over 104 weeks
HCRG CARE SERVICES LTD	1,748	83	73	176	665	303	422	23	3
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	3,843	77	79	103	472	179	1,115	1,034	784
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	673	32	37	59	171	117	192	65	0
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST									
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	4,631	321	350	549	1,381	513	1,489	28	0
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	3,132	117	124	323	950	282	535	801	0
EAST CHESHIRE NHS TRUST	746	54	67	182	238	99	105	1	0
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	1,428	57	69	76	217	140	691	178	0
MERSEY CARE NHS FOUNDATION TRUST	830	117	112	137	357	89	18	0	0
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST									
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	5,229	204	262	242	786	476	1,778	1,432	49
WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST	326	48	47	80	138	13	0	0	0

Analytical Narrative for January 2026 data:

- Total children & young people reported on Bridgewater waiting lists in January 2026: **5229** (increase of **1.65%** on December 2025)
- Long waits for children & young people on Bridgewater waiting lists in January 2026: **476** waiting **>12-18 weeks**, **1778** waiting **>18-52 weeks**, **1432** waiting **>52-104 weeks**, and **49** waiting over **104 weeks**.
- Children & young people waiting over **52 weeks on** Bridgewater waiting lists has increased by **75** to **1481** from last month.

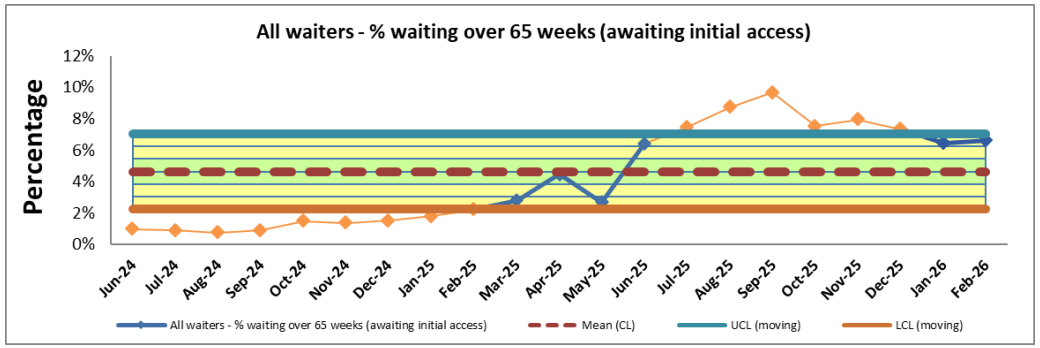
Operations: Exception Reporting

All Bridgewater patients waiting awaiting initial access to service – Including Dental and Dermatology Services.



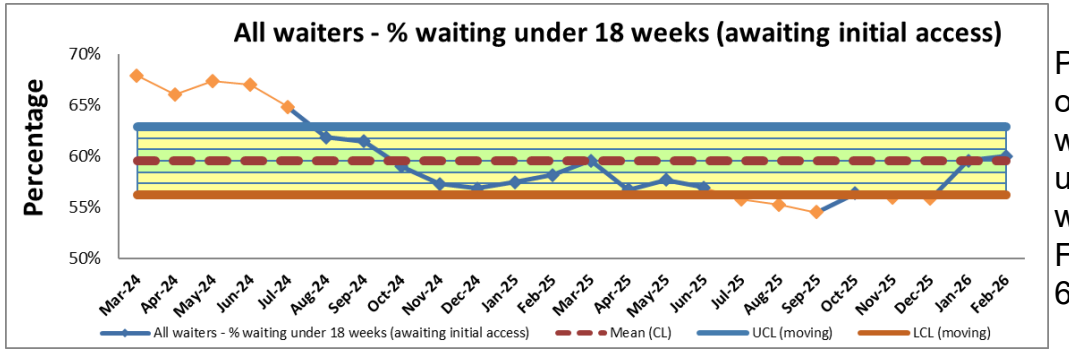
Over 52 weeks	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Warrington	1044	1289	1556	1676	1738	1852	1881	1502	1598	1433	1163	972
Halton	360	409	287	606	794	918	932	707	748	833	829	868
Dental	25	42	31	15	13	10	7	6	3	3	0	2
Total Over 52 weeks	1429	1740	1874	2297	2545	2780	2820	2215	2349	2269	1992	1842

Percentage of patients waiting over 52 weeks in February is 10%.



Over 65 weeks	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Warrington	344	539	348	857	956	1109	1182	906	995	816	665	598
Halton	195	238	100	354	488	620	675	518	510	569	561	621
Dental	95	100	195	105	96	117	124	4	0	2	0	2
Total Over 65	634	877	643	1316	1540	1846	1981	1428	1505	1387	1226	1221

Percentage of patients waiting over 65 weeks in February is 6.63%.



Under 18	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Warrington	5459	4655	4855	5042	5276	5400	5141	5076	4783	4401	4946	4848
Halton	1824	1518	1553	1645	1746	1586	1300	1442	1403	1389	1523	1543
Dental	4185	4221	3979	4365	4004	4118	4062	4326	4551	4797	4902	4660
Total Under 18	11468	10394	10387	11052	11026	11104	10503	10844	10737	10587	11371	11051

Percentage of patients waiting under 18 weeks in February is 60.02%.

Operations: Exception Reporting

All Bridgewater patients waiting awaiting initial access to service – Including Dental and Dermatology Services.

Halton	**621**
Community Paediatrics (Halton)	52
Halton Paediatric Neurodevelopment	562
Podiatry (Halton)	7
Warrington	**598**
Dermatology Service	74
Paediatric Community Medical Service	32
Podiatry Service	1
Warrington Paediatric Neurodevelopment	491
Grand Total	**1219**

Analytical Narrative / Operational Narrative:
The percentage of patients waiting >18 weeks has improved again in M11, following a state of steady decline. For waiters under 18 weeks, we would expect variation between 55% and 65%. For waiters over 52 weeks, we would expect variation to be between 4% and 13%.

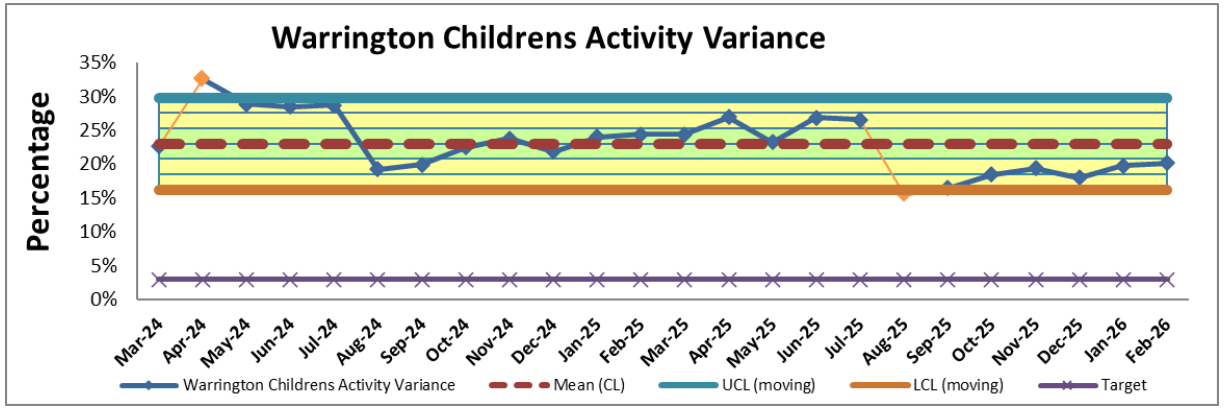
If we aspire to align with elective targets, we would need to achieve 65% of patients waiting less than 18 weeks by March 2026.

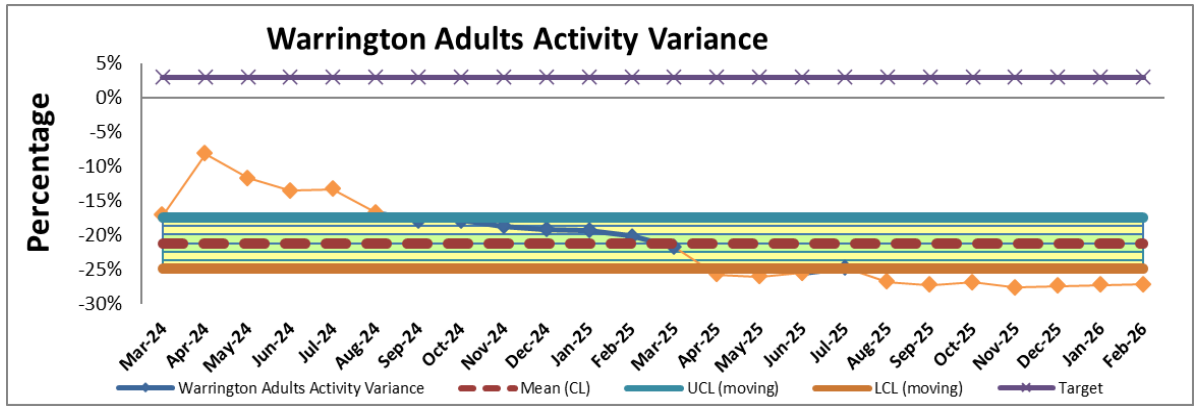
Operational narrative - Services with over 65 week waits

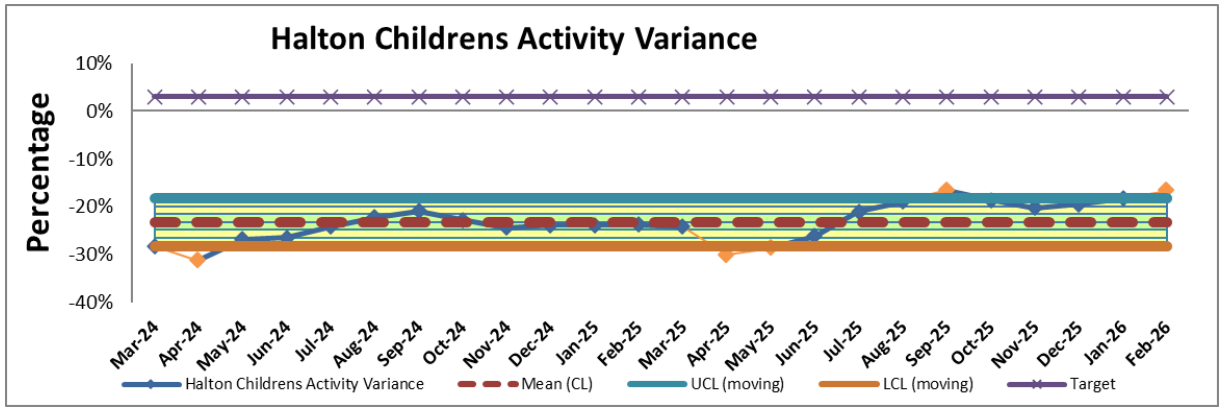
Community Paediatrics Warrington and Halton - Appointments offered to highest risk cohort of stratified caseload. Trajectories under development. Trust will present the information to commissioners as capacity is clearly unable to meet demand. This work has commenced
Dermatology - Engagement continues with NHSE regarding 65+ week waits. Waiting list initiative implemented from 28.11.2025 and very positive progress has been made to date. Waiting list initiative will continue through to the end of the financial year. The service is expected to achieve a below 52-week position.
Podiatry Warrington – Recruited to vacancies, all posts are in place as of early January. Plans have been developed to reduce waiting times below 52 weeks by the end of the financial year. The service is expected to achieve a below 52 week position with only 1 patient currently outstanding, this YTD has now been cleared.
Halton Podiatry – Waiting list action plan in place. The service currently has 3 people waiting over 65 weeks and 42 people waiting over 52 weeks. Additional clinics have been put into place to support waiting list plan have commenced 23rd February 2026. Operational manager is working with data team to cleanse waiting list.
Paediatric Neurodevelopment Diagnostic Assessment Pathway Warrington and Halton - The number of children and young people waiting for an initial appointment as part of the Autism and ADHD diagnostic assessment pathway continues to increase. The team continues to experience a level of demand which exceeds capacity. The team hold weekly performance and allocation meetings to ensure those with highest clinical need (identified via the risk stratification tool) are offered available appointments. Trajectories under development. Trust will present the information to commissioners as capacity is clearly unable to meet demand. This work has commenced
Dental – The Dental service had no patients waiting over 65 weeks for initial assessment at the end of Feb. All Dental high waits are now only waiting for general anaesthetic which we have 87over 65 weeks due to theatre capacity and 2 others waiting for treatment.

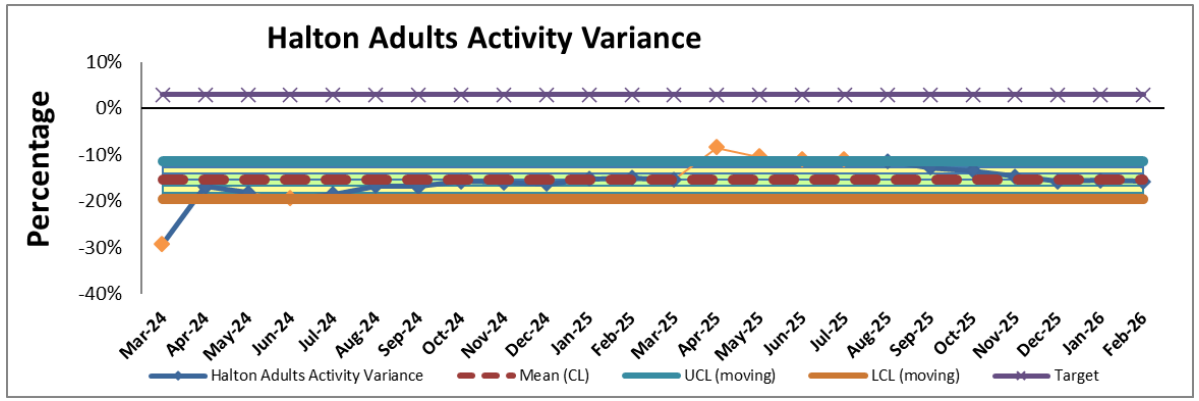
Operations: Exception Reporting

Activity Variances Local Target: 3%



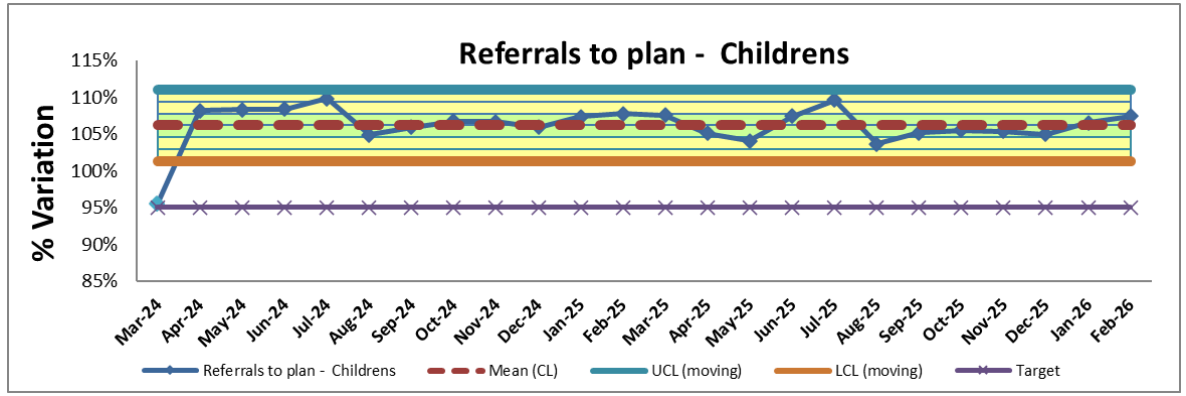


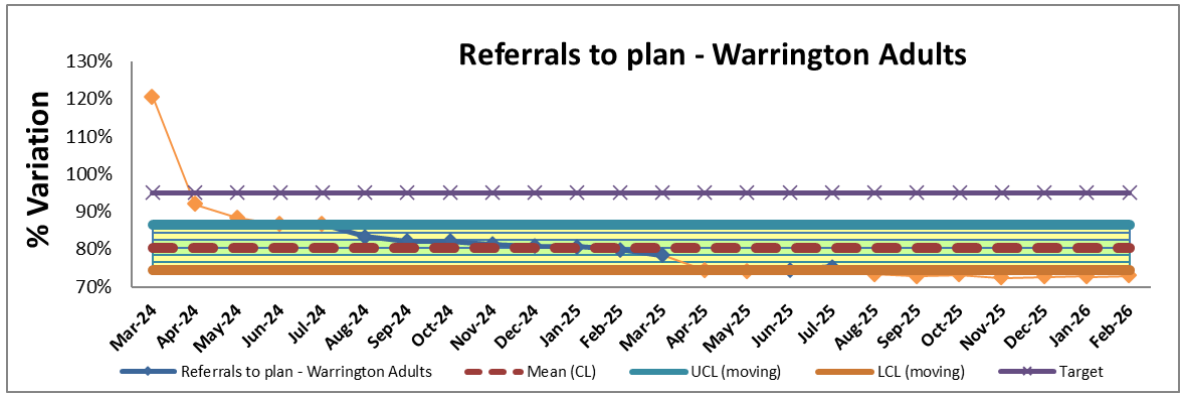


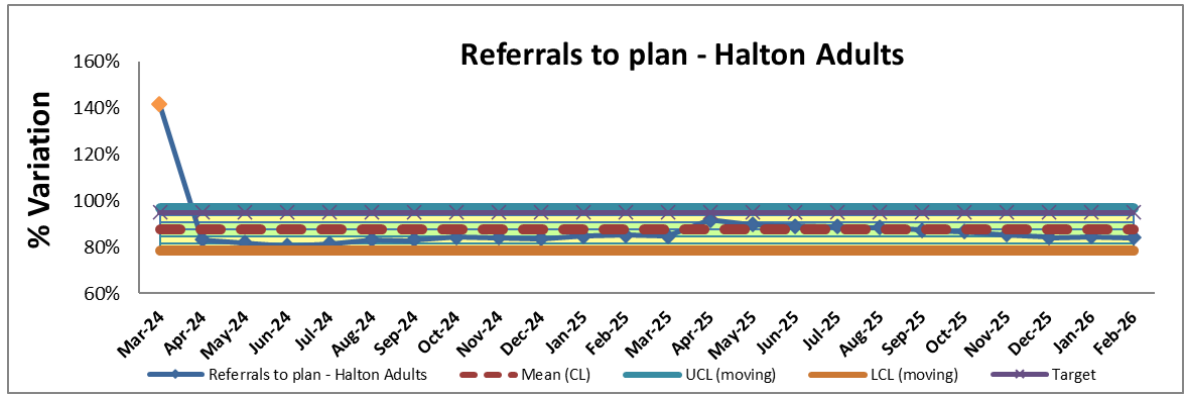


Operations: Exception Reporting

Referrals to plan Local Target 95%





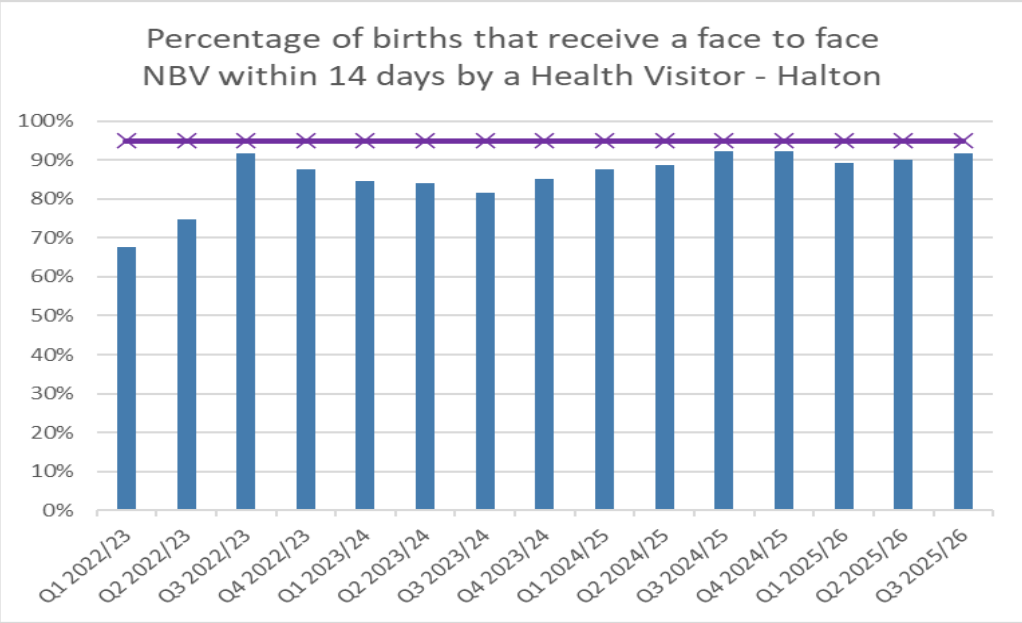


Analytical / Operational Narrative for Activity Variance and Referrals to Plan

The work to develop new Activity targets is almost complete. However some services require a more in depth review due to model and case mix changes.

The outputs are to be reviewed at Performance council prior to discussion at March planning meeting with ICB.

Operations: Exception Reporting



Analytical Narrative

The data has continuously been below the Trust target of 95% however has seen a slight increase during Quarter 3 2025/26.

Percentage of births that receive a face-to-face NBV within 14 days by a Health Visitor – Halton

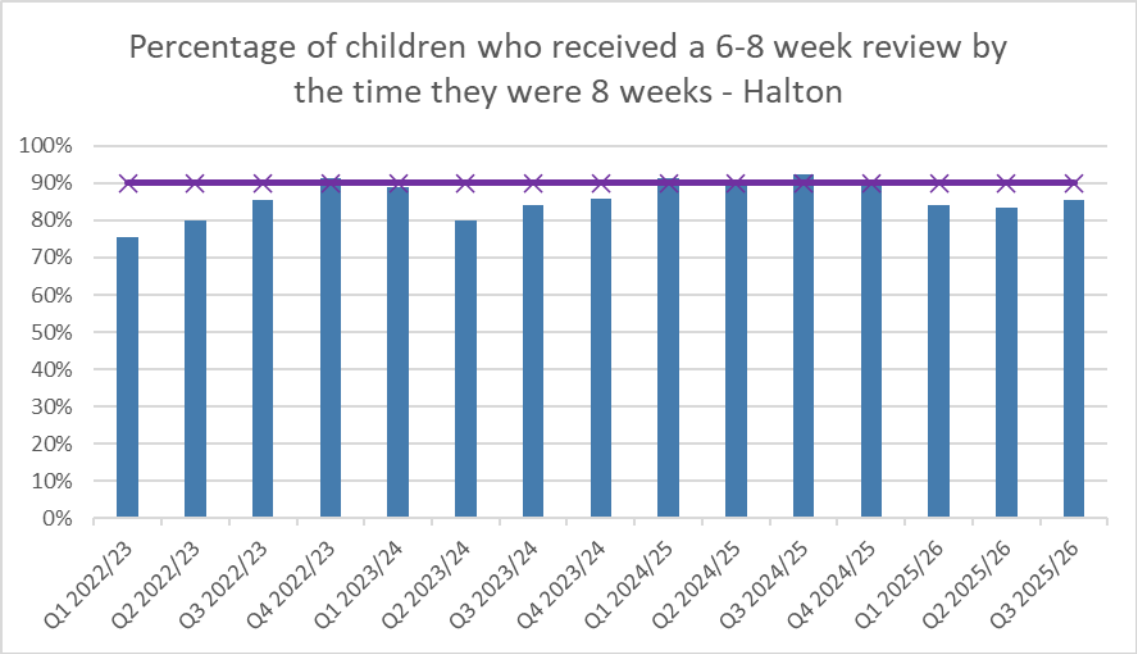
National Target: 95%
Local Commissioner Target 90% Quarter 3 Compliance – 91.67%

Operational Narratives

The service monitors all New Birth Visits that take place outside of the day 14 timescale. During quarter 3 the majority of contacts that didn't meet the 14-day target for this indicator were due to infants being in hospital neo natal units or where no access visits occurred.
Very occasionally visits are unable to take place as planned due to staff sickness however these numbers are low

The local authority commissioner has lowered this target locally to 90% which has been in place in Halton for over 4 years.

Operations: Exception Reporting



Analytical Narrative

The data shows team performance met the required target in 2024/25, however, has been below target during Q1/Q2 and Q3 2025/26.

Percentage of children who received a 6–8-week review by the time they were 8 weeks – Halton

National Target: 90% Quarter 3 Compliance – 85.50%

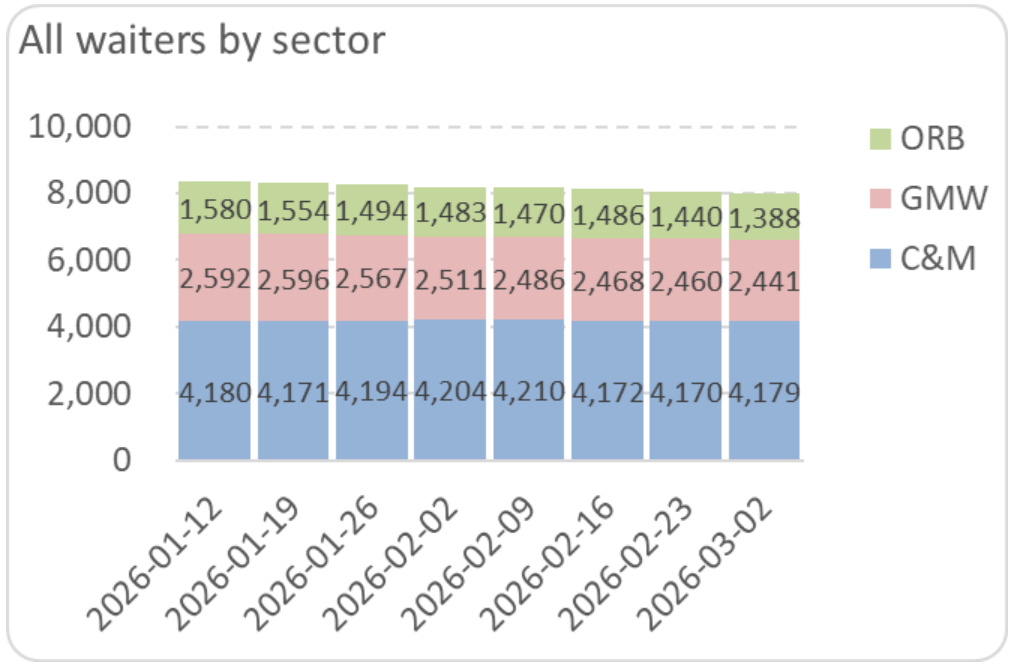
Operational Narrative

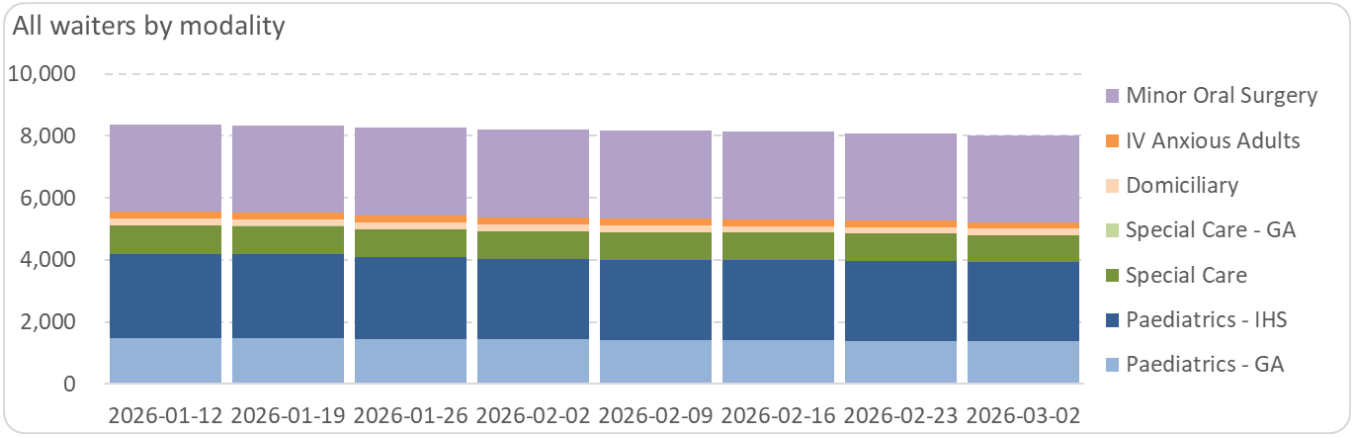
New Birth and 6–8-week contacts are now reported via CSDS which has new parameters which has affected compliance figures since Q1. The team have been working with BI to ensure robust recording and reporting of activity.

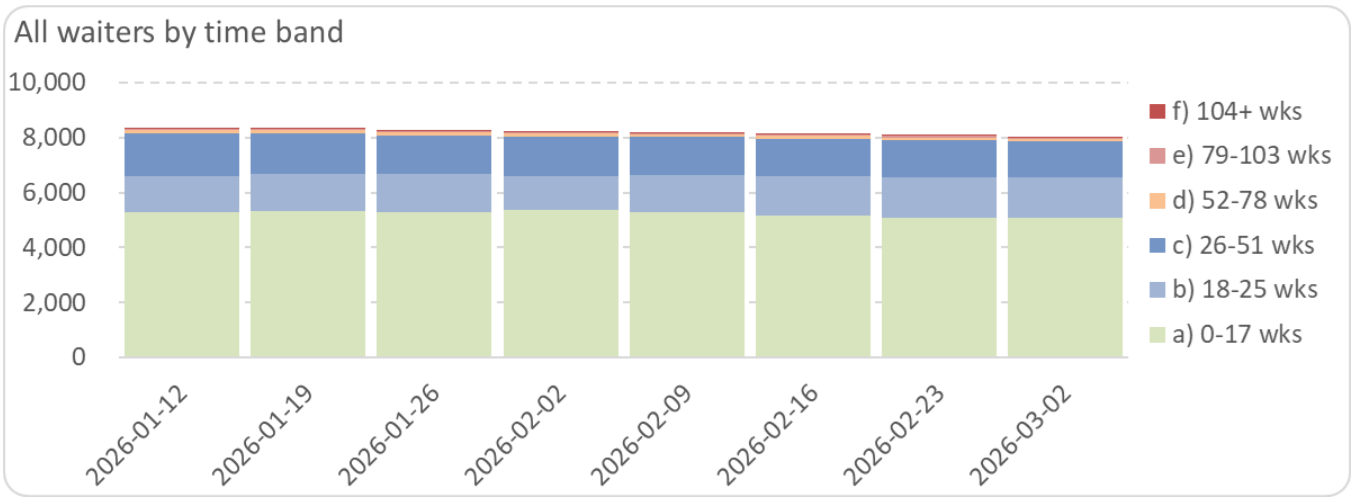
The team also exception report all contacts that take place outside of the required timeframes. In Q3 the majority of visits not completed by 8 weeks of age related to Infants being in Neonatal unit, parents requesting their appointment be reschedule/No Access visit and families moving into the area

Operations: Exception Reporting

Dental – Waiters by Sector / Time band / Modality







Operations: Exception Reporting

Dental – All Waiters by time band (includes assessment and treatment waits)

Snapshot date	a) 0-17 wks	b) 18-25 wks	c) 26-51 wks	d) 52-78 wks	e) 79-103 wks	f) 104+ wks
2026-01-12	5293	1321	1558	116	51	13
2026-01-19	5316	1365	1476	106	52	6
2026-01-26	5305	1381	1403	107	51	8
2026-02-02	5368	1245	1428	102	48	7
2026-02-09	5305	1320	1397	87	51	6
2026-02-16	5175	1424	1373	86	61	7
2026-02-23	5088	1469	1370	75	61	7
2026-03-02	5098	1457	1324	64	58	7

Analytical / Data Quality Narrative

The numbers of waiters within each time band has remained mainly consistent, although a slight increase in patients waiting 0-17 weeks and a slight decrease in 18-25 weeks, decrease in 26-51 weeks, weeks 52-78 and above have also decreased since last month.

The Performance Team is currently visualising this data using SPCs. The high number of waiters over 104 weeks relates to Neurodiverse Paediatric GA patients in Greater Manchester, where theatre capacity continues to be prioritised based on clinical need. GM patient numbers continued to fall in February, C&M patient numbers have shown an increase in volume.

Dental services are making diary adjustments, ensuring full visibility of clinicians full working hours to accurately determine capacity and generate efficiencies. This work is improving data collection through enhanced electronic reporting of capacity and diary utilisation. We are confident that Dentally waiting lists are now accurate, as confirmed by the BI Team using data from the data warehouse and confirmed on Qlik.

All measures required to support the ongoing reduction of long waiters are in place across both sectors.

Operations: Exception Reporting

Dental – Waiters by Sector / Time band / Modality
Cheshire & Mersey Operational Narrative

Over 65 week waits - Cheshire & Mersey have 0 patients over 65 weeks.
Waiters are targeted via opt ins, earliest possible assessment appointments and a minimum wait for treatment. but this remains challenging.
Minor Oral Surgery. (MOS) creates the most pressure and absence/annual leave and maternity leave has led to delays due to a reduction in capacity. Halton and St Helens has the largest volume of waiters and daily waitlist 'huddles' in place with key staff to manage flow.
We currently have **no waiters** over 52 weeks across all pathways-
Structured 'golden' appointments also now in place across all sites to ensure all contracts are being delivered equally and we are working to achieve KPIs. Special attention given to Special care new patients and children .The following actions are contributing to performance improvement:

- Performance data contributes to weekly waitlist management meetings with HOS, DNTM and DNTL reps. This includes scrutinising discharges/cancellations/DNAs and prioritising patient lists to target/apply resources in key areas.
- Weekly waitlist reviews identify pressure points and give each site /pathway specific targets.- DAILY for MOS in Halton/St Helens
- Weekly booking efficiency meetings assist managing patient flow and maximising activity proving successful- target is 0 gaps for week ahead each Friday.
- Operational flexibility enabled allowing targeting of areas where demand is high/staff booking at alternative sites to reduce waits and aim to fulfil KPIs
- Receptionists now tasked with moving patients back and slotting in high waiters (who may have experienced cancellations) to reduce risk of breaches.- fortnightly meetings in place to maintain vigilance.
- Reviews of admin time for dentists, long treatment plans with multiple appointments in place, length of appointment times all in focus.
- Consistent communication from HOS and Clinical Lead about maximising clinical time- and reducing additional time out of diaries for clinicians for meetings/training etc without express permission- data is emerging to evidence this via auditing diaries.
- Agile working by all staff means we deliver capacity where it is needed- i.e. moving staff this month to Halton and St Helens MOS clinics (the biggest volume of patient referrals) as Warrington/Sandbach are managing their waiters effectively currently. CDS staff are proving flexible – Chester is our emerging concern with staff leaving/retiring but we ae planning for this now.

Operations: Exception Reporting

Dental – Waiters by Sector / Time band / Modality

Greater Manchester Operational Narrative

Over 65 week waits - Greater Manchester (GM) had 87 patients waiting over 65 weeks. This has decreased by 2 since last month due to GA theatre capacity and urgent referrals being given priority over high waiters. We continue to experience challenges with our theatre access for children with additional needs with very limited capacity which has led to 7 children experiencing waits in excess of 104 weeks which has not changed since last month.

RBH list for children that are neuro diverse, we only have 6 patients every 6 weeks, and the highest waiters are for this hospital with the highest waiter being at 125 weeks in Feb. This is risk of 12 on the risk register. We are have completed a paper exercise to move patients from RBH list to other lists in GM that have more capacity. We still have 178 patients on this list, this has decreased by 23 since last month, this will take about 29 weeks to see all patients, we have 67 on this list over 65 weeks unless we can secure more theatres in C&M (WHH) or other. There are 139 patients over 52 weeks waiting for GA.

Managers book assessments in order of receiving referral or clinical priority. Now booking in assessments from 25 weeks to ensure 1st treatment by 31 weeks.

The following actions are contributing to performance improvement:

- High waiters in GM are being offered other clinics with more capacity if patients are happy to travel.
- CD has completed validation of GA patients and reviewing open treatments plans, reducing each month
- Assessments are to be booked at 25 weeks in all clinics for assessments, to ensure all treatments completed by 52 weeks. Not always possible due to appointments available. The aim is to reduce to 18 weeks for assessments. Monthly calls with Managers including Clinical director and BI team to go through high waiters, cancellations, discharge and to discuss any issues with reports.
- Following acceptance and discharge criteria to reduce waiting lists from 65 weeks to 35 weeks is proving successful. The total volume on waiting list is reducing in GM since previous months, due to more efficient booking and data quality issues completed in GM. End of Feb GM waiters was 3994 Feb 2026
- Reviewing admin time, time out of clinics, multiple appointments, meetings, triage and open courses of treatments, sickness etc to increase capacity.
- N&E have a lot of open treatment plans with multiple appointments; therefore, they have high waiters due to appointment availability.
- Sickness is increasing in GM which results in patients being cancelled and has a big impact on high waiters.
- Decrease in patients waiting in GM ORB and a decrease in patients in W&S. Decreased in GM as whole from over 5171 Feb 2025

Quality

Executive Summary

There are 9 Quality indicators reporting as red and 22 green indicators in February 2026.

The 9 indicators which were red in February are as follows:

- % of incidents causing moderate harm (Score 3) – Deterioration in Month
- % of incidents causing severe/fatal harm (Score 4-5) – Deterioration in Month
- DOC (Duty of Candour) for moderate harms and above 10-day compliance – Deterioration in Month
- Information Governance Training – Deterioration in Month
- Percentage of BCHFT risks identified as 12 or above – Deterioration in Month
- BCHFT patient safety Falls per 1,000 bed days - bed based – Deterioration in Month
- % of Category 4 Pressure Ulcers acquired in Bridgewater – Deterioration in Month
- % of Cat 3 Pressure Ulcers acquired in Bridgewater – Deterioration in Month
- IPC assurance audit compliance – Improvement in Month

Quality: Exception Reporting

Trust Scorecard

Quality													
KPI Name	Target	Trend Line	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Number of Never Events	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
% Incidents reported within 48 hrs of discovering an incident has occurred	87%		90.99% (▼)	85.12% (▼)	84.71% (▼)	85.98% (▲)	82.08% (▼)	87.22% (▲)	87.07% (▼)	89.47% (▲)	88.15% (▼)	85.97% (▼)	85.15% (▼)	89.18% (▲)	94.2% (▲)
% of incidents causing moderate harm (Score 3)	1%		0% (▲)	0.83% (▼)	2.55% (▼)	1.22% (▲)	5.78% (▼)	2.78% (▲)	4.76% (▼)	2.34% (▲)	3.33% (▼)	2.88% (▲)	2.97% (▼)	2.24% (▲)	2.9% (▼)
% of incidents causing severe/fatal harm (Score 4-5)	0%		0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0.37% (▼)	0% (▲)	0% (►)	0% (►)	0.97% (▼)
Patient Safety Incident Investigations compliance submitted within 90 days	90%		100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)
DOC (Duty of Candour) for moderate harms and above 10-day compliance	100%		100% (►)	100% (►)	100% (►)	100% (►)	0% (▼)	75% (▲)	66.67% (▼)	100% (▲)	30% (▼)	72.73% (▲)	85.71% (▲)	100% (▲)	50% (▼)
% of BCHFT patient safety incidents that are medication incidents	7%		9.73% (▼)	5% (▲)	6.37% (▼)	8.54% (▼)	5.78% (▲)	3.33% (▲)	4.08% (▼)	5.85% (▼)	4.81% (▲)	7.55% (▼)	5.45% (▲)	7.46% (▼)	5.31% (▲)
% of Patient safety medication incidents causing moderate harm (Score 3)	0%		0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)
% of Patient safety medication incidents causing severe/fatal harm (Score 4-5)	0%		0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)
Information Governance Training	95%		94.87% (▲)	95.44% (▲)	95.55% (▲)	95.43% (▼)	94.57% (▼)	93.69% (▼)	92.95% (▼)	92.97% (▲)	93.32% (▲)	94.52% (▲)	95.13% (▲)	94.25% (▼)	93.59% (▼)
Safeguarding Childrens Level 1	95%		98.05% (▼)	98.29% (▲)	98.19% (▼)	98.19% (▲)	98.19% (▲)	98.25% (▲)	98.16% (▼)	98.08% (▼)	98.3% (▲)	98.56% (▲)	98.26% (▼)	98.02% (▼)	97.73% (▼)
Safeguarding Childrens Level 2	95%		98.47% (▼)	98.89% (▲)	98.61% (▼)	98.27% (▼)	97.92% (▼)	97.74% (▼)	96.75% (▼)	97.52% (▲)	97.8% (▲)	97.68% (▼)	97.04% (▼)	97.36% (▲)	96.16% (▼)
Safeguarding Childrens Level 3	95%		98.64% (▼)	98.99% (▲)	99.66% (▲)	99.66% (▲)	98.97% (▼)	98.97% (▼)	98.59% (▼)	98.85% (▲)	100% (▲)	98.88% (▼)	99.25% (▲)	97.04% (▼)	96.7% (▼)
Safeguarding Adults Level 1	95%		97.88% (▼)	98.43% (▲)	98.21% (▼)	98.15% (▼)	98.28% (▲)	98.14% (▼)	97.84% (▼)	97.9% (▲)	98.26% (▲)	98.36% (▲)	98.34% (▼)	98.03% (▼)	97.51% (▼)
Safeguarding Adults Level 2	95%		98.88% (▼)	99.05% (▲)	99.04% (▼)	98.87% (▼)	99.04% (▲)	98.77% (▼)	97.18% (▼)	97.32% (▲)	97.43% (▲)	97.48% (▲)	97.26% (▼)	97.05% (▼)	96.48% (▼)
Safeguarding Adults Level 3	95%		97.64% (▼)	99.22% (▲)	99.48% (▲)	98.96% (▼)	98.16% (▼)	97.66% (▼)	96.04% (▼)	96.99% (▲)	97.57% (▲)	98.65% (▲)	99.18% (▲)	97.87% (▼)	97.04% (▼)
% of BCHFT risks managed in line with policy ie risks with in date reviews	92%		83.23% (▼)	100% (▲)	96.23% (▼)	96.15% (▼)	83.44% (▼)	85.06% (▲)	100% (▲)	88.05% (▼)	96.62% (▲)	93.75% (▼)	91.72% (▼)	97.1% (▲)	95.42% (▼)
Percentage of BCHFT risks identified as 12 or above	11%		15.57% (▼)	12.1% (▲)	9.43% (▲)	9.62% (▼)	9.27% (▲)	8.44% (▲)	9.38% (▼)	11.32% (▼)	8.11% (▲)	12.5% (▼)	15.17% (▼)	15.22% (▼)	16.34% (▼)

Quality: Exception Reporting

Trust Scorecard

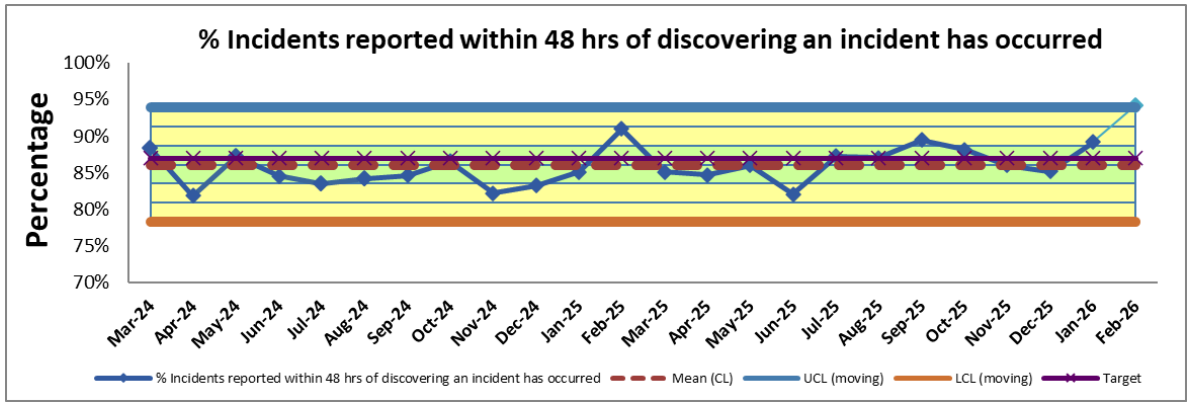
Quality														
KPI Name	**Target**	**Trend Line**	**Feb-25**	**Mar-25**	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**
% of BCHFT patient safety falls identified as serious	0%		0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)
BCHFT patient safety Falls per 1,000 bed days - bed based	8		12.79 (▲)	12.83 (▼)	12.01 (▲)	5.2 (▲)	10.7 (▼)	14.57 (▼)	8.91 (▲)	3.35 (▲)	5.98 (▼)	11.83 (▼)	1.02 (▲)	4.25 (▼)	9.06 (▼)
Total number of BCHFT acquired pressure ulcers	15		14 (▲)	23 (▼)	21 (▲)	25 (▼)	26 (▼)	21 (▲)	35 (▼)	29 (▲)	40 (▼)	29 (▲)	16 (▲)	12 (▲)	15 (▼)
% of Category 4 Pressure Ulcers acquired in Bridgewater	0%		0% (►)	0% (►)	0% (►)	0% (►)	3.85% (▼)	0% (▲)	2.86% (▼)	6.9% (▼)	0% (▲)	3.45% (▼)	6.25% (▼)	0% (▲)	13.33% (▼)
% of Cat 3 Pressure Ulcers acquired in Bridgewater	3%		14.29% (▼)	13.04% (▲)	23.81% (▼)	8% (▲)	26.92% (▼)	28.57% (▼)	17.14% (▲)	6.9% (▲)	17.5% (▼)	20.69% (▼)	18.75% (▲)	25% (▼)	33.33% (▼)
MRSA - Total Number of outbreaks (Community)	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
C.Diff - Total Number of outbreaks (Community)	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
E Coli- Total Number of outbreaks (Community)	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
Bacteraemia - Total Number of outbreaks	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
Complaints that are managed within the policy timelines	100%		100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)
National Patient Safety Alerts opened and managed in line with policy timescales	100%		100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)
% of all policies within review date	90%		95.56% (▼)	96.67% (▲)	97.41% (▲)	98.89% (▲)	97.75% (▼)	97.05% (▼)	96.01% (▼)	96.74% (▲)	98.18% (▲)	97.03% (▼)	95.56% (▼)	94.83% (▼)	95.9% (▲)
IPC assurance audit compliance	90%		82% (▼)	83% (▲)	79% (▼)	73.2% (▼)	84.2% (▲)	89% (▲)	89.6% (▲)	90.8% (▲)	86.2% (▼)	90% (▲)	91.2% (▲)	84.8% (▼)	86.4% (▲)
Record keeping Audit completion compliance	90%			100% (►)			100% (►)			100% (►)			100% (►)		
Overall CQC rating (Yearly)	Good												Requires Improvement(►)		
Assessment, diagnosis and treatment of lower leg wounds (CQUIN13)	50%		61.76% (▼)			93.94% (▲)									

Quality: Exception Reporting

Trust Scorecard

% Incidents reported within 48 hrs of discovering an incident has occurred		Points above upper control limit
% of incidents causing severe/fatal harm (Score 4-5)		Points above upper control limit
Safeguarding Childrens Level 1		Points below lower control limit
Safeguarding Childrens Level 3		Points below lower control limit
Safeguarding Adults Level 1		Points below lower control limit
% of Category 4 Pressure Ulcers acquired in Bridgewater		Points above upper control limit

Quality: Exception Reporting



KPI Name	Unit	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
% Incidents reported within 48 hrs of discovering an incident has occurred	Num	103	133	141	142	157	128	153	238	239	172	239	195
	Denom	121	157	164	173	180	147	171	270	278	202	268	207

Analytical Narrative

The compliance has increased over the past two months and is now outside of the control limits. We were seeing a mostly consistent trend of data points sitting close to the mean and fluctuating around the target. In the past six months, the target has been met four times and remains achievable.

% Incidents reported within 48 hrs of discovering an incident has occurred

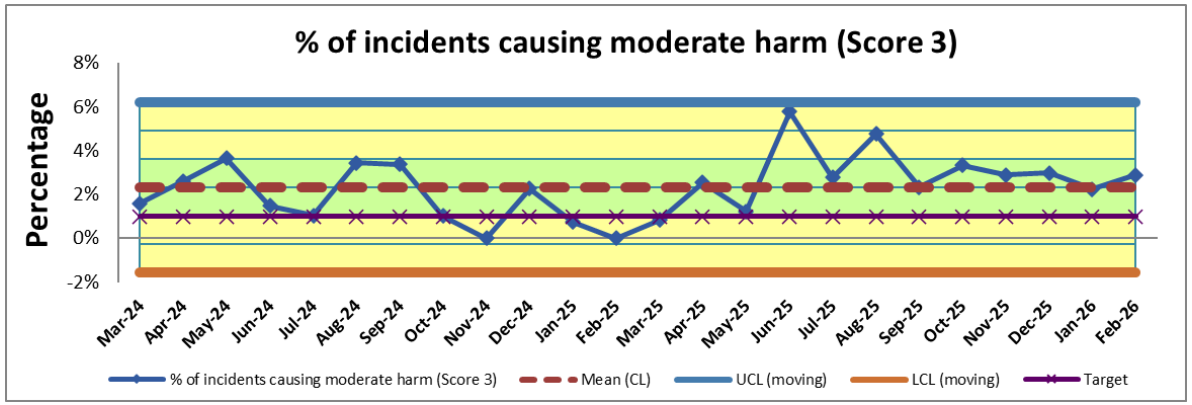
Target: 87% Compliance in February – 94.2%

Operational Narrative

The performance for this target in February 2026, increased to 94.2% compared to 89.18% in January 2026, both of which are in excess of the target which is 87%. This is an indicator of improved & prompt reporting of incidents in the Trust.

The need to report incidents promptly will remain a key element of the Trust's risk management arrangements.

Quality: Exception Reporting



KPI Name	Unit	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
% of incidents causing	Num	1	4	2	10	5	7	4	9	8	6	6	6
moderate harm (Score 3)	Denom	120	157	164	173	180	147	171	270	278	202	268	207

Analytical Narrative

The past nine months has seen a spike of moderate harm incidents with the data sitting above the mean and the target. We often see fluctuations around the mean with incidents being reviewed and regraded. The target sits within limits and is achievable.

% of incidents causing moderate harm (Score 3)

Target: 1% Compliance in February – 2.90%

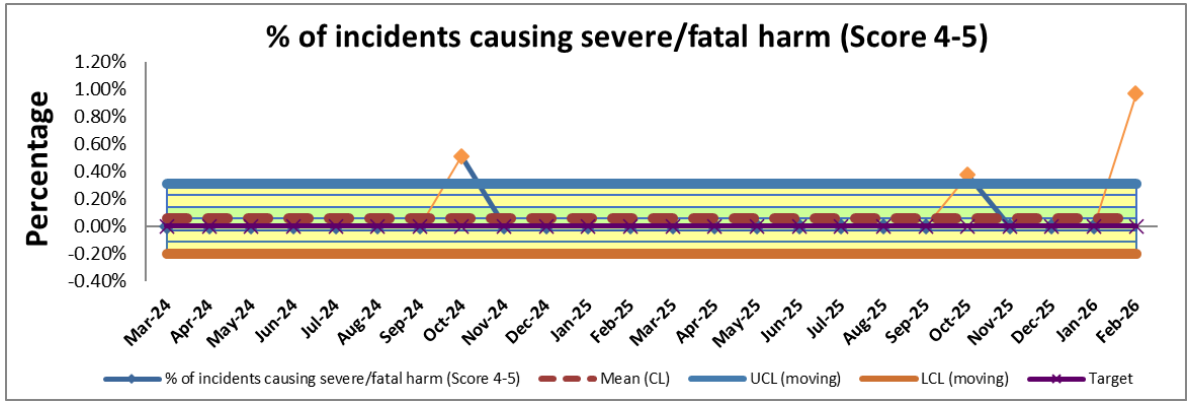
Operational Narrative

The performance for this indicator remained above target for the last nine data points, however for the last 5 data points it remained slightly in excess of the mean level of reporting for this indicator, with minimal variation.

All of the moderate harms reported in February 2026 were pressure ulcers, there were 5 category 3 and 1 category 4 pressure ulcer(s). One of the category 3 pressure ulcers was considered to be related to a medical device.

All moderate harm incidents are reviewed at the Directorate Incident Review and Learning Group meetings with monitoring of outcomes and learning at Patient Safety Incident Review Framework and Learning Panel.

Quality: Exception Reporting



KPI Name	Unit	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
% of incidents causing	Num	0	0	0	0	0	0	0	1	0	0	0	2
severe/fatal harm (Score 4-5)	Denom	120	157	164	173	180	147	171	270	278	202	268	207

Analytical Narrative

The data has breached control limits twice in the past five months. We often see fluctuations with incidents being reviewed and regraded. The target sits within limits and is achievable.

% of incidents causing severe/fatal harm (Score 4-5)

Target: 1% Compliance in February – 0.97%

Operational Narrative

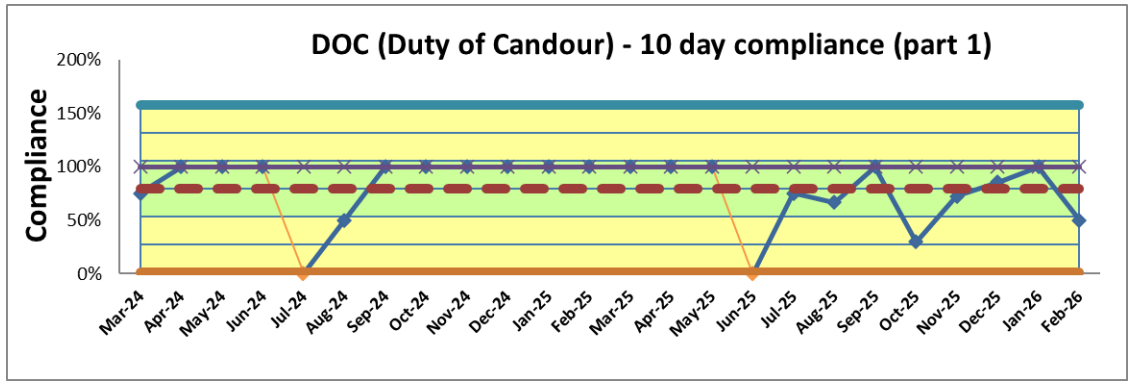
The performance for this indicator was 0.97% in February 2026, compared to 0% in January 2026.

One incident relates to a patient who became unwell while being visited by a therapist, during which the patient became unresponsive. This patient required CPR and hospitalisation. The case has been reviewed and downgraded to a low harm.

The second incident relates to a patient who had missed a number of treatment room appointments despite staff offering appointments and home visits. Due to safeguarding concerns the Team Lead visited the patient at home and identified a category 4 pressure ulcer. The patient required hospitalisation. This is subject to an after-action review, although the initial view was that this incident met the criteria for severe harm.

Corrected compliance for February – 0.48%

Quality: Exception Reporting



KPI Name	Unit	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
DOC (Duty of Candour) - 10 day compliance (part 1)	Num	1	1	1	0	6	6	6	6	8	6	5	4
	Denom	1	1	1	4	8	9	6	20	11	7	5	8

Analytical Narrative

We are seeing an inconsistent trend due to the low numbers of incidents. The target remains within control limits and is achievable.

DOC (Duty of Candour) - 10-day compliance (part 1)
Target: 100% Compliance in February – 50%

Operational Narrative

During February 2026, there were 8 incidents that required part 1 Duty of Candour. In four cases this was completed within the Trust's 10-day threshold.

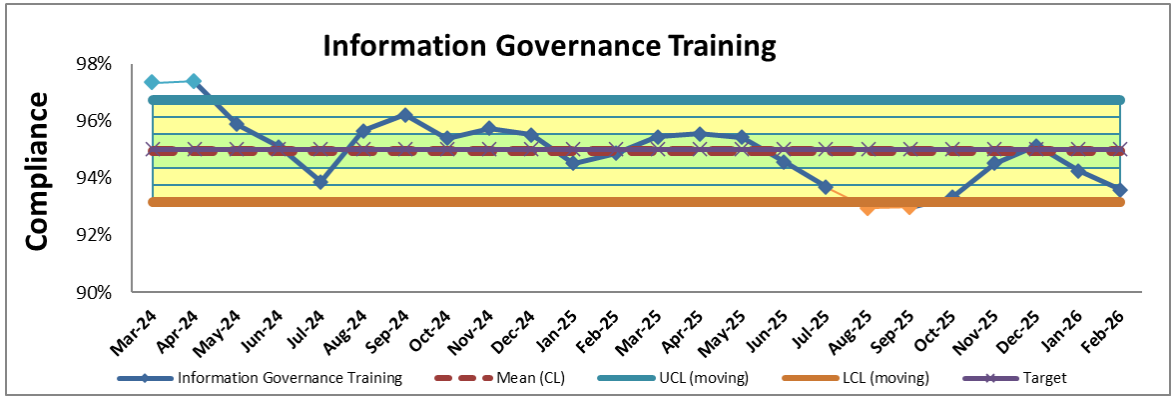
After review the harm level was downgraded for two cases, and duty of candour was not required. The remain two cases, which were non-compliant at day 10, have since been completed.

Future data will be refreshed to reflect the subsequent downgrading of these incidents.

The correct application and recording of duty of candour is included within incident training. Compliance is reviewed at Directorate Incident Review and Learning Group meetings with monitoring of outcomes and learning at Patient Safety Incident Review Framework and Learning Panel.

Corrected compliance for February- 67%

Quality: Exception Reporting



KPI Name	Unit	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Information Governance Training	Num	1486	1460	1461	1445	1426	1397	1349	1356	1346	1328	1345	1328
	Denom	1557	1528	1531	1528	1522	1503	1451	1453	1424	1396	1427	1419

Analytical Narrative

The trend of data points remains within control limits yet remains below the target, after an increase in compliance.
The target remains close to the mean, within control limits and is achievable.

Information Governance Training

National Target: 95% February Compliance – 93.59%

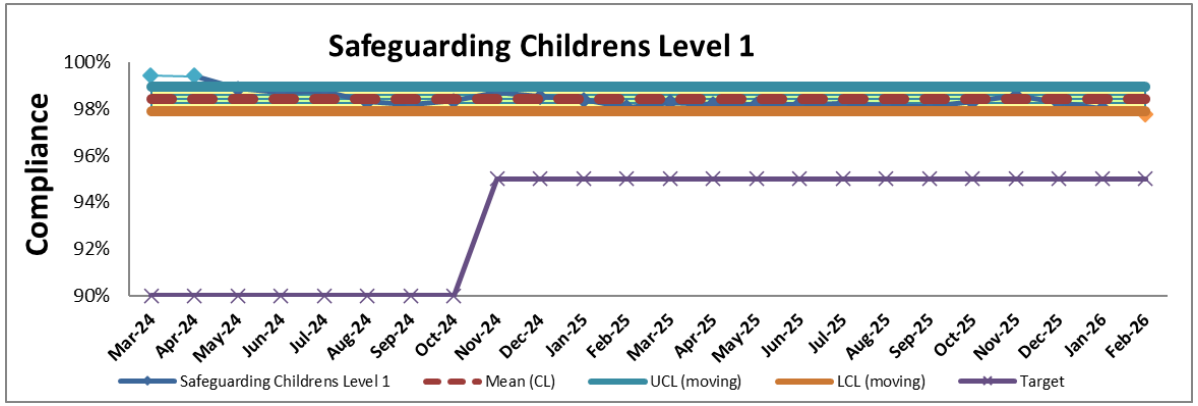
Operational Narrative

Whilst target compliance was reached in December 2025, the compliance has continued to fall in January and February 2026.

Targeted work will be undertaken within the Directorate Leadership Teams; to support sustained improvements in compliance.

This will be monitored at Performance Council.

Quality: Exception Reporting



KPI Name	Unit	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Safeguarding Childrens	Num	1494	1464	1467	1468	1459	1437	1381	1391	1366	1358	1389	1377
Level 1	Denom	1520	1491	1494	1495	1485	1464	1408	1415	1386	1382	1417	1409

Analytical Narrative

The data is outside the lower control limit after 3 months of deterioration. The target remains below the control limits and is achievable.

Safeguarding Children Level 1

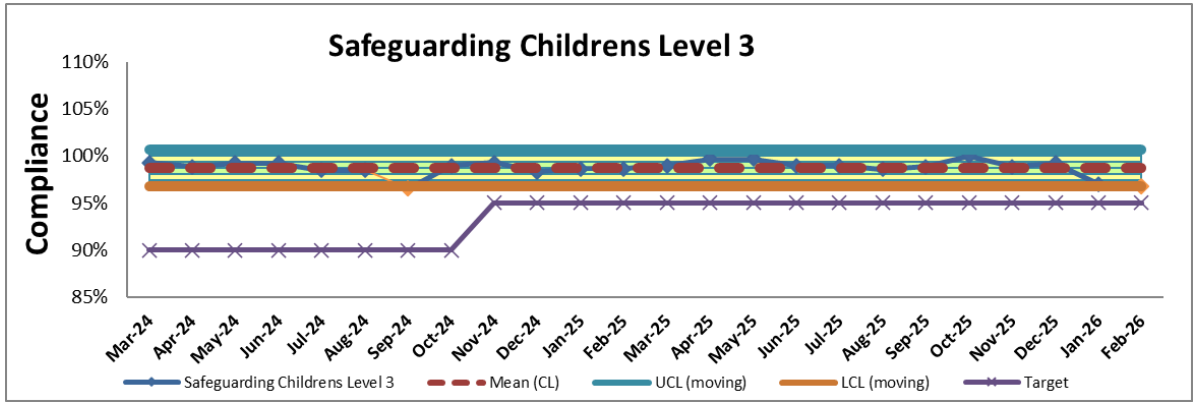
Local Target: 95% February Compliance – 97.73%

Operational Narrative

Compliance rates for level 1 safeguarding children training continue to remain above both the 95% local target and the 90% target set by Cheshire and Merseyside ICB within the quality schedule.

The Safeguarding team continue to identify and contact relevant staff members to request training is prioritised for completion and to identify and address any anomalies impacting on compliance.

Quality: Exception Reporting



KPI Name	Unit	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Safeguarding Childrens	Num	294	290	292	289	287	280	258	262	264	266	262	264
Level 3	Denom	297	291	293	292	290	284	261	262	267	268	270	273

Analytical Narrative

The data is outside the lower control limit after 3 months of deterioration. The target remains below the control limits and is achievable.

Safeguarding Children Level 3

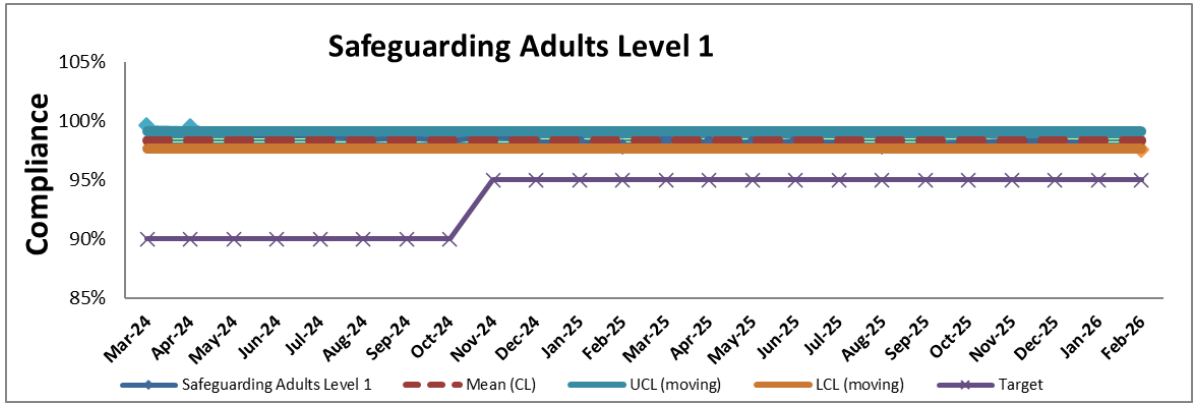
Local Target: 95% February Compliance - 96.70%

Operational Narrative

Level 3 safeguarding children training compliance rates, continue to remain above both the 95% local target and the 90% target set by Cheshire and Merseyside ICB within the quality schedule.

The Safeguarding team continue to identify and contact relevant staff members to request training is prioritised for completion and to identify and address any anomalies impacting on compliance

Quality: Exception Reporting



KPI Name	Unit	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Safeguarding Adults Level 1	Num	1508	1485	1486	1485	1474	1450	1397	1408	1382	1362	1390	1372
	Denom	1532	1512	1514	1511	1502	1482	1427	1433	1405	1385	1418	1407

Analytical Narrative

The data is outside the lower control limit after 3 months of deterioration. The target remains below the control limits and is achievable.

Safeguarding Adults Level 1

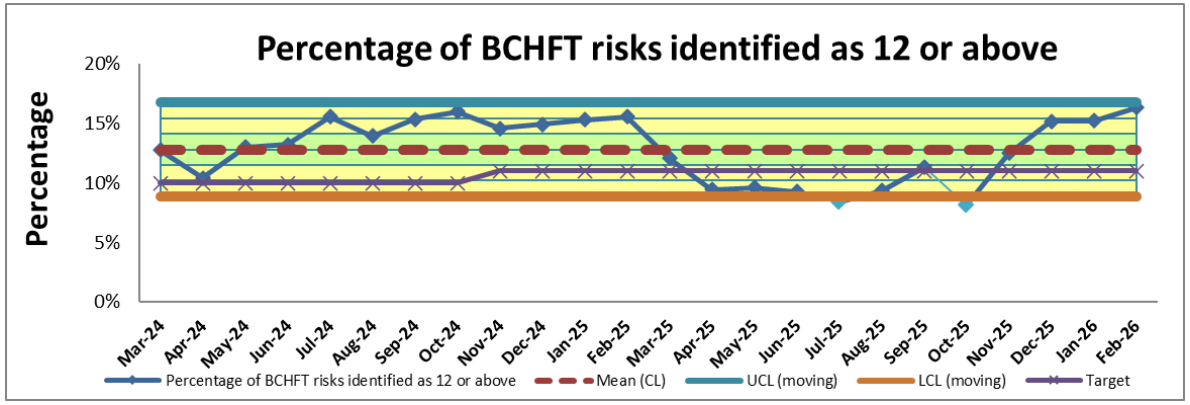
Local Target: 95% February Compliance – 97.51%

Operational Narrative

Positive compliance rates for level 1 safeguarding adults training figures that are not only above our local target of 95%, but also exceed the 90% benchmark set by Cheshire and Merseyside ICB as outlined in the quality schedule.

The Safeguarding team continue to identify and contact relevant staff members to request training is prioritised for completion and to identify and address any anomalies impacting on compliance.

Quality: Exception Reporting



KPI Name	Unit	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Percentage of BCHFT risks identified as 12 or above	Num	19	15	15	14	13	15	18	12	18	22	21	25
	Denom	157	159	156	151	154	160	159	148	144	145	138	153

Analytical Narrative

The data remains above target yet within control limits. The past four months has seen an increase. The target remains within control limits and is achievable.

Percentage of BCHFT risks identified as 12 or above

Local Target: 11%

Compliance in February - 16.34%

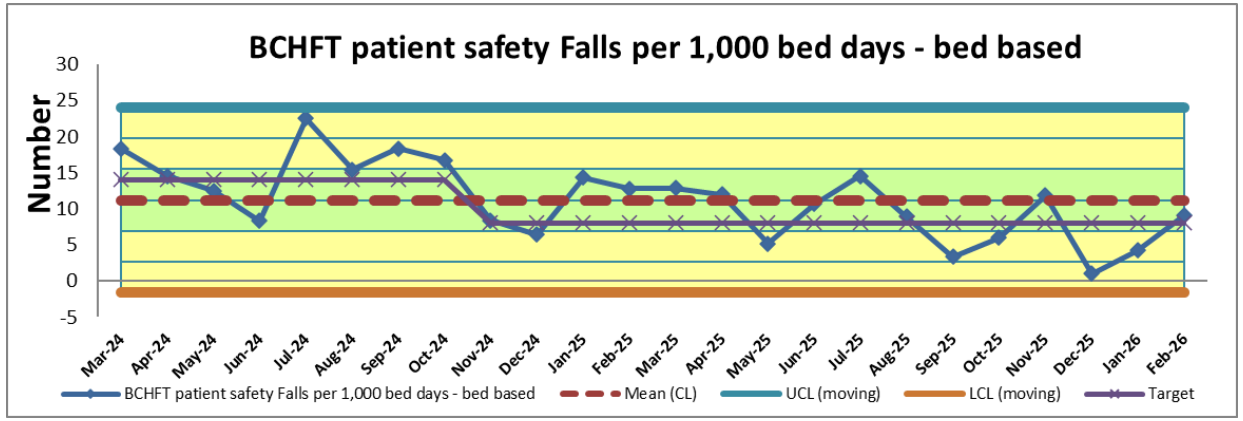
Operational Narrative

The compliance for February 2026, was 16.34% against a target of 11%. This was the third consecutive data point which exceeded the mean level of reporting for this indicator; however performance remains within the upper control limit. This performance shows a minor increase of 1.13%, compared to January 2026, when the performance was 15.21%.

The highest numbers of risks, which score 12 or higher, continue to be in Dermatology and Community Equipment Stores, each have 4 risks scoring 12 or above.

The Trust continues to monitor progress of risks and take assurance regarding the scoring of its risks from the risk review process that is carried out at Risk Management Council.

Quality: Exception Reporting



KPI Name	Unit	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
BCHFT patient safety Falls per 1,000 bed days - bed based	Num	12	11	5	12	13	8	3	5	11	1	4	8
	Denom	935	916	961	1122	892	898	895	836	930	978	942	883

Analytical Narrative

There has been an inconsistent trend with data points either side of the target, with the recent performance remaining below the mean. However, the data points and target remain within control limits.

BCHFT patient safety Falls per 1,000 bed days - bed based

Local Target: 8

February Compliance – 9.06

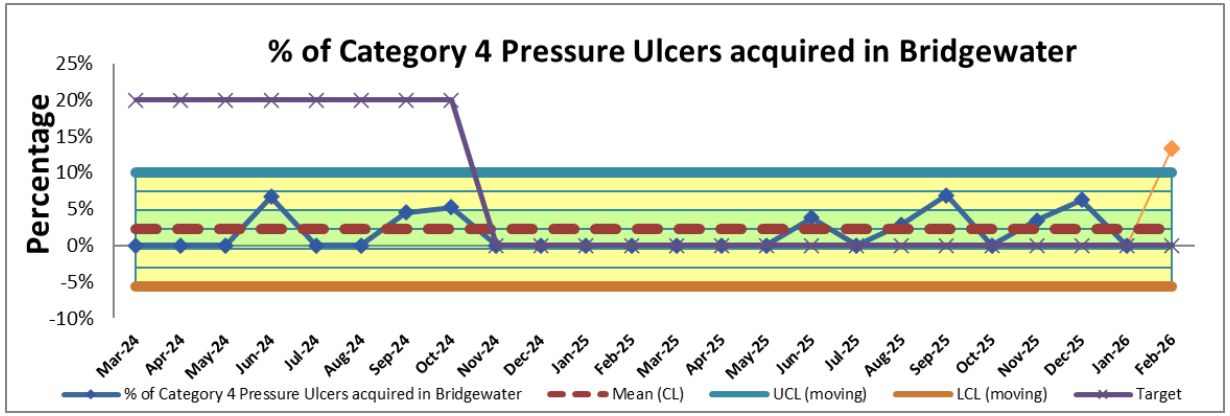
Operational Narrative

Of the 8 falls reported: 7 were unwitnessed and 1 witnessed. All falls resulted in either no harm or low harm, there was no moderate or severe harm reported.

Reviews undertaken within the Directorate Incident Review and Learning Group identified that all proactive and preventative measures were in place and that the falls were preceded by patients attempting to mobilise independently.

The Falls Priority Group continues to drive proactive assessment and prevention and are testing the use of a carer insight into a fall checklist.

Quality: Exception Reporting



KPI Name	Unit	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
% of Category 4 Pressure Ulcers acquired in Bridgewater	Num	0	0	0	1	0	1	2	0	1	1	0	2
	Denom	23	21	25	26	21	35	29	40	29	16	12	15

Analytical Narrative

We expect to see an inconsistent trend due to the low numbers of category 4 pressure ulcers reported. Pressure Ulcer incidents can also be regraded once reviewed. The target remains within control limits and is achievable.

% of Category 4 Pressure Ulcers acquired in Bridgewater

Local Target: 0%

Compliance in February – 13.33%

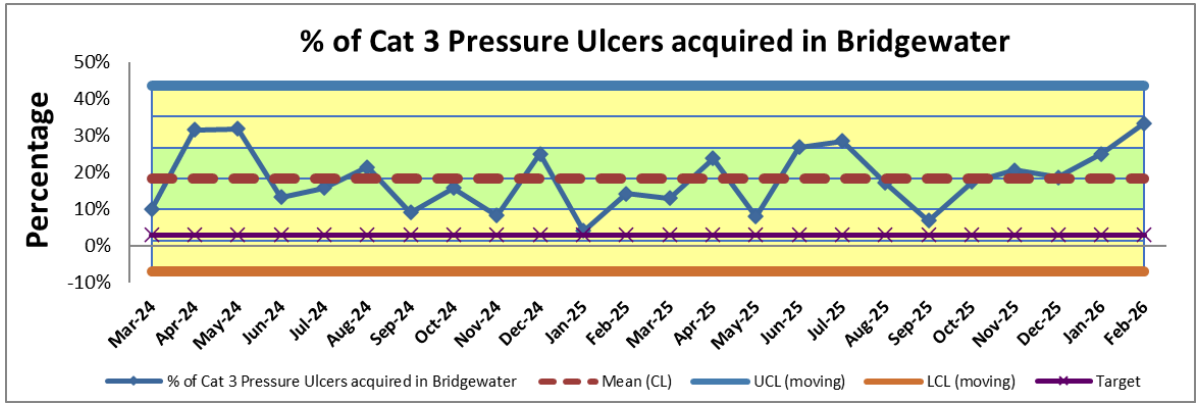
Operational Narrative:

INCIDENT NUMBERS: 74280 73982

The first incident relates to a patient who has complex health needs, requiring regular Tissue Viability Nurse monitoring and support. Despite all interventions the patient's ulcer deteriorated from a category 3 to a category 4 pressure ulcer.

The second incident relates to a patient who had not attended treatment room appointments. Despite all interventions and efforts, with treatment room staff visiting him at home, the patient had developed a category 4 pressure ulcer. An after action review is being completed to identify any additional learning.

Quality: Exception Reporting



KPI Name	Unit	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
% of Cat 3 Pressure Ulcers acquired in Bridgewater	Num	3	5	2	7	6	6	2	7	6	3	3	5
	Denom	23	21	25	26	21	35	29	40	29	16	12	15

Analytical Narrative

We are continuing to see an increasing trend which can be expected due to a reduction of pressure ulcers reported and the low numbers of category 3 pressure ulcers reported. Pressure Ulcer incidents can also be regraded once reviewed. All data points are within standard variation, as is the target.

% of Category 3 Pressure Ulcers acquired in Bridgewater

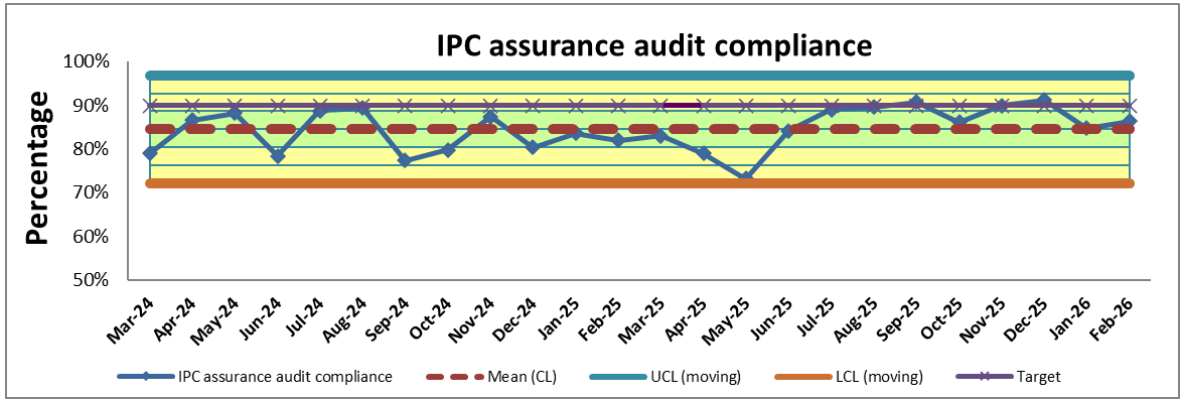
Local Target: 3% Compliance in February – 33.33%

Operational Narrative:

INCIDENT NUMBERS:74220 74179 74144 74004 (73931)
The inconsistent trend in category 3 pressure ulcer incidence remains within standard variation, although an increase in month. There was 1 incident in the Halton borough and 4 in the Warrington borough across different teams. 1 incident was recorded as a category 3, however this deteriorated to a category 4 pressure ulcer in month, which involved a medical device, which was reported as a separate incident.

All incidents have been reviewed through the Directorate Incident Review and Learning Group meetings. No new learning was identified, although quality improvement work continues to be progressed, led by the Pressure Ulcer Priority Group and monitored by Patient Safety Incident Review Framework and Learning Panel.

Quality: Exception Reporting



KPI Name	Unit	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
IPC assurance audit compliance	%	83.0%	79.0%	73.2%	84.2%	89.0%	89.6%	90.8%	86.2%	90.0%	91.2%	84.8%	86.4%

Analytical Narrative

All data points are within normal variation, yet the past eight months have seen the data above the mean and close to target, achieving the target twice in the past four months. The target sits within limits and is achievable.

IPC assurance audit compliance

Local Target: 90% February Compliance – 86.4%

Operational Narrative

Overall compliance saw a slight increase this month, with Halton adults and Halton children's dashboards showing progress. Although a small number of teams have not submitted any data, this has notably lowered compliance rates both within the directorates and overall.

The IPC team has collaborated with senior leaders in each Directorate to enhance internal processes aimed at boosting compliance, which will be monitored on a weekly basis and reported through Quality Council.

People

Executive Summary

Two out of four People indicators are shown as red in February 2026.

The two indicators which were red in February are as follows:

- Staff turnover (rolling) – Deterioration in Month
- Sickness absence rate (Actual) – Improvement in Month

People

Trust Scorecard

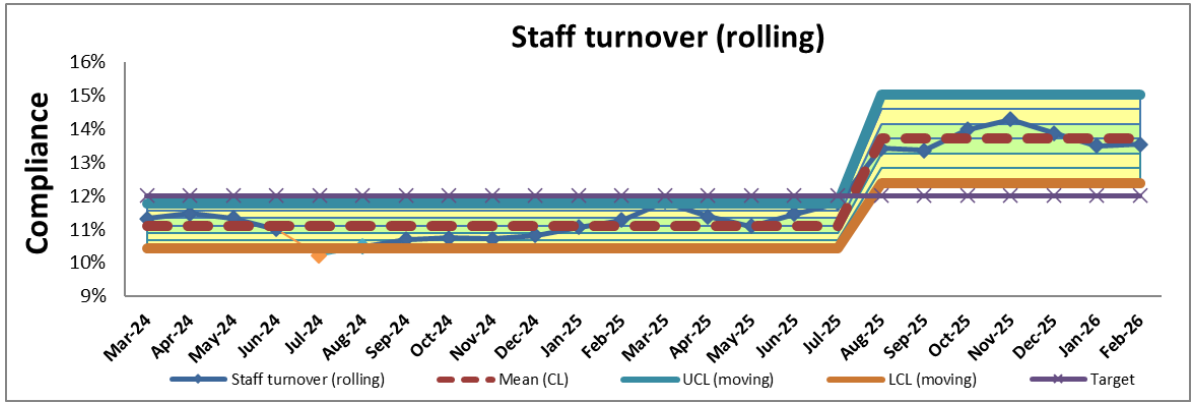
People														
KPI Name	Target	Trend Line	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Staff turnover (rolling)	12.00%		11.28% (▼)	11.83% (▼)	11.38% (▲)	11.1% (▲)	11.46% (▼)	11.79% (▼)	13.42% (▼)	13.35% (▲)	13.97% (▼)	14.28% (▼)	13.87% (▲)	13.49% (▲)	13.54% (▼)
Sickness absence rate (Actual)	5.50%		6.23% (▲)	6.33% (▼)	6.91% (▼)	6.57% (▲)	6.96% (▼)	7.27% (▼)	7.93% (▼)	8.15% (▼)	8.49% (▼)	8.15% (▲)	9.31% (▼)	8.69% (▲)	8.1% (▲)
% of staff with a current PDR	85.00%		87.91% (▲)	88.18% (▲)	87.43% (▼)	86.68% (▼)	85.14% (▼)	82.06% (▼)	83.23% (▲)	81.32% (▼)	83.34% (▲)	84.06% (▲)	83.17% (▼)	84.37% (▲)	85.48% (▲)
% Overall Mandatory Training Compliance	85.00%		96.11% (▲)	96.58% (▲)	96.97% (▲)	97.13% (▲)	96.69% (▼)	96.35% (▼)	96.14% (▼)	95.93% (▼)	95.81% (▼)	95.6% (▼)	94.95% (▼)	95% (▲)	94.16% (▼)

People

Trust Scorecard

% Overall Mandatory Training Compliance		Points below lower control limit

People: Exception Reporting



Analytical Narrative

We are now above target and outside of the control limit due to the School Aged Immunisation Teams TUPEing out of the Organisation in August 2025. We have reset the control limits this month to show the process change and we are now within control limits.

Staff turnover (rolling)

Local Target: 12%

February compliance – 13.54%.

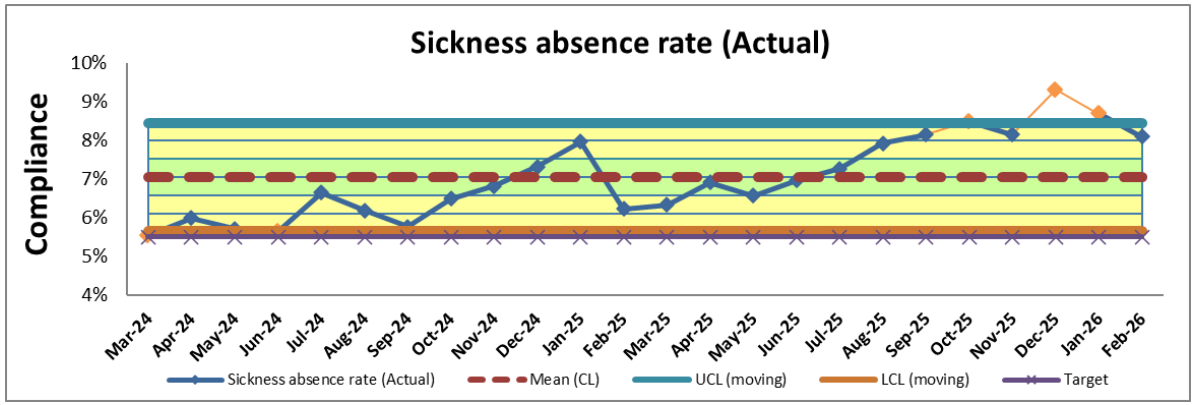
Operational Narrative

In August, the Warrington and Halton School Aged Immunisation teams TUPEd out of the organisation. This plus the target of headcount reduction across the organisation has contributed to the increase and exceeding the upper control limit.

The work of the People Operational Delivery Council (POD) continues to monitor the People data and make improvements where possible through the delivery of the NHS People Plan, People Promises and People Strategy.

Whilst staff ‘retention’ has been the focus of this indicator, the current focus is headcount ‘reduction’, and this should see increased turnover as a result.

People: Exception Reporting



Analytical Narrative

This indicator has reduced for two continuous months and is now within control limits, albeit still above target. We will continue to monitor this.

Sickness absence rate (Actual)

Local Target: Red: >5.50% Green: =<5.50%

February compliance – 8.10%

Operational Narrative

Data is now within the control limits from February 2026 and has shown a downward trajectory since December 2025. Absence remains above target.

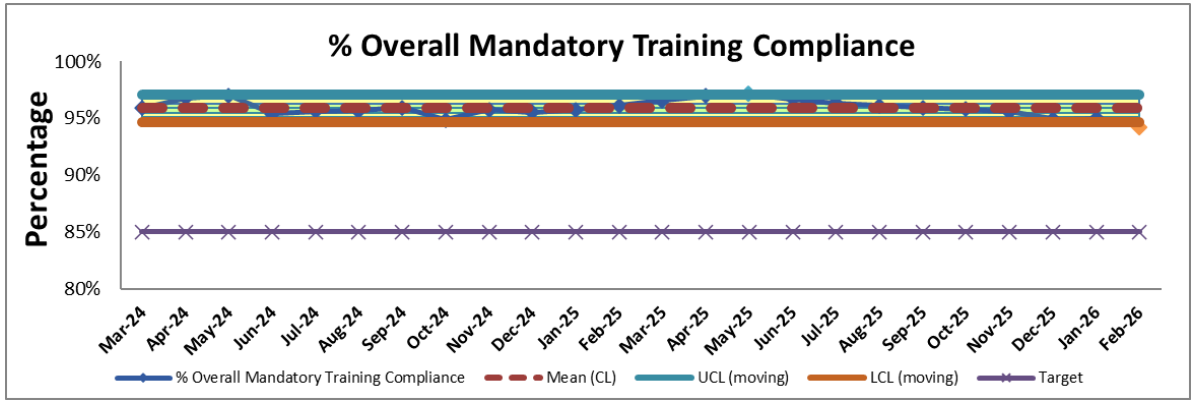
Anxiety, Stress and Depression, Cold/Flu and Gastrointestinal reasons continue to be the highest reasons for absence.

Weekly monitoring of absence via e-Roster is being used to target earlier interventions and highlight necessary actions to managers. Monthly monitoring meetings taking place.

Revised sickness absence policy currently under consultation.

The top 3 services have been identified with regular update reports to EMT. These are part of a wider cohort of the top 12 and are receiving targeted support. We have seen a 1.21% reduction in absence when at its highest -December

People: Exception Reporting



Analytical Narrative

The indicator has been on a downward trend since June 2025, with the exception of January 2026. However, this is now outside control limits, yet still achieving the target.

% Overall Mandatory Training Compliance

Local Target: 85%

February compliance – 94.16%

Operational Narrative

Mandatory Training rates have decreased from 95% in January 2026 to 94.16% in February 2026. Mandatory Training rates are being monitored via The Education Governance meeting, the DLTs and Performance Council with weekly reporting available via the Qlik system.

Planned dates for completion are being requested by DLTs and HR. Reasons for non-compliance are being scrutinised. Proactive monitoring is taking place via the HR Team on future expiry dates to limit further non-compliance.

Finance

Month Eleven Finance Report

1.1 Financial performance

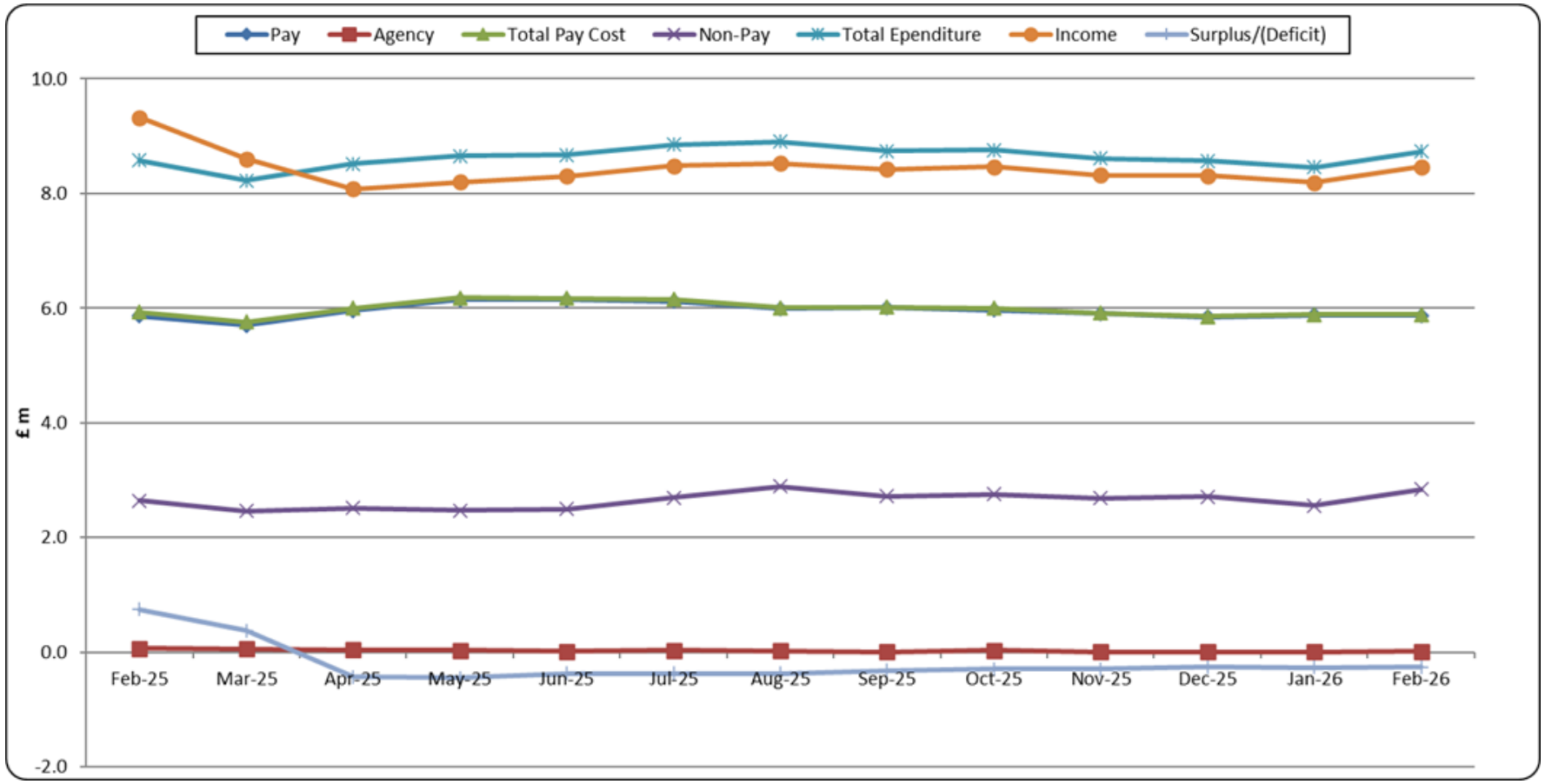
Summary Performance Month 11 2025-26	Month 11 Plan	Month 11 Actual	Month 11 Variance	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	Forecast Outturn M12
	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)	(£M)
Income	(8.34)	(8.47)	0.13	(91.92)	(91.89)	(0.03)	(100.27)	(100.27)
Expenditure - Pay	5.97	5.87	0.10	66.41	66.05	0.37	72.37	72.37
Expenditure - Pay - Integration Savings	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Expenditure - Agency	0.07	0.02	0.05	1.03	0.24	0.79	1.10	1.10
Expenditure - Non Pay	2.53	2.73	(0.20)	27.80	28.76	(0.96)	30.83	30.79
Expenditure - Non Pay - Integration Savings	0.00	0.00	0.00	0.00	0.00	0.00	(2.90)	0.00
EBITDA	0.22	0.15	0.08	3.32	3.15	0.17	1.13	3.99
Financing	0.03	0.11	(0.08)	0.36	0.53	(0.17)	0.39	0.43
Normalised (Surplus)/Deficit	0.25	0.26	(0.00)	3.68	3.67	0.00	1.52	4.42
Exceptional Costs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Net (Surplus)/Deficit after Exceptional Items	0.25	0.26	(0.00)	3.68	3.67	0.00	1.52	4.42
Other Adjustments	0.00	0.00	0.00	0.00	0.06	(0.06)	0.00	0.00
Adjusted Net (Surplus)/Deficit	0.25	0.26	(0.00)	3.68	3.73	(0.06)	1.52	4.42
Savings - CIP Levels 1 & 2	0.50	0.65	0.16	4.98	5.15	0.17	5.48	5.48
Savings - CIP Level 3	0.00	0.00	0.00	0.00	0.00	0.00	2.90	2.90
Capital	0.31	0.06	0.25	2.12	0.93	1.19	2.10	2.10
Cash	5.48	5.56	0.08	5.48	5.56	0.08	6.85	5.08
Use of Resources Metric	N/A	N/A		N/A	N/A		N/A	N/A

Favourable Variance Adverse Variance

Finance

Key Headlines

1.2 Rolling Run Rates 2024/25 to 2025/26



Finance

2. CUMULATIVE PERFORMANCE AGAINST NHSE PLAN - Key headlines month eleven

- The Trust is reporting an adjusted deficit at Month eleven of £3.68m, in line with plan.
- The Trust has a Level 1 and 2 savings requirement, excluding system savings, of £5.48m (5.02%). The Trust has an additional system stretch savings target of £2.90m (Level 3). The Level 3 savings will not be delivered.
- The Trust is reporting a savings achievement of £5.15m against a plan of £4.98m.
- Income is £91.89m against a plan of £91.92m.
- Expenditure is £95.57m against a plan of £95.60m.
- Pay is £66.05m against a plan of £66.41m.
- Agency spend is £0.24m against a plan of £1.03m.
- Non pay expenditure is £28.76m against a plan of £27.80m.
- Capital charges are above plan by £0.17m.
- Capital expenditure is £0.93m at month eleven, planned spend is £2.12m.
- Cash is £5.56m.

Finance

3. FORECAST OUTTURN AND KEY POINTS TO NOTE

At month eleven, the Trust is reporting an adjusted deficit of £3.68m, in line with the planned deficit of £3.68m.

At this stage, the forecast outturn reported position is a deficit of £4.42m - equal to the original plan excluding the stretch target. Forecast outturn has now been amended in line with the original plan, formal approval is awaited.

It should also be noted that as at month eleven, there are £194k of savings directly recorded against integration. Additionally, the savings schemes already delivering are being reviewed to identify where integration has contributed to the scheme delivering savings, where identified. Joint workstreams with WHH continue to work on identifying integration savings opportunities.

During 2024/25, all departments identified recovery plans. All budget managers have been instructed to continue with all recovery plans throughout 2025/26 to keep run rates in line with budgets. Any services who report an overspend position have been instructed that recovery plans are required in the month following to identify what actions are being taken to recover the financial position. DLTs have been instructed to monitor and report on all recovery plans and monthly recovery meetings with Executives continue.

The Trust has already implemented a revised robust workforce approval process in line with the ICB guidance. This process scrutinises all recruitment requests and includes consideration of joint/collaborative working opportunities with WHH. This is a joint process with WHH.

The Trust is continuing with all additional grip and control measures. Measures introduced include non-clinical agency/contractor removal, escalated non pay approval limits, reviewing the process and efficiency of rotas, discretionary spend freeze, resolution of non-contracted activity and service over performance. This list is not exhaustive and will continue to be added to in 2025/26.

Alongside the above, as part of the month end review process, all non-recurrent savings delivered in 2025/26 are critically reviewed to establish if they can be converted to recurrent savings.

Appendix

Indicator	Detail
Operations	
Diagnostic waiting times – 6 weeks	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The national target is 99% or over within 6 weeks.
Four-hour A&E Target	All patients who attend a Walk in Centre or Urgent Care Centre (A&E Type 4) should wait no more 4 hours from arrival to treatment/transfer/discharge. The national target is 95%.
Cancellation by Service	The Trust aspires to ensure that no patient will have their appointment cancelled. In exceptional circumstances, however the service may need to cancel patient appointments. In these instances, patients/carers will be contacted and offered an alternative appointment at their convenience acknowledging the maximum access times target.
Cancellation by patient / Was not brought	A patient cancellation or rescheduling request occurs when the patient contacts the service to cancel their appointment. Short notice cancellations i.e.: within 3 hours of appointment time should also be recorded as cancellation.

Communities Matter

Creating stronger, healthier, happier communities.

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Monthly Clinical Harms Review Report

Information Team

Reporting Period: Month 11

52 + week waits and outstanding clinical harm reviews

Services with patients waiting over 52 weeks (data as at 02/03/2026)			
Directorate	Service Line	Total over 52 weeks	Number of outstanding
Warrington Adult	Dermatology Service	201	201
Warrington Adult	Podiatry Service	3	2
Halton Adult	Podiatry (Halton)	52	
Warrington Child	Warrington Community Paediatricians	767	423
Halton Child	Halton Children's Therapies and Community Paediatricians	823	487
Dental	Dental	1	0

* No reply from Halton Podiatry about number of outstanding

Data Quality Issues

Harm reviews completed in month

Number of harm reviews completed in reported month			
Directorate	Dec-25	Jan-26	Feb-26
Warrington Child	13	16	16
Halton Child	32	26	3
Warrington Adults	0	17	0
Halton Adults	3	5	0
Dental	61	68	37

Harm levels recorded in reported month					
Directorate	**Low Harm**	**Moderate**	**Severe**	**Fatal**	**Total**
Warrington Child	2	0	0	0	**2**
Halton Child	0	0	0	0	**0**
Warrington Adults	0	0	0	0	**0**
Halton Adults	0	0	0	0	**0**
Dental	0	0	0	0	**0**

Harms recorded as PSII's in reported month					
Directorate	**Low Harm**	**Moderate**	**Severe**	**Fatal**	**Total**
Warrington Child	0	0	0	0	0
Halton Child	0	0	0	0	0
Warrington Adults	0	0	0	0	0
Halton Adults	0	0	0	0	0
Dental	0	0	0	0	0

Dental data for CHR is still in development and not available electronically yet.

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Thank You

01925 946400

bchft.enquiries@nhs.net

www.bridgewater.nhs.uk

Communities Matter

Creating stronger, healthier, happier communities.

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

NHS Oversight Framework

File created on: 18/03/2026

NHS Oversight Framework - Organisation Detail

Org type	Org Name Full	Aggregation Source	Indicator	Period Frequency	Period	Value	National Value	Target / Standard (not met if)	Change from previous period	3 period continuous change	Rank
MHPRV	BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST (RY2)	MH Provider	S000a: NHSOF Segmentation	Month	2025 01	2:Flexible support					
		MH Provider	S035a: Overall CQC rating	Month	2025 01	2 -Requires improvement					46/62
		MH Provider	S059a: CQC well -led rating	Month	2025 01	2 -Requires improvement					48/62
		MH Provider	S063a: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from a) managers	Annual; calendar year	2023	6.78%	9.94%		↓		21/66
		MH Provider	S063b: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from b) other colleague	Annual; calendar year	2023	13%	17.7%		↓		26/66
		MH Provider	S063c: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from c) patients / service users, .	Annual; calendar year	2023	16.4%	25.1%		↓		3/66
		MH Provider	S067a: Leaver rate	Month	2024 12	5.91%	6.94%		↓		7/67
		MH Provider	S068a: Sickness absence rate	Month	2024 09	5.81%	5.01%		↓		47/67
		MH Provider	S069a: Staff survey engagement theme score	Annual; calendar year	2023	7.29/10	6.89/10		↑		16/66
		MH Provider	S071a: Proportion of staff in senior leadership roles who are from a BME background	Annual; calendar year	2023	10.7%		12%	↑		26/64
		MH Provider	S071c: Proportion of staff in senior leadership roles who are disabled	Annual; calendar year	2023	7.14%		3.2%	↑		13/64
		MH Provider	S072a: Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientatio.	Annual; calendar year	2023	60.8%	56.4%		↓		35/67
		MH Provider	S121a: NHS Staff Survey compassionate culture people promise element sub-score	Annual; calendar year	2023	7.56/10	7.09/10		↑		15/66
		MH Provider	S121b: NHS Staff Survey raising concerns people promise element sub-score	Annual; calendar year	2023	7.1/10	6.46/10		↑		11/66
		MH Provider	S133a: Staff survey - compassionate and inclusive theme score.	Annual; calendar year	2023	7.76/10	7.3/10		↑		13/66
		MH Provider	S134a: Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants (WRES).	Annual; calendar year	2023	1.4		1	↑		26/64
		MH Provider	S135a: Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants (WDES)	Annual; calendar year	2023	1		1	↑		39/64

Rank Banding

- Highest performing quartile
- Interquartile range
- Lowest performing quartile

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Thank You

01925 946400

bchft.enquiries@nhs.net

www.bridgewater.nhs.uk

North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	**BM/26/04/010a(i)**	**Date of Board meeting:**	1 April 2026

Date of meeting:	10 February 2026
Name of meeting and chair:	Quality Safety Assurance Committee in Common (QSAC), chaired by Cliff Richards
Was the meeting quorate:	Yes

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

Agenda reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
QAC/26/02/05	**Deep Dive into Antimicrobial Resistance**	The committee received a presentation noting • Review of current targets for Antimicrobial Resistance • Actions in place to improve performance against targets • Improving trends noted across all metrics • Noted staffing challenges have improved • Focused interventions planned in ED Laboratory merger with Mersey and west Lancashire will create some challenges	**Moderate Improving picture need to continue to see sustained improvement towards target**	**Substantial: Review via Quality Safety Assurance Committee . Reported to IPC Sub Committee quarterly.**	**Update to IPC subcommittee Q4.**
QAC/26/02/04	**Typing Backlog update**	The committee received a presentation noting • Reduction of 2609 letters outstanding compared to December 2025. • Slight increase in urgent letters noted.	**Moderate Improving picture – although**	**Substantial**	**Update to Quality Safety Assurance**

		• Consultation of Medical Secretaries concluded. • Behind trajectory by 1852 letters- due delay to roll out of process due to an error being identified in workflow for secretaries– new workflow on track for roll out February 2026. • Phase 2 went live December 2025; phase 3 planned for February 2026. • NHSE still reviewing plans for funding Remains on Risk Register scored at 15	**behind trajectory. Need to continue to recover in line with plan**	**Quarterly oversight at QSAC**	**Committee Q4.**
QAC/26/02/16	**Sepsis High Level Update Q3**	The committee received a report noting • December compliance for ED Lactate 90%, Blood Cultures 72%. Antibiotic administration challenged. • No adverse events have been recorded in quarter relating to Sepsis. • Patient Safety Improvement Nurses undertake review of all Red Flag Sepsis - 111 pts in Q3 all had appropriate recognition and escalation. • 39 deaths recorded with Sepsis on death certificate, Structured Judgement Reviews – demonstrated good care Corporate Risk 579 increased to 12 due to non- compliance with KPI targets	**Moderate** **Monthly Improving picture, appropriate escalation and care identified – need to improve compliance with KPIs particularly antibiotic administration within 1 Hour.**	**Substantial Quarterly oversight at QSAC. Monthly reporting via Patient Safety and Clinical Effectiveness**	**Update to QSAC in Q4.**
QAC/26/01/228	**Clinical Pharmacy Service Supply,**	The committee received a report noting	**Moderate** **Good assurance**	**Substantive** **Oversight at QAC monthly.**	**Progress report back to QAC in 6 Months**

	Discharge and Reconciliation	• 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 resilience of the tool.
			regarding mechanisms and performance to manage risk. Digital tool not sustainable in its current form required Digital Team support.	**reported monthly to Patient Safety and Clinical Effectiveness Committee**	**monitoring via PSCESC**

The Committee also received the following items.

QAC/26/02/06 Quality IPR metrics
QAC/26/02/07 IQPR
QAC/26/02/08 ED Improvement
QAC/26/02/12 Quality Council Report
QAC/26/02/13 Maternity Update
QAC/26/02/14 Learning from Experience
QAC/26/02/15 Serious Incident Oversight
QAC/26/02/16 Sepsis High Level Update
QAC/26/02/17 Infection Control Q3 Update
QAC/26/02/18 Palliative Care and End of Life Report
QAC/26/02/19 Integration Update
QAC/26/02/20 High Level Enquiries update
QAC/26/02/21 BCH Audit recommendations
QAC/26/02/22 BCH- WHH Quality IPR Reporting Alignment overview

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.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	**BM/26/04/010a(ii)**	**Date of Board meeting:**	1 April 2026

Date of meeting:	10 March 2026
Name of meeting and chair:	Quality Safety Assurance Committee in Common (QSAC), chaired by Elaine Inglesby
Was the meeting quorate:	Yes

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

Agenda reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
QAC/26/03/31	**Deep Dive into Never Events**	The committee received from the Medical Director noting • Analysis of events in last 24 months • 2 themes identified Trauma and Orthopaedics and Pain Service Procedures • Noted reduction in never events at Warrington site following safety culture work. • Sir Captain Tom Moores(CSTM) Theatres undergoing rapid improvement intervention Oversight will be manged via formal Planned care Quality recovery Plan overseen by Deputy Medical Dorector reporting to the Executive Management Team	**Moderate Improving picture noted with Warrington Hospital Theatre Safety. Further assurance required re CSTM**	**Substantial: Review via Quality Safety Assurance Committee . Reported to IPC Sub Committee quarterly.**	**Update to Patient Safety and Clinical Effectiveness March 2026. Escalation to QSAC as required.**

QAC/26/03/34	**ED Improvement Update**	The committee received a presentation noting • 2% improvement in 12 hours compared to January 2025 • Average time in Department reduced • No criteria to reside figure has increased to 156 patients • Increase in Hospital Acquired pressure ulcers and falls in December – immediate actions in place • Special cause improvement from August 2025 onwards in Sepsis performance Harm profile has increased in Q3 for incidents recorded against the Emergency Department – themes identified – actions in place	**Moderate Improving picture in performance, some quality metrics have deteriorated. Further assurance required regarding Red Lines Tool Kit.**	**Substantial Monthly oversight at QSAC.**	**Update to Quality Safety Assurance Committee April 2026**
QAC/26/03/35	**Fractured Neck of Femur Assurance and Future Plan**	The committee received a report noting • Improvements in time to theatre in 36 hours improved from 29% January 2026 to 65.7% in February 2026. • 100% of patients were admitted to Ward A6 compared to 93% in January • 67% mobilised timely after theatre- further work to be undertaken on pain management. • Overall Best Practice Tarriff was 42 % compared to 19 % (December 2025) Case mix adjusted 30-day mortality remains above the control limit for 2 quarters	**Moderate Monthly Improving picture, sustained improvement are required with improved focus on pain management to aid early mobilisation**	**Substantial Quarterly oversight at QSAC. Monthly reporting via Patient Safety and Clinical Effectiveness**	**Update to QSAC in Q4.**
QAC/26/03/41	**Bridgewater updates re Dermatology, Neurodevelopment and Community Equipment Stores**	The committee received a report noting • Risk Register risk noted at 15 relating to clinical harm reviews in Dermatology. 2 week wait referrals have noted to increase from average of 75 pw to 155.	**Moderate Good assurance regarding mechanisms and**	**Substantive Oversight at QSAC Quarterly . Will be**	**Deep Dive into Community Equipment Stroes April 2026**

		• Noted unable to meet increased demand for neurodevelopmental diagnostic assessments – risk stratification process in place. • Risks identified with Community Equipment Service relating to IPC standards, servicing, building issues and equipment checks- immediate actions are in place	**performance to manage risk. Digital tool not sustainable in its current form required Digital Team support.**	**reported to Patient Safety and Clinical Effectiveness Committee**	

The Committee also received the following items.

The Committee also received the following items.

QAC/26/03/32 Board Assurance framework
QAC/26/03/33 Annual Quality KPI refresh
QAC/26/03/36 Patient safety And Clinical Effectiveness Update
QAC/26/03/38 Bridgewater Serious Incidents
QAC/26/03/39 Maternity Update
QAC/26/03/40 Learning from Deaths
QAC/26/03/41 Mental Health Update
QAC/26/03/42 Quality Priorities Update Q3
QAC/26/03/43 Integration Update
QAC/26/03/44 Terms of Reference Review
QAC/26/03/45 High Level Enquiries
QAC/26/03/46 Bridgewater Audit Recommendations
QAC/26/03/47 High Quality Impact Assessment Update
QAC/26/03/48 Information Governance and records committee Quarterly Update
QAC/26/03/49 Controlled Drugs accountable Officer Improvement Framework

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.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	BM/26/04/010b(i)	Date of Board meeting:	1 April 2026

Date of meeting:	18.02.2026
Name of meeting and chair:	Strategic People Committee, Chaired by Julie Jarman
Was the meeting quorate:	Yes

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

Agenda reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
SPCiC/26/02/209	**Deep Dive – Medical Rostering & System Change**	The presentation described the significant programme underway to move the WHH and BCH Medical and Dental workforce from their existing roster management systems to a new system which will incorporate rostering, job planning, exception reporting and temporary staffing. The benefits of this are increased grip and control with for example, job planning not having to be transferred between systems and being able to be mapped to rosters, and much more robust data reporting to support productivity oversight. The system also has the ability to enable preference rostering. There has been engagement across the Trust regarding roll out. There are also financial savings from implementing the new system based on the costs of the current systems.	Assured	Assured	Not applicable

		A full benefits realisation will be undertaken following implementation.			
SPCiC/26/02/210 (i)	**WHH Chief People Officer Report**	The current MARS round attracted 130 applications. All panels have now been completed, including Equality Impact Assessments, with outputs presented to EMT. Individuals approved for MARS will be required to leave the Trust by 31 March 2026. The Trust Board will be informed of any EMT decisions. A revised MARS process is being prepared to commence from April. The new process will require formal approval through NARC. Approved by SPC. Significant work is underway to meet the requirements of the Sexual Safety charter commitments. The Charter sought to create nationally comparable data for the first time. A full update would be provided on work including training and oversight via the EDI report to SPCiC in March 2026.	Assured	Assured	March 2026
SPCiC/26/02/211	**Workforce Brief on National, Regional, ICB, or Local Workforce Issues**	The Government and the Royal College of Nursing (RCN) have jointly announced a major package of national nursing workforce reforms aimed at recognising and strengthening the value of the nursing profession. The reforms include improvements to pay, career progression, and early-career support, such as increased graduate starting pay, a fully funded review of all Band 5 nursing roles, and the introduction of a new national nursing preceptorship framework. An update on the progress of the Band 5/6 nursing job description review was provided. Local job descriptions have been compared against new national profiles released in June 2025, with no significant differences identified. Work is underway to develop generic job descriptions across nursing.	Moderate assurance – awaiting more national guidance on approach	Assured	Updates to be provided via CPO report

The Committee also received the following reports:

For Information:
SPCiC/26/02/208 – Staff Story – Newly Appointed Fellows
SPCiC/26/02/214 – Better Care Together Integration Update (Workforce and Corporate Services)

For Approval:
SPCiC/26/02/212 Workforce Integrated Performance Recommendations 2026/27

For Assurance:
SPCiC/26/02/215 – Due Diligence Report
SPCiC/26/02/217 – Safer Staffing Report
SPCiC/26/02/218 – Guardian of Safe Working Q3 Report
SPCiC/26/02/219 – Midwifery Safer Staffing Report Q3
SPCiC/26/02/220 – Workforce Inclusion and Culture Sub-Committee Chairs Log
SPCiC/26/02/221 – Workforce Review Group

For Discussion:
SPCiC/26/02/216 – People and Workforce EDI Strategy 2026/27

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.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	BM/26/04/010 (b)	Date of Board meeting:	1 April 2026

Date of meeting:	18 March 2026
Name of meeting and chair:	Strategic People Committee, Chaired by Julie Jarman
Was the meeting quorate:	Yes

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

Agenda reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
SPCiC/26/03/228	**Deep Dive – Staff Survey**	The presentation detailed: • Participation / response rates (WHH: 39%; BCH: 52.5%) • High-level results across all 9 People Promise elements • Protected characteristics insight (race, disability, sexual orientation) • Key organisational risks (advocacy, morale, psychological safety, staffing, workload) • Next steps and proposed priority actions for SPC assurance The survey highlights clear, consistent themes across both legacy organisations:	Moderate assurance – delivery not yet commenced	Assured	As per SPC CoB 2026/27

		• Shared challenges focus on staff voice, morale, workload and fairness • Shared strengths include compassion, inclusion, teamwork and managerial support At an organisational level as part of the Medium-Term Planning Framework, there is a requirement to undertake an analysis to support a minimum of three organisational actions which must be reported to the Board. This cannot be completed until a full analysis of the free text comments is completed (due to be released to each Trust in March 2026).			
SPCiC/26/03/229	**Hot Topic – Workforce Plan 2026/27**	An overview of the workforce plan for 2026/27 was provided for both Trusts with significant reductions identified. Details of the schemes to support the workforce plan reductions were detailed to the Committee. There was discussion at the Committee regarding ownership of the relevant programmes of work as well as how achievable the programmes of work were. The Committee highlighted the requirement to ensure robust QIAs and EIAs for all programmes. The interdependency with workforce design and new service models was identified, with the request to ensure the Committee were kept informed of this programme of work. Data from the quarterly People Pulse Staff Survey will also be analysed in the depts. with significant workforce programmes of change to monitor impact on staff.	Moderate assurance – delivery not yet commenced	Assured	Bi-monthly IPR to SPC

The Committee also received the following reports:

For Assurance:
SPCiC/26/03/230 – Board Assurance Framework Consolidation of WHH and BCH
SPCiC/26/03/231 – WHH Chief People Officer Report
SPCiC/26/03/232 – Workforce Brief on National, Regional, ICB or Local Workforce Issues and Transforming People Services Update
SPCiC/26/03/233 – WHH Workforce Integrated Performance Report February 2026
SPCiC/26/03/235 – Culture Plan 2025/26 Bi-Annual Update
SPCiC/26/03/237 – Safer Staffing Report
SPCiC/26/03/242 – WHH Assessment of Compliance Against the NHS England Improving Working Lives of Resident Doctors 10 Point Plan
SPCiC/26/03/244 – Workforce Review Group

For Approval:
SPCiC/26/03/234 – Workforce EDI Strategy 2026/27
SPCiC/26/03/236 – EDI Annual Report 2025/26
SPCiC/26/03/239 – People Strategy 2026/27
SPCiC/26/03/240 – Workforce Governance Structure
SPCiC/26/03/241 – Review of Committee Terms of Reference

For Information:
SPCiC/26/03/238 – Better Care Together Integration Update (Workforce and Corporate Services) / Due Diligence Report / Integrated Governance Structures / Policy Update

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.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	**BM/26/04/010c(i)**	**Date of Board meeting:**	1 April 2026

Date of meeting:	23 February 2026
Name of meeting and 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 reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
FSPCiC/26/02/197	**Hot Topic – Productivity: The Way Forward**	The Committee in Common received the report noting:- • 2025/26 developed plans were £5.8m with non cash releasing benefits of £2.8m realised year to date at M10 • 2026/27 productivity plan is £10.8m Theatres • Consistent improvement in capped utilisation • Reduction in late starts, now 2-3 minutes from peer average • Day case rates remain high	The Committee received **no** assurance with the requirement for the paper to come back again next month	The Committee **noted** and discussed the report receiving **moderate** assurance	**FSPCiC March 2026**

		• Change in metrics for 2026/27 with a focus on the waiting list and what has been booked to deliver Outpatients • Clinic templates have been the main focus in 2025/26 • Focus to be on transformational delivery of outpatients in 2026/27. To be brought back next time with a greater focus on how to deliver improved productivity in 2026/27 with a focus on what will be different from 2025/26.			
FSPCiC/26/02/198	**Operational Plan Update**	The Committee in Common received the report noting:- • WHH non compliant with deficit control limit in year 1 and 2 (compliant in year 3) • Feedback not yet received on the plan submission Combined position for WHH and BCH presented with a 6% CIP, work ongoing to develop specific schemes to achieve this	The Committee received **no** assurance given the risk to deliverability of the plan	The Committee **noted** the report received **moderate** assurance	**Trust Board March 2026**
FSPCiC/26/02/199(i)	**Finance Update**	The Committee in Common received the report noting:- • Month 10 deficit position is £0.5m worse than plan at £34.8m (before deficit support funding (DSF)) due to integration costs. • 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 Committee received **moderate** assurance due to the risk of overall plan delivery	The Committee **noted** the report and is **assured**	**FSPCiC March 2026**

		• The Trust underlying deficit is £45.5m with the variance to plan driven by the stretch target, non-recurrent benefits in 2025/26 and some risk regarding non-recurrent CIP. • £17.2m CIP delivered at month 10, however £7.7m delivered recurrently, push to turn non-recurrent to recurrent. • All schemes fully developed, delivery risk reducing, £1.1m in high risk compared with £8.4m in month 4. If financial performance continues this should be mitigated in year. • Income continues to be off plan mainly in Endoscopy, T&O and Gynae, consistent performance throughout the year. Dynamic plans in place support delivery. • 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.			
FSPCiC/26/02/201	**Corporate Performance Report**	The Committee in Common received the report noting:- • ED 4 hour performance 68% (including Widnes UTC), (improvement from last month and best ranking since provider tables published). • Percentage waiting over 12 hours remains a challenge. • Medical and surgical SDEC flows to be separated which may impact on 12 hour wait however it is likely to improve the 4 hour metric.	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 March 2026**

		• Maintained RTT performance at 61%, 52 week wait is the biggest challenge, on track to deliver 1-1.5% by the end of the year), 65 week wait achieved a zero position. It has been indicated that an exit from tier 2 is possible at the end of Q4 if performance improvement is maintained. Cancer performance – 98% 31 day wait consistently achieved, 80% 62 day wait achieved although is a deterioration from last month, 28 day Faster Diagnosis is 78% which has been improving month on month although this still remains below target.			

Items for noting

FSPCiC/26/02/199 (ii) Cost Pressures
FSPCiC/26/02/199 (iii) Cash Support Update – supported cash request for Q1
FSPCiC/26/02/199 (iv) Monthly CIP Update
FSPCiC/26/02/199 (v) Monthly Productivity Update
FSPCiC/26/02/199 (vi) Capital Expenditure and Schemes over £500k – supported and approved the movement in capital contingency
FSPCiC/26/02/203 Delivery Unit Assurance Report – Dashboard
FSPCiC/26/02/204 Integration Update including due diligence
FSPCiC/26/02/205 Pay Assurance Report including MARS update
FSPCiC/26/02/206 Benefits Realisation Quarterly Report – Q3
FSPCiC/26/02/207 Elective Recovery Update
FSPCiC/26/02/208 Medical Workforce Review Group Quarterly Report – Q3
FSPCiC/26/02/213 WHH Digital Services HLB and Digital Board minutes – Q3

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.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	**BM/26/04/010c (ii)**	**Date of Board meeting:**	1 April 2026

Date of meeting:	23 March 2026
Name of meeting and chair:	Finance, Sustainability and Performance 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 reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
FSPCiC/26/03/221	**Deep Dive – Productivity**	The Committee in Common received the report noting:- • 2026/27 productivity plan is £9m of which £6.5m opportunity has been identified to date with PIDs and QIAs being developed, work continues to identify additional schemes. • Benchmarking indicates that there is no opportunity in Elective and Outpatients, however there is opportunity in these areas will continue to be explored. • Delivery unit changes planned for 2026/27 with a strong focus on operational delivery	The Committee received **moderate** assurance as there is still work to deliver against the plan	The Committee **noted** and discussed the report and is **assured**	**FSPC April 2026**

		and new leadership in Planned Care and Theatres is expected. • Change in metrics for 2026/27 with a focus on the waiting list and timely booking. • Transformation resource to be realigned with delivery of the operational plan (transformation team is a devolved model to Care Groups with the Head of Improvement role overseeing transformation). • Focus on detailed activity planning and then monitoring against this to make sure the plan is met, the tracking of this will be at clinician level. A similar approach is being taken as BCH to ensure that there is alignment as the trusts integrate.			
FSPCiC/26/03/222	**Hot Topic – PwC Actions**	The Committee in Common received the report noting:- • The forecast non-recurrent CIP in 2025/26 is £9.6m of which £7.1m is included in the underlying deficit which forms part of the 2026/27 plan, the remaining £2.5m is being reviewed by Care Groups in order to mitigate this (£1.4m has been confirmed with £1.1m to be identified). • Request from NHSE to increase CIP of 6% (£26.4m) to 7% (£30.8m), letter has been sent by the Trust and awaiting a response. • Weekly governance CIP submission, fully developed schemes increasing week on week with £9.4m at 16 March 2026.	The Committee received **no** assurance given the risk of delivering the plan	The Committee **noted** and discussed the report and is **assured**	

		• CIP profile has been updated in the latest plan submission, maintaining the 40:60 profile however with a lower target in Q1 compared to Q2 as some schemes only expected to start from Q2. If 7% CIP is required this would be profiled in Q4 to give a 35:65 profile. • Contract negotiations continue with a £5m variance in relation to TIF, Endo and CDC, discussions ongoing to finalise the contract position prior to the start of 2026/27. BCH have a variance of £1m on the contract and contract negotiations are ongoing and expected to be finalised prior to the start of 2026/27.			
FSPCiC/26/03/224	**WHH Finance Update**	The Committee in Common received the report noting:- • Month 11 deficit position is £0.6m worse than plan at £38.4m (before deficit support funding (DSF)) due to unfunded integration costs. • Risk adjusted forecast excluding DSF has been submitted at a £40.7m compared to a plan of £28.7m. The variance consists of £11.2m stretch target and the unfunded impact of integration (£0.8m). • The Trust underlying deficit is £45.5m with the variance to plan driven by the stretch target and non-recurrent CIP offset by non-recurrent benefits in 2025/26. • £19.4m CIP delivered at month 11, however £9.4m delivered recurrently (£10m	The Committee received **moderate** assurance due to the risk of overall plan delivery and level of non-recurrent CIP	The Committee **noted** the report and is **assured**	**FSPC April 2026**

		non-recurrent). The forecast non-recurrent CIP in 2025/26 is £9.6m of which £7.1m is included in the underlying deficit which forms part of the 2026/27 plan, the remaining £2.5m is being reviewed by Care Groups in order to mitigate this (£1.4m has been confirmed with £1.1m to be identified). • Care Groups tasked with turning non-recurrent savings recurrent. • All schemes fully developed, delivery risk reducing with £nil remaining in high risk compared with £8.4m in month 4. • Income continues to be off plan mainly in Endoscopy, T&O and Gynae, consistent performance throughout the year. Dynamic plans in place support delivery. • Bank not meeting 10% reduction, mainly due to IA and A&E medical staffing. Agency on plan, mainly driven by nursing.			
FSPCiC/26/03/225	**BCH Finance Report**	The Committee in Common received the report noting:- • Month 11 deficit position is on plan at £3.7m. • £5.2m CIP delivered at month 11 with 95% being delivered recurrently. • Non-pay expenditure is £1m above plan mainly due to unexpected rent reviews. This has mainly been offset by an underspend on agency expenditure. Risk adjusted forecast has been submitted at a £4.4m compared to a plan of £1.5m.	The Committee received **moderate** assurance due to the risk of overall plan delivery	The Committee **noted** the report and is **assured**	**FSPC April 2026**

		The variance consists of £2.9m stretch target.			
FSPCiC/26/03/228	**WHH Corporate Performance Report**	The Committee in Common received the report noting:- • Q3 NOF released with an improvement in the overall performance domain (4 to a 3), elective and the cancer programme however there is a deterioration in UEC. Patient safety has also been reported as a 1. • ED 4 hour performance 68% (including Widnes UTC), (small deterioration from last month) mainly due to a continuing deterioration in NCTR. • Percentage waiting over 12 hours remains a challenge. • Increase in RTT performance at 63%, 52 week wait is the biggest challenge, on track to deliver by the end of the year), 65 week wait reported one patient breach who has now been treated. It has been indicated that the Trust will remain in tier 2 despite the improvements. The Trust has queried this and is awaiting a response, strong indication that the Trust will come out in Q1 with a change to the tiering assessment expected. Cancer performance – all cancer standards achieved, 99% 31 day wait consistently achieved, 85% 62 day wait achieved, 78% 28 day Faster Diagnosis achieved.	The Committee received **moderate** assurance given the balance between NOF improvements whilst some metrics are not achieving	The Committee **noted** the report and is **assured**	**FSPC April 2026**

FSPCiC/26/03/229	**BCH Performance Council Report and Integrated Performance Report (IQPR)**	The Committee in Common received the report noting:- • Audiology now compliant, Dental reported last month therefore only Dermatology reported by exception. • Cancer performance – 62 day and 2 week wait continuing to improve in line with recovery trajectory. • FDS standards improvement requires change to the process (e.g. validation and clinical variation rather than just a biopsy as a standard approach) with a recommendation report expected over the next month. Following integration the Performance Council will report into the Performance Review Group (PRG) at the hospital going forward.	The Committee received **moderate** assurance given some metrics are not achieving	The Committee **noted** the report and is **assured**	**FSPC April 2026**
FSPCiC/26/03/232	**Performance Reporting 2026/27**	The Committee in Common received the report noting:- • Risk around combined reporting when performance of the two Trusts is combined and the potential impact that this will have on the NOF. • Focus on community dermatology, Widnes UTC and waiting times in RTT, Cancer, Diagnostic and A&E. The Trust continues discussions with NHSE to establish how and when the combined reporting will commence.	The Committee received **moderate** assurance given the potential risk around NOF reporting	The Committee **noted** the report and is **assured**	

Items for noting

FSPCiC/26/03/223 Board Assurance Framework Consolidation of WHH and BCH Board Assurance Frameworks
FSPCiC/26/03/224(ii) WHH Cost Pressures
FSPCiC/26/03/224 (iii) WHH Cash Support Update
FSPCiC/26/03/224 (iv) WHH Monthly CIP Update
FSPCiC/26/03/224 (v) WHH Monthly Productivity Update
FSPCiC/26/03/224 (vi) WHH Capital Expenditure and Schemes over £500k – supported and approved the movement in capital contingency
FSPCiC/26/03/226 Joint Final Operational Plan
FSPCiC/26/03/227 Annual Budget Setting Report (Draft budgets approved subject to potential plan changes)
FSPCiC/26/03/230 WHH PAF Review and Refresh of Trust KPIs – supported for Trust Board approval
FSPCiC/26/03/231 Delivery Unit Update 2026/27
FSPCiC/26/03/233 Integration Update
FSPCiC/26/03/234 FPSC ToR – approved
FSPCiC/26/03/235 Committee Effectiveness – Annual Survey
FSPCiC/26/03/236 WHH Elective Recovery Update
FSPCiC/26/03/237 BCH Estates, Health and Safety and Green Plan Update
FSPCiC/26/03/238 BCH Audit Recommendations – Month 11
FSPCiC/26/03/239 EPRR Update and WHH Event Planning Group Meeting

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.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	**BM/26/04/010 (d)**	**Date of Board meeting:**	1 April 2026

Date of meeting:	26 February 2026
Name of meeting and chair:	Audit Committee, Chaired by Michael O'Connor
Was the meeting quorate:	Yes

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

Agenda reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
AC/26/02/83–85	**Internal Audit Plan and fees, Internal Audit Progress Report & Internal Audit Follow up Report**	Internal audit reports were reviewed, with generally positive findings. Substantial assurance was received in several areas, with limited assurance in relation to IT third-party controls, reflecting national challenges. Actions are in place to address this.	**Assured –** The Committee received assurance that there are no significant weaknesses or delays were identified, and recommendations are being actioned	**Assured -** The Committee received assurance robust processes are in place	**Audit Committee – April 2026**
AC/26/02/89–90	**Counter fraud arrangements**	The Committee approved the counter-fraud work programme and received assurance that appropriate arrangements are in place to	**Assured** – it was evidenced that the Trust were delivering to a	**Assured** – it was evidenced that the Trust were delivering to a	**Ongoing oversight by Audit Committee.**

		prevent, detect and respond to fraud, including preparation for new national requirements.	substantial standard	substantial standard	
AC/26/02/91–92	**Review of Losses & Special Payments and Review of Quotation & Tender Waivers**	The Committee noted continued improvement in losses and special payments and a reduction in retrospective procurement waivers, demonstrating stronger financial controls.	**Assured –** the Committee agreed that improvements had been made and there was clear and measurable progress.	***Assured -*** the Committee received assurance of embedded process	**Audit Committee – April 2026**

Other agenda items:
AC/26/02/81– Board Assurance Framework
AC/26/02/82– Committee Assurance Updates
AC/26/02/88– Report and Update External Audit
AC/26/02/93- Annual Report & Accounts Timetable
AC/26/02/81 – Draft Annual Accounts Accounting Policies
AC/26/02/81 – North West Skills Development Network Bi-annual Report
AC/26/02/81 – MIAA Audit Actiomn Plan Update – Medical Job Planning

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.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda reference:	**BM/26/04/010 (e)**	**Date of Board meeting:**	1 April 2026

Date of meeting:	5 March 2026
Name of meeting and chair:	Charitable Funds Committee, Chaired by Steve McGuirk
Was the meeting quorate:	Yes

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

Agenda reference	Agenda item	Issue and lead officer	Delivery assurance	Governance assurance	Follow up / review date
CFC/26/03/42	**Charity Impact Story**	The committee heard an impact story detailing the benefit that charity funding brings, with a presentation from Tom Dore, who is fundraising for the charity by running 7 marathons in 7 days as a thank you for the care his partner and daughter received in 2024.	**The Committee received high assurance as hearing first hand the positive impact the charity can make**	**The Committee received high assurance as committee members hear directly the positive impact**	**June 2026**
CFC/26/03/43	**Fundraising Report and Quarterly Workplan**	CFC noted the quarterly fundraising report, including updating on 30th birthday plans, key campaigns, legacy donations. CFC approved investment in communications support. **Lead:** Kate Henry / Helen Higginson	**The Committee received substantial assurance as the Charity is on track for delivering**	**The Committee received high assurance as performance is monitored at each meeting of the Committee**	**June 2026**

			against its strategy	**and a Charity Leadership meeting has been established**	
CFC/26/03/44	**Operational Plan**	CFC received and supported the charity's operational plan for 2026/27 **Lead:** Hayley Smith	**The Committee received substantial assurance as plans for 26/27 are aligned to the strategy**	**The Committee received high assurance as annual reporting processes are in place and working well**	**June 2026**
CFC/26/03/45	**Finance Report**	CFC noted the financial position for Q3 (1 October to 31 December 2025) and the period 1 April to 31 December 2025: • Income is £77k above plan in quarter 3 and £165k YTD. • Expenditure (overheads) is £2k below plan in quarter 3 and £1k above plan YTD. • Expenditure (disbursements of funds) is £78k in quarter 3 and £154k YTD. • The net fund balance is £692k. • The balance after commitments for purchases, reserves and overheads is £250k. **Lead:** Tina Littler	**The Committee received substantial assurance as income is ahead of plan**	**The Committee received high assurance as sufficient processes and reporting are in place**	**June 2026**
CFC/26/03/46	**Bid Applications**	One bid was approved by CFC: • Delamere Centre therapeutic support for cancer patients An update was provided on bids under £5k approved since the last committee meeting, either by the director of comms and engagement (up to £1k) or by execs (up to £5k). **Lead:** Helen Higginson	**The Committee received high assurance that the approved bids will be delivered and any unspent funds returned**	**The Committee received high assurance as the application process is robust, proportionate, and aligned with the Governing Document**	**June 2026**

CFC/26/03/48	**Charity budget (financial plan)**	CFC received and approved the charity's stress-tested budget and cashflow for 2026/27, with a conservative income assumption of £390k. **Lead:** Tina Littler	**The Committee received substantial assurance as the financial plan was deemed prudent and appropriate**	**The Committee received high assurance as quarterly and annual reporting processes are in place and working well**	**June 2026**

The committee also received reports on:

- **CFC/26/03/47** – Investment update
- **CFC/26/03/49** – Overhead policy review
- **CFC/26/03/50** – Cycle of business 2026/27

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.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/04/04/011**			
Subject:	**Fragile Clinical Services**			
Date of meeting:	1 April 2026			
Action required:	**To note**			
Author(s):	Paul Fitzsimmons, Executive Medical Director			
Executive director sponsor:	Paul Fitzsimmons, Executive Medical Director			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
				✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
Executive summary:	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 Chronic Pain Service Rheumatology Services de-escalated from Fragile Services oversight since last report: Cancer Services Services entering Fragile Services oversight since last report: None			

<table>
<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 and subsequent de-escalation from Fragile Services
Note that following limited improvement within Planned Care Fragile Services (Fractured Neck of Femur and Chronic Pain) with associated patient safety risk, Planned Care were escalated into a formal Planned Care Quality Recovery Plan in January 2026 with performance improvements seen in February 2026
Receive further Fragile Service Oversight reports</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">Not Applicable</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2"></td></tr>
<tr><td>Date of meeting</td><td colspan="2"></td></tr>
<tr><td>Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">None</td></tr>
<tr><td>Freedom of information status (foia):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>Freedom of information exemptions applied:
(if relevant)</td><td colspan="3">None</td></tr>
</table>

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. Key elements

2.1 Fragile Services De-escalated from oversight since last board

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.

Robust systems and processes now in place and tested through audit for cancer pathway upgrades, standardised MDTs, surveillance access pathways and automated histology driven referrals and upgrades being rolled out speciality by speciality.

Significant improvement actions have been delivered with a corresponding significant decrease in incidents, with PSCESC recommending to QAC that Cancer Services be de-escalated from Fragile Services oversight.

Two remaining open actions in Urology will be incorporated into the Urology Fragile services action plan and a final assurance report to confirm sustained improvement will come to PSCESC in 6 months

2.2 Services entering Fragile Services oversight since last Board

None

2.3 Services remaining under Fragile Services oversight since last Board

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 were escalated in January 2026 into a formal Planned Care Quality Recovery Plan. This reports twice weekly to the Deputy Medical Director with a bi-weekly escalation report to the Executive Management Team and monthly to QAC.

Orthopaedics – Fractured Neck of Femur

Summary

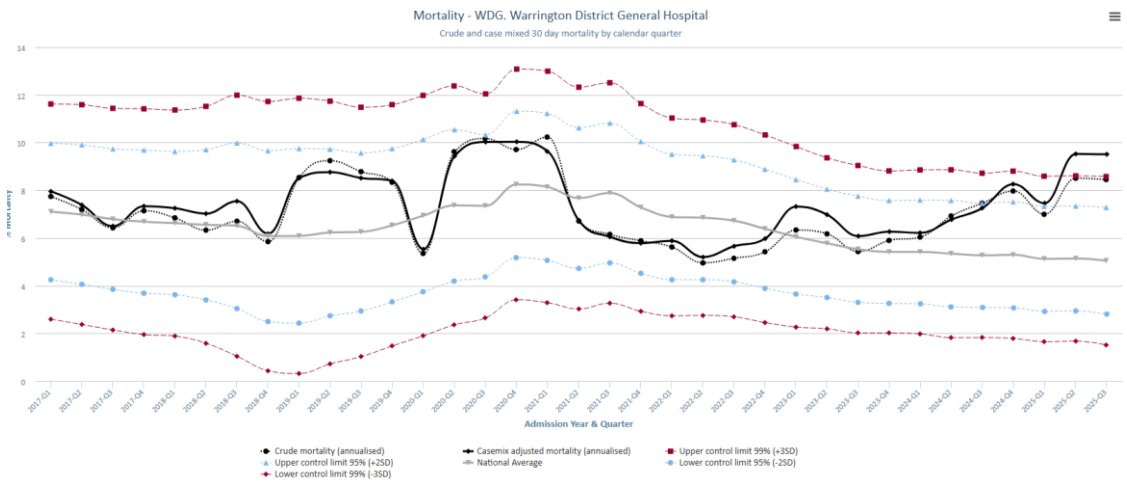
After improvement in Q1, National Hip Fracture Database data has demonstrated a deterioration in mortality in Q2 and Q3 2025/26 resulting in an outlier status alert being received by the Trust

Improvement in prompt surgery has not been adequate leading to escalation into a formal Planned Care Quality Recovery Plan in January 2026. Following this performance has increased significantly in February with 65.7% of patients receiving surgery within 36 hours (January 29.5%, National average 57%)

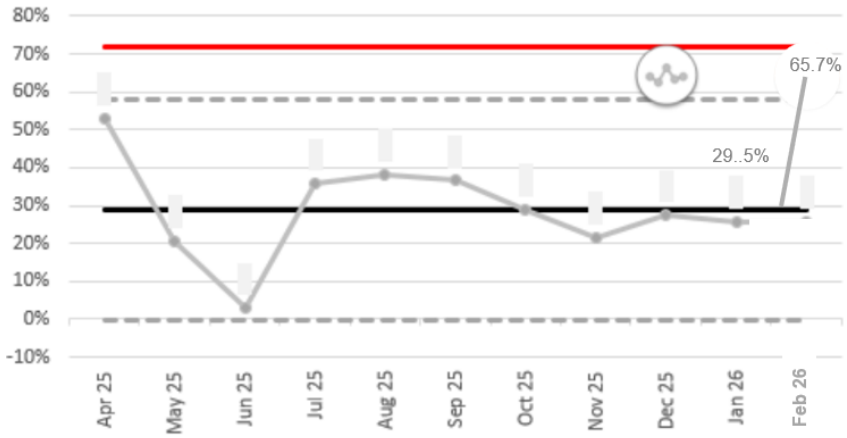
As part of the Planned Care Quality Recovery plan, a mortality review of all deaths over the last 12 months has been undertaken and data quality issues identified that have likely incorrectly increased the casemix adjusted mortality rate – controls are now in place to ensure data quality is maintained.

The Trust's National Hip Fracture Database (NHFD) data has shown Case mix adjusted and mortality for fractured neck of femur moved out of predicted range in the reporting quarters Q2 and Q3 2025/26 and are above the 95% control limit.
Crude mortality remains within the 95% control limit at the upper end of the expected range.

Figure 1 – Hip Fracture Crude and Case Mix Adjusted Mortality



Actions directly overseen by the Deputy Medical Director as part of the Planned Care Quality Recovery plan have resulted in improvement in prompt surgery in February:



The service now needs to sustain and further improve this performance in a sustainable and efficient theatres model.

A mortality review has been undertaken for all fracture neck of femur deaths in the last 12 Months, this will report to QAC. This review has identified that 9 of 35 (25.7%) of deaths did not have an ASA grade submitted to the NHFD. This is very likely to have resulted in significant underestimation of risk of death in these patients by the NHFD casemix adjusted mortality algorithm, and this has been confirmed by case note review of clinical risk. This may explain the discrepancy seen between NHFD Casemix adjusted mortality and both crude mortality and SHMI, which are not outliers. Controls are now in place to ensure data integrity.

These data issues will not distract or detract from the focus on accountability for delivering actions to improve the performance of this service for our patients.

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

Following escalation into a formal Planned Care Quality Recovery Plan in January, progress noted.

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
- Opioid/gabapentoid prescribing SOP and standardised GP and patient letter format have been produced and have had primary care critique with constructive feedback
- Initial meeting with Primary Care regarding future service model
- Meeting with East Chesire regarding their community model

Key Actions for Next Reporting Period

- Finalise and operationalise SOPs and standardised letters
- Clinical Model Workshop (May 2026) to define future service model with key stakeholders

Medium Term Actions

- Work with commissioners to de-medicalise and transform service into a community based, therapist led reablement service – Q3 2026/27

Urology

Summary

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

- P2 – waiting list has stabilised, but is not reducing
- P3 waiting lists continue to reduce
- P4 waiting lists continue to improve 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 and diagnostic cystoscopy position very significantly improved with undated waiting list now fewer than 25 patients for both (from a peak >200 and >300 respectively)

  Completed Actions
  - Increased endoscopy cystoscopy capacity by 40/week
  - Nurse delivered cystoscopy now live
  - 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

  Key Actions for Next Reporting Period
  - WLI and outsourced sessions where required to support activity plan and safety
  - Complete revenue request for 6th Urologist
  - Complete validation of patients transferred onto new prostate surveillance access plan

  Medium Term Actions:
  - Urology to be included in system work on developing sustainable models for fragile services

<u>Rheumatology</u>

Summary

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.

Improvement in prescribing backlog, patient enquiry backlog, DMARD monitoring and prescription process. Significant outpatient backlogs and ongoing risk around DMARD monitoring remain.

Key areas of risk identified for improvement include:

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

Completed Actions:

- Single email point of access introduced for all email patient queries
- Reduction in DMARD prescription backlog to 78
- Reduction in Biologic prescription backlog from 324 to 107
- DMARD processes amened to include basic failsafe but require further refinement
- Locum consultant in post
- Dedicated specialist pharmacist in post
- Medical and Nursing job plan changes made to support demand and capacity mismatch

Key Actions for Next Reporting Period:

- Reduce prescription backlogs to zero
- Finalise DMARD monitoring process in line with best practice
- Develop virtual DMARD education programme for patients
- Undertake demand capacity exercise and GIRFT pathway review

3. 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 and subsequent de-escalation from Fragile Services

- Note that following limited improvement within Planned Care Fragile Services (Fractured Neck of Femur and Chronic Pain) with associated patient safety risk, Planned Care were escalated into a formal Quality Recovery Plan in January 2026 with performance improvements seen in February 2026

- 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	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	March 2026
Chronic Pain Service	June 2025	Ongoing
Rheumatology Service	Nov 2025	Ongoing

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/04/012**			
Subject:	**Maternity & Neonatal Highlight report January / February 2026**			
Date of meeting:	**1 April 2026**			
Action required:	To note			
Author(s):	Tina Moors Interim Director of Midwifery			
Executive director sponsor:	Ali Kennah - Chief Nurse			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	**#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans. **#115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff.			
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 and improving safety and outcomes for this cohort.
Executive summary:	This paper provides an overview of activity, performance and quality within the maternity and neonatal services for the period January and February 2026. This paper provides the Board of Directors with oversight of the Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH) position in relation to key national safety and quality issues, compliance with the Maternity Incentive Scheme Year 7, and local improvement actions. The paper provides a summary in relation to the following reports for oversight and discussion: • Appendix 1: Quarter 3 Avoiding Term Admission into Neonatal Unit (ATAIN) Report • Appendix 2: Maternity Incentive Scheme (MIS) to include Saving Babies Lives Care Bundle (SBLCB) • Appendix 3: Maternity and Neonatal Quality Review Report • Appendix 4: Transitional Care Audit Q3 • Appendix 5: CQC Maternity Survey Quality and safety performance during the period remained stable. No maternal or neonatal deaths were reported, and although there were one severe and two moderate harm incidents, overall incident reporting remained strong, with 141 reports submitted. OASI rates remained below the 12-month rolling mean. Key themes included higher-than-target neonatal term admissions and a slight rise in postpartum haemorrhage over 1000ml. Improvement projects continue in both areas, including the development of a grunting baby pathway, strengthened fetal monitoring practice, and implementation of the regional PPH guideline. Significant progress was also made in reducing delays in induction of labour, falling from 21% in December to 8.16% in January.

	Workforce indicators were largely positive. Mandatory training compliance remained high across all categories, and vacancy and turnover rates were both low, supporting service stability. Appraisal compliance, however, remained below target at 79%, with an improvement plan in progress. Performance against patient-facing metrics was strong, notably with 96.6% of women seen within 15 minutes in maternity triage. User experience feedback continued to highlight positive staff engagement and communication. Governance processes remain robust, with four MNSI cases under investigation, four complaints being reviewed, and no Regulation 28 notices issued. Quality improvement activity continued across multiple domains, including a review of 14 postnatal readmissions in Quarter 3, of which four were considered avoidable. Learning has informed actions to strengthen infection prevention, results follow-up, and personalised postnatal care planning. The newly launched Maternity Care Bundle, introduced in January 2026, also showed early positive levels of compliance. The Trust remains an outlier regarding Avoiding Term Admissions (ATAIN), with a Q3 term admission rate of 9.18% against a national target of 6%. Respiratory issues accounted for most admissions, with learning indicating some avoidable cases linked to pathway adherence. Improvement measures underway include revised opioid guidance, enhanced neonatal respiratory support, and embedding consistent MDT review processes. All safety actions for Maternity Incentive Scheme Year 7 have been met, with the declaration submitted on time following CEO and ICB sign-off. Preparations are now underway for Year 8, with requirements due at the end of March 2026. The CQC Maternity Survey 2025 results showed performance broadly in line with national averages, with particular strengths in partner involvement, mental health support, and antenatal communication. Areas identified for improvement included postnatal information, feeding support outside standard hours, and discharge delays. An action plan has

<table>
<tr><td></td><td colspan="3">been developed and is being monitored through Women's Health governance processes.

Overall, maternity and neonatal services continue to demonstrate strong performance, effective risk management, and a positive culture of improvement. Key risks relating to neonatal admission rates and appraisal compliance remain under active management, with targeted actions in place. The report is presented for the Board of Directors to note the contents of the report.</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval
✓</td><td>To note</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The Trust Board is asked to note the contents of this report.</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">QASCiC26/03/39i
QASCiC26/03/39ii
QASCiC26/03/39iii
QASCiC26/03/39iv
QASCiC26/03/39v</td></tr>
<tr><td>Date of meeting</td><td colspan="2">January and February 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Noted and approved</td></tr>
<tr><td>Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring</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>Freedom of information exemptions applied:
(if relevant)</td><td colspan="3">None</td></tr>
</table>

1. Background/context

This paper provides an overview of activity, performance, and quality within the Maternity and Neonatal Services for the period January and February 2026.
The paper provides Board with oversight of the WHH position in relation to key national safety and quality issues, compliance with the Maternity Incentive Scheme Year 7, and local improvement actions.

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

- Appendix 1: Quarter 3 Avoiding Term Admission into Neonatal Unit (ATAIN) Report
- Appendix 2: Maternity Incentive Scheme (MIS) to include Saving Babies Lives Care Bundle (SBLCB)
- Appendix 3: Maternity and Neonatal Quality Review Report
- Appendix 4: Transitional Care Audit Q3
- Appendix 5: CQC Maternity Survey

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

2. Key elements

Quality and Safety and Workforce Metrics

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

(Detailed reports appendix 3)

This report provides assurance to the Trust Board regarding the quality, safety, and performance of Maternity and Neonatal Services, aligned to national requirements and the Maternity Incentive Scheme (Safety Action 9).

2.1 Key Quality & Safety Indicators

- No maternal or neonatal deaths reported.
- 1 severe harm event and 2 moderate harm events recorded.
- 2 cases of OASI (3rd/4th degree tears) – rates remain below the 12-month rolling mean, indicating no escalation in risk.
- 141 patient safety incidents reported, demonstrating active incident reporting culture.

Key themes identified:

- Term admissions to Neonatal Unit (above national target)
- Postpartum haemorrhage (PPH) ≥1000ml

2.2 Areas of Focus & Improvement

- Neonatal admissions (ATAIN):
  Current rate remains above national target (9.18% vs 6%). Actions include development of a “grunting baby pathway” to safely reduce avoidable admissions.
- Postpartum Haemorrhage (PPH):
  Slight increase noted; however, robust governance is in place.
  Implementation of the regional PPH guideline and ongoing quality improvement work is expected to improve outcomes.
- Induction of Labour (IOL):
  Significant improvement in delays:
  - Total delays reduced from **21% (Dec) to 8.16% (Jan)**
  - Sustained improvement in process and flow
    Work continues to optimise outpatient pathways and reduce variation.

2.3 Workforce Position

- Training compliance: Above target (Mandatory 89%, Role-specific 90%, Safeguarding 92%)
- Appraisals (PDR): 79% (below target; improvement plan in place)
- Turnover: 9.8% (below Trust target)
- Vacancy rate: 0.2% (significantly below target)

2.4 Performance & Activity

- Maternity Triage:
  - 96.6% of women seen within 15 minutes (exceeds KPI)
  - Minimal breaches; strong performance maintained
- Service User Experience:
  Positive feedback continues; staff engagement supported through recognition initiatives.

2.5 Governance & Assurance

- MNSI investigations: 4 cases ongoing; oversight maintained
- Complaints: 4 received in January; all under investigation
- Coroner Regulation 28: None received

2.6 Quality Improvement & Strategic Workstreams

- **Postnatal Readmissions:**
  There were **14 postnatal readmissions** in Quarter 3, a slight reduction from the previous quarter. Of these, **4 were deemed avoidable** and **10 unavoidable**. Key causes included wound infections, hypertension, and pain. Reviews have identified opportunities to improve **infection prevention, timely follow-up of results, and postnatal care planning,** with learning shared to reduce recurrence and improve patient outcomes.

- **Maternity Care Bundle (MCB):**
  The Maternity Care Bundle was introduced in January 2026 to standardise best practice across key clinical areas and improve maternal outcomes. Initial benchmarking indicates the service is largely compliant, with further implementation and progress tracking to be undertaken in line with national guidance

- **Key Risks & Assurance**
  - Neonatal admission rates (ATAIN) remain a key risk area.
  - Induction of labour delays previously identified risk now showing sustained improvement.
  - Continued focus required on appraisal compliance and reduction of avoidable harm.

Atain Q3

This report summarises term admissions to the Neonatal Unit (NNU) at WHH from 1 October to 31 December 2025. Each case is reviewed by a multidisciplinary team (MDT) including obstetricians, neonatologists, midwives, neonatal nurses, and operational management. The ATAIN Group meets fortnightly to capture learning, with capacity to increase frequency if required.

(Detailed report Appendix 1)

During Q3, the term admission rate was 9.18%, exceeding the national target of 6% and the NWNODN target of 5.6%, marking the highest rate recorded. WHH remains an outlier in the region despite robust initiatives, including the “PEEP for 30” project, expansion of Transitional Care (TC), and updated fetal monitoring guidance. Ongoing measures include mandatory CTG training, weekly MDT workshops, and enhancements to the maternity diabetes pathway, which are expected to impact future admissions.

Respiratory issues accounted for 73% of term admissions, with four cases deemed avoidable due to incomplete pathway adherence, maternal opioid exposure, or delayed sepsis recognition. Unavoidable admissions were managed appropriately according to current guidelines. Other factors included hypoglycaemia, jaundice, and hypothermia. Planned improvements, such as revised opioid prescribing, the grunting baby pathway, and CPAP implementation in theatre and delivery rooms, aim to reduce short-term and avoidable admissions.

Key learning includes: overcautious admissions contributing to separation of mothers and babies, positive outcomes from CPAP use, early identification of jaundice, strong MDT planning, and thorough documentation. ATAIN findings are being integrated into wider service improvements, including diabetes care and NEWTT2 monitoring for earlier detection of neonatal deterioration.

The ATAIN action plan is monitored monthly via the Women’s and Children’s Clinical Business Unit Governance Meeting and reported to the Quality, Safety, and Assurance Committee in Common. The Trust Board is requested to review and discuss these findings as part of the quarterly maternity and neonatal overview.

Maternity Incentive Scheme (MIS)

Current position against MIS Year 7

The Trust position, outlining that all safety actions have been met (two require external verification however WHH's robust processes have ensured the requirements have been met) for MIS Year 7 was presented on 4 February 2026 to the Board. The LMNS attended the Board meeting, in line with the requirements of MIS.

Following the presentation to Board, the self-declaration form was signed by the Chief Executive Officer. The declaration form was countersigned by the Integrated Care Board and has been submitted to NHS Resolution for validation, ahead of the deadline on 3 March 2026.

The Trust Board minutes from February 2026 will be shared with the Local Maternity and Neonatal System (LMNS) for completion.

MIS Year 8

MIS Year 8 requirements will be published on 31 March 2026. Launch events will be taking place throughout April 2026. The maternity SLT are registered to attend. Updates on MIS Year 8 will be provided to the Quality, Safety and Assurance Committee in Common in May 2026.

CQC Maternity Survey

The annual CQC Maternity Survey collects feedback from women and people aged 16 and over who had a live birth in February 2025. At WHH, 123 responses were received, representing a 41.3% response rate, slightly below the 2024 rate of 44%. Respondents reflected the ethnic diversity of the maternity population at WHH. Overall, results were broadly comparable to national averages, with one question somewhat worse than most trusts and 57 questions about the same.

(Detailed Report Appendix 5)

Lowest scoring areas (2025) included: opportunities to ask questions after birth (5.9), access to feeding support outside standard hours (6.1), information about physical recovery (6.2), discharge delays (6.3), and waiting times in triage (6.3, new question). All were broadly in line with national averages, showing no significant outliers.

Highest scoring areas included partner involvement during labour (9.4), midwife enquiry about mental health (9.4), clarity of antenatal communication (9.2), responsiveness when patients were worried during labour (9.2), and adequate mental health support in pregnancy (9.1). Compared to 2024, scores were largely maintained, with minor decreases in some questions on respect, dignity, and pain management. Regionally, WHH performed similarly to other trusts in the 'During your pregnancy' section.

The maternity SLT has reviewed the findings and developed an action plan to drive improvement. Key initiatives include the introduction of a patient feedback form in June 2025, accessible via QR codes across patient areas, to gather timely feedback and inform service

enhancements. Focused work has been undertaken to address lowest scoring areas, including improving postnatal support, communication, and pain management.

3. Actions required/responsible officer

Nil

4. Measurements/evaluations

Nil

5. Trajectories/objectives agreed

Nil

6. Monitoring/reporting routes

The action plan is overseen by the Maternity SLT through Women's Health Governance, with escalation to the Women's and Children's Clinical Business Unit Governance Committee as needed, and input from Patient Experience teams.

7. Timelines

Nil

8. Assurance committee (if relevant)

The contents of this report have previously been noted and discussed at Quality Safety Assurance Committee on 11 November 2025 and 9 December 2025.

9. Recommendations

Trust Board members are requested to note the survey findings, review the action plan, and support ongoing improvements in maternity services at WHH and to note the content of this paper for information.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/04/012i**			
Subject:	**2025-2026 Quarter 3 Avoiding Term Admission into Neonatal Unit (ATAIN) Report**			
Date of meeting:	1 April 2026			
Action required:	To note			
Author(s):	Annabel Grossmith – Consultant Obstetrician & Gynaecologist Emma Bentham – Personal Assistant (Women's and Children's CBU) Helen Wall – Assurance & Improvement Manager (Women's and Children's)			
Executive director sponsor:	Ali Kennah, Chief Nurse			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
		✓		
	Further Information / Comments:			
Executive summary:	• Q3 2025/26 ATAIN rate (Avoiding Term Admission into Neonatal Unit) is 9.18%, which does not meet the national target (6%) or the NWNODN target (5.6%). • All admissions including those <6 hours have been included as this is the national and regional expectation. • All term admissions in Q3 were reviewed and learning from these cases informs the ATAIN action plan.			

	• An ATAIN action plan is in place to improve the service position against ATAIN standards. • The ATAIN action plan is monitored at the monthly Women's & Children's (WCH) Governance Meeting.		
Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**
Recommendation:	The Trust Board of Directors is asked to receive and discuss the findings of this paper.		
Previously considered by:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QSACiC/26/03/39i**	
	Date of meeting	10 March 2026	
	Summary of Outcome		
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***None***		
Freedom of information status (foia):	Release Document in Full		
Freedom of information exemptions applied: ***(if relevant)***	None		

1. Background/context

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

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

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

2. Key elements

WHH ATAIN position

The findings of this report have been collated from the review of all cases of term babies that were admitted to the Neonatal Unit (NNU) during the Q3 reporting period from 1 October 2025 to 31 December 2025.

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

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

2.2 Summary of unexpected term admissions to NNU

The Q3 ATAIN rate was 9.18% which does not meet the national target of 6% or the NWNODN target of 5.6%. The service remains an outlier in the NWNODN for term admissions, and this quarter has the highest rate to date, which was not anticipated.

WHH has remained an outlier for much of the last three years despite careful MDT analysis and understanding of our data and robust projects put in place to address recurring themes. For example, ‘PEEP for 30’ project (up to 30 minutes of respiratory

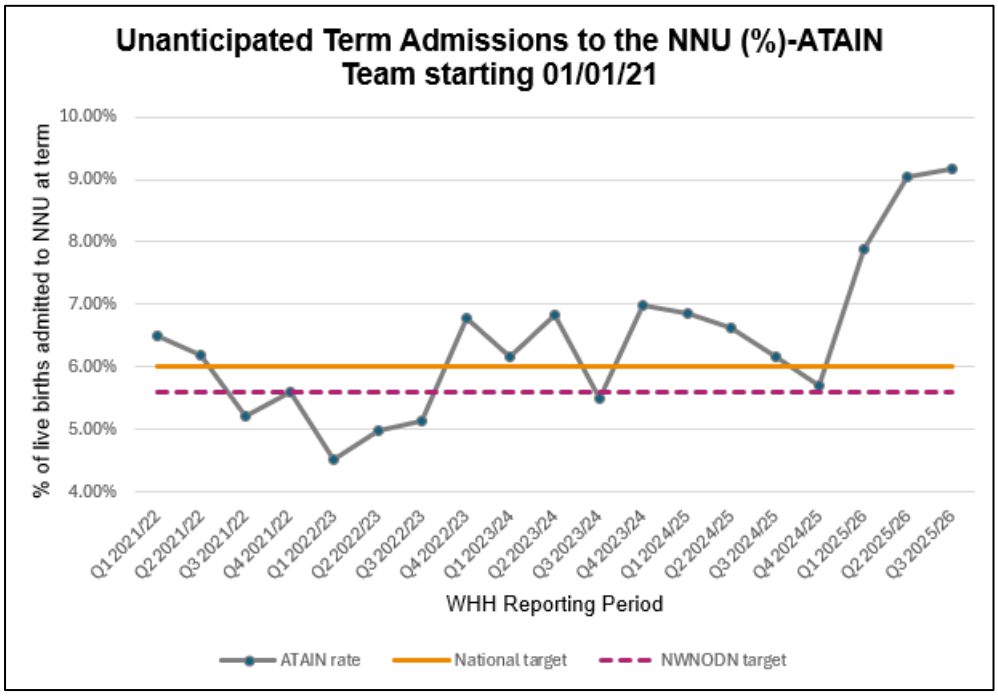
support at delivery prior to considering NNU admission) has avoided significant numbers of admissions; our Transitional Care (TC) offering has been expanded to be more consistent and there has been a change in training and guidance in fetal monitoring in our low risk settings.

There is ongoing MDT CTG mandatory training and weekly MDT CTG workshops to continue to develop and consolidate CTG interpretation skills.

There is ongoing work on the maternity diabetes pathway of care as a significant number of admissions are babies of mothers with diabetes. Action plans have been identified as necessary in our previous report which have not as yet impacted on this quarter's figures. It is anticipated that an impact will be evident next quarter.

Findings from a recent joint women's health and anaesthetic audit have highlighted possible issues regarding opioid use during labour and caesarean section. Specifically, opioids have been associated with respiratory depression in neonates and a corresponding increase in admissions for respiratory distress. In response to these findings, tramadol has been withdrawn from use during labour, and a broader review of opioid administration practices is ongoing to mitigate neonatal risk and improve outcomes, which is anticipated to lead to a change in prescribing practices from December 2025.

Below is a summary of unanticipated term admissions to Neonatal Unit from January 2021 – December 2025.



As part of the ATAIN review, the team will consider whether an admission to NNU was avoidable if care had been optimal. The table below shows the breakdown of these figures over the past year. The percentage of avoidable admissions has further reduced with again a high number of unavoidable admissions (similar number to the previous quarter). The care in the unavoidable cases was subject to detailed MDT review and was found to be appropriate in all aspects, based on our current guidelines, suggesting that it is difficult to reduce this figure. However, the planned changes to opioid prescribing, the diabetic pathway and the implementation of a grunting baby pathway may reduce the likelihood of some of the currently unavoidable admissions.

WHH Oct 2024 - Sep 2025	Number of Term Admissions	Outcome of ATAIN review		% avoidable
		Avoidable Admissions	Unavoidable Admissions	
Q3 Oct – Dec 2024	37	8	27	21.6%
Q4 Jan – Mar 2025	33	9	24	27.3%
Q1 Apr – Jun 2025	45	16	28	35.6%
Q2 Jul – Sep 2025	59	16	43	27.1%
Q3 Oct – Dec 2025	56	11	45	19.6%

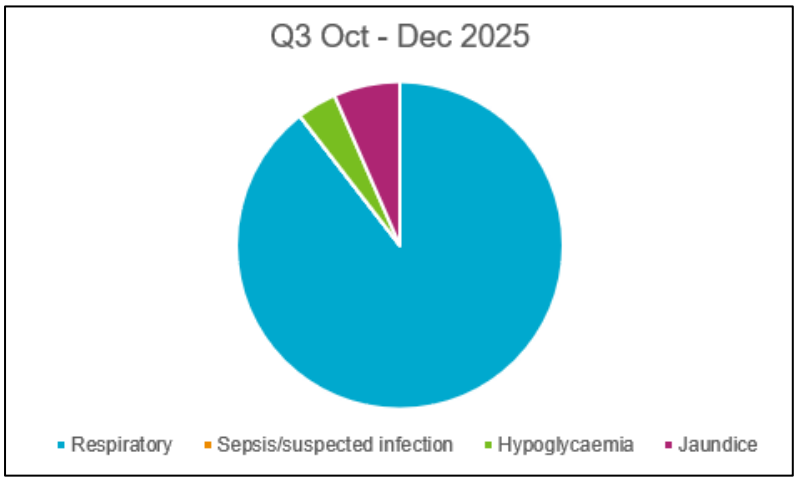
2.3 Reasons for term admissions (recorded on BadgerNet by ATAIN admission criteria)

73% (41) of term admissions were for management of a respiratory problem requiring observation. This may include signs of respiratory distress (including grunting) and low oxygen saturation (SATs or oxygen requirement). 4 of these cases were deemed avoidable, two of which identified that the PEEP for 30 pathway was not completed, one of which the mother received diamorphine prior to birth, which would not be in line with the recently updated guideline in relation to diamorphine dosage and the other displayed symptoms that had resolved on admission to NNU. One case also received diamorphine prior to birth, the dosage of which would fall outside of our newly implemented guideline. The fourth admission may have been prevented with earlier identification of maternal sepsis.

WHH Number Live Births		Term Admissions		Respiratory Symptoms		Sepsis/ Suspected Infection		Hypoglycaemia		Jaundice		Hypothermia	
		Number	% Live births	No of babies	% Term admissions	No of babies	% Term admissions	No of babies	% Term admissions	No of babies	% Term admissions	No of babies	% Term admissions
Q4 Jan – Mar 2025	580	33	5.69%	19	58%	3	9.1%	3	9.1%	1	3%	2	6.1%
Q1 Apr – Jun 2025	571	45	7.88%	27	60%	1	2.2%	0	0%	3	6.7%	1	2.2%

Q2 Jul – Sep 2025	652	59	9.05%	36	61%	3	5.1%	2	3.4%	1	1.7%	0	0%
Q3 Oct – Dec 2025	610	56	9.18%	41	73%	0	0%	1	1.8%	3	5.4%	3	5.4%

The below table details primary reasons for term admissions to NNU at WHH:



2.4 Themes and Learning: Outcomes of ATAIN review

Reasons for categorising term admissions as avoidable included:

- Baby 1: temperature was not managed appropriately after birth
- Baby 2: earlier identification of maternal sepsis may have avoided GA caesarean section and may have avoided baby's admission
- Baby 3: mother received diamorphine at higher dose than recently amended guideline
- Baby 4: full PEEP for 30 pathway not completed and baby's symptoms resolved on admission to NNU
- Baby 5: no clinical indication for admission and possible missed opportunity to challenge decision making
- Baby 6: baby could have received triple phototherapy on TC
- Baby 7: inappropriate management of baby's temperature following birth. This baby could have been supported on TC.
- Baby 8: mother received diamorphine 2 hours prior to delivery at a higher dose than recently amended guideline would allow
- Baby 9: baby could have been observed on TC.
- Baby 10: baby admitted due to maternal request. Baby required phototherapy that could have been facilitated at the bedside on postnatal ward.
- Baby 11: baby had asymptomatic low blood sugar and could have received oral glucogel

Themes are therefore:

1) **Overcautious admission to NNU** (7 cases) – policy in place to encourage challenging decision to admit where not indicated. Whilst it is not dangerous to

be overcautious, it often leads to overmedicalistion, and separates mums and babies which has other significant repercussions
2) **Possibly related to opioid prescribing**: the policy has now changed and this may avoid future admissions (2 cases)

2.4.1 Good Practice:

- CPAP used at deliveries instead of PEEP, which facilitated cuddles prior to babies transferring to NNU
- Early recognition of jaundice by midwife
- PEEP for 30 pathway successfully implemented in cases
- Excellent documentation in theatre
- Good antenatal care with screening and support
- Early identification of deteriorating babies
- Good MDT debrief, support and debrief for patient, registrar well supported
- Good planning for caesarean section for mum with BMI 63

2.4.2 Learning Points/Themes

Grunting baby pathway: Pathway has been drafted and is currently being reviewed by midwifery colleagues. The pathway will then go through March governance processes.

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

2.4.3 Recommendations:

- New project introducing CPAP in theatre recovery and in delivery rooms underway to reduce number of very short admissions to NNU
- Grunting baby pathway developed to allow closer monitoring of babies with some concerns but no indication for TC or NNU admission, without separation from parents – some amendments to be made prior to being approved at March governance/guideline meeting
- Opiate prescribing changes now agreed and implemented (in December) which may help reduce the number of respiratory admissions
- Continue to promote awareness of ATAIN shared learning, including facilitating attendance at ATAIN meetings by trainees and midwifery colleagues in addition to the core MDT group, and presenting findings at joint audit meetings
- Continued review of ATAIN actions at the start of each ATAIN meeting to ensure timely completion.
- Ensure learning from ATAIN feeds into wider service workstream to improve pathways for those with diabetes in pregnancy
- NEWTT2 now introduced which includes routine oxygen saturation monitoring on neonates and will allow earlier detection of deterioration

- Exploring option for ATAIN group members to visit WUTH ATAIN meeting as per LMNS advice

3. Monitoring/reporting routes

The ATAIN action plan is monitored at the Women's and Children's Clinical Business Unit Governance Meeting monthly, prior to reporting to the Quality, Safety and Assurance Committee in Common. This report will be shared at the March 2026 Women's and Children's Clinical Business Unit Governance Meeting.

4. Recommendations

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/04/012ii**			
Subject:	**Maternity Incentive Scheme Year 7 Update**			
Date of meeting:	1 April 2026			
Action required:	**To note**			
Author(s):	Helen Wall – Assurance & Improvement Manager (Women's and Children's)			
Executive director sponsor:	Ali Kennah, Chief Nurse			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
		✓		
	Further Information / Comments:			
Executive summary:	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)			

<table>
<tr><td></td><td colspan="3">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.
• 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: Requirements met.
• Safety Action 10 – MNSI/EN: Requirements met; external review by Maternity and Neonatal Safety Improvement Programme and NHS Resolution is pending.

WHH's final position for MIS Year 7 was presented to Board on 4 February 2026 with the LMNS in attendance. Following the presentation, the MIS declaration form was signed by the Chief Executive Officer. This has been countersigned by the Integrated Care Board and has been submitted to NHS Resolution for validation within the specified timeline.</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 Board is asked to:

Note the current status of the MIS submission.</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">QSACiC/26/03/39ii</td></tr>
<tr><td>Date of meeting</td><td colspan="2">10 March 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">Submit to Trust Board</td></tr>
</table>

Freedom of information status (foia):	Release Document in Full
Freedom of information exemptions applied: ***(if relevant)***	None

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. Key elements

2.1 Current position against MIS Year 7

The Trust position, outlining that all safety actions have been met (two require external verification however WHH's robust processes have ensured the requirements have been met) for MIS Year 7 was presented on 4 February 2026 to the Board. The LMNS were in attendance at the Board meeting, in line with the requirements of MIS.

Following the presentation to Board, the self-declaration form was signed by the Chief Executive Officer. The declaration form was countersigned by the Integrated Care Board and has been submitted to NHS Resolution for validation, ahead of the deadline on 3 March 2026.

The Trust Board of Directors minutes from February 2026 will be shared with the Local Maternity and Neonatal System (LMNS) for completion.

2.2 MIS Year 8

MIS Year 8 requirements will be published on 31 March 2026. Launch events will be taking place throughout April 2026. The maternity SLT are registered to attend. Updates on MIS Year 8 will be provided to the Quality, Safety and Assurance Committee in Common in May 2026.

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 March 2026 to ensure continued oversight and alignment with service improvement priorities.

4. Recommendations

The Trust Board of Directors members are requested to note the current status of the MIS submission.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/04/012iii**			
Subject:	**Maternity & Neonatal Quality Review – January 2025**			
Date of meeting:	1 April 2026			
Action required:	**To note**			
Author(s):	Tina Moors – Interim Director of Midwifery			
Executive director sponsor:	Ali Kennah, Chief Nurse			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
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 and provides oversight of matters related to Maternity and Neonatal Care focussing attention on improving outcomes for this protected group.			
Executive summary:	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 QSACiC 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 January 2026 there were 0 fatal, 1 severe harm event in the maternity or Neonatal Services. There were 2 moderate harm events, 2 (OASI) 3rd/4th degree tear			

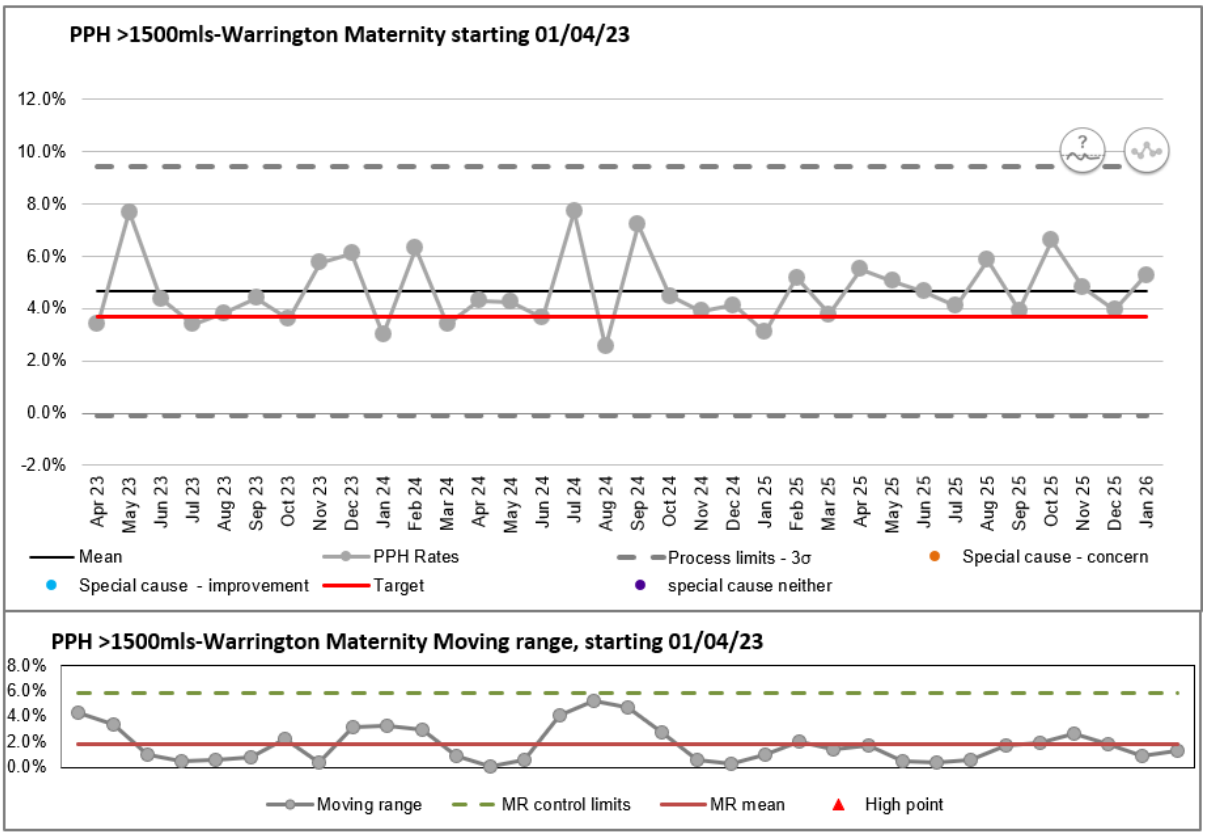
	Themes from Maternity/Neonatology patient safety events in January 2025 are as follows: Admission of term babies admitted to Neonatal Unit (NNU) Postpartum Haemorrhage (PPH) 1000ml-1500ml Postpartum Haemorrhage (PPH) >1500ml At the end of January mandatory training compliance and role specific training across maternity and child health colleagues is above 85%. Compliance with PDR completion is below Trust Target with a position of 79%. 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 9.8% 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 0.2% The service continues to share good practice and compliments with the team The service continues to achieve its KPIs for Maternity Triage. Work continues with regard to induction of labour (IOL) particularly in reducing delays. An overview of the sevice's position with regard to cases being investigated by MNSI is provided for oversight. An update regarding Maternity Workstreams Qtr 3 Postnatal Readmissions Maternity Care Bundle There were 4 complaints were received in the Maternity and Neonatal Services in January 2025 No Regulation 28 enquiries have been received.		
Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**
Recommendation:	The Trust Board of Directors are asked to note the contents of the report.		
Previously considered by:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	QSACiC/26/03/39iii	
	Date of meeting	10 March 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		
Freedom of information exemptions applied: ***(if relevant)***	None		

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. Key elements

Harm Events

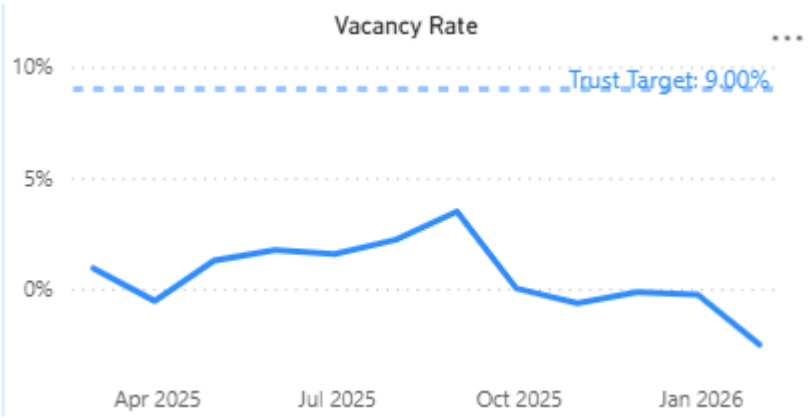


3. Actions required/responsible officer

Text - Nil

4. Measurements/evaluations

Workforce Metrics and Measures



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.

Maternity Triage

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

Triage attendances January 2025-January 2026	
Month	**Attendances**
January	621
February	547
March	638
April	521
May	577
June	587
July	602
August	588
September	623
October	668
November	562
December	564
January	571

Current performance

- In January 2026 571 triage attendances (396 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 37 minutes.
- 96.6% of all attenders were seen within 15 minutes of arrival (best practice guidance). This meets KPI of 90% review within 15 minutes.

- 9% of attenders were seen within less than 30 minutes of arrival (NICE guidance). Again, this meets KPI which stipulates 95% review within 30 minutes.
- 0 Women categorised as red on arrival.
- 18% of attendees were categorised orange on arrival, showing a reduction to December 2025 when the proportion was 30.4%.

Triage Action Plan

- 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

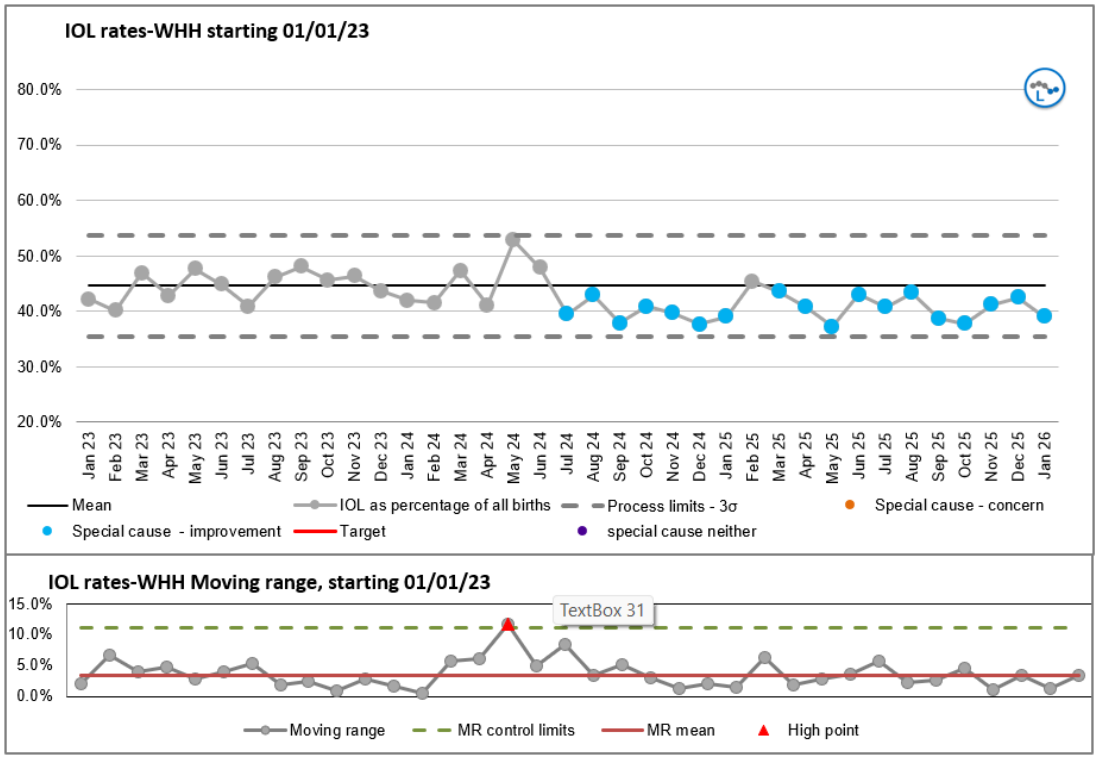
- January 2026 Breaches. 4 Women Total Waited >30 minutes. No women categorised Red.

Induction of Labour

Quality, Safety and Assurance Committee in Common noted 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 January 2026, presented as a percentage of all births.
The SPC chart for WHH IOL rates demonstrated special cause improving variation, with 11 months demonstrating data below the mean showing sustained improvement.

January rate: 39.04% (73/187)

12 month rolling mean (01/02/25-31/01/26): 41.05%



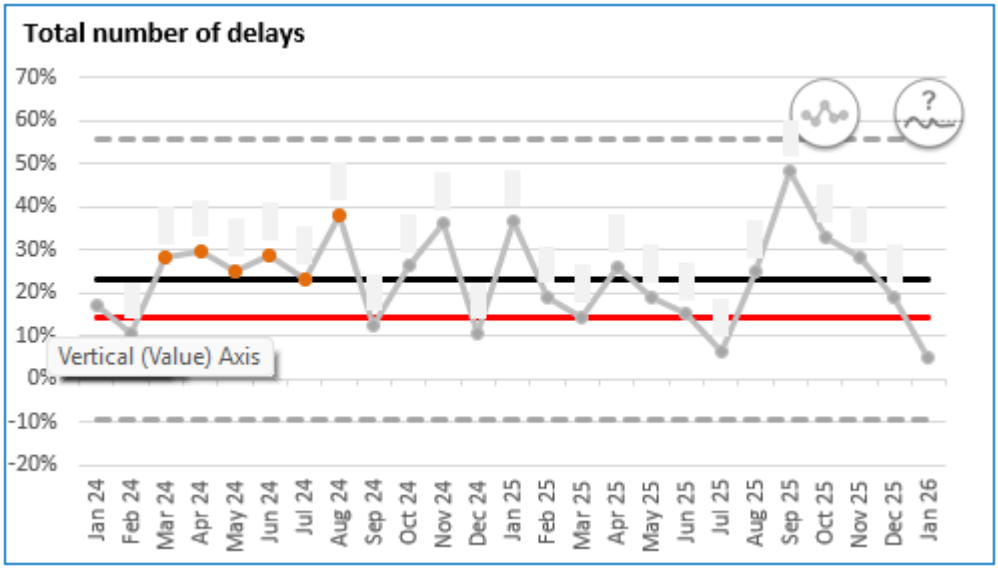
Currently on Badgernet NHS Choices leaflet is available and leaflets specific to WHH have also been developed and will be available via BadgerNet. These are designed to inform patients about the IOL process, associated risks and benefits, declining IOL, and induction prior to 39 weeks. Filming for the 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 delays data for January demonstrates further clear improvement following the increase we observed in September.

- In December, delays over 12 hours reduced to 17.5%, and delays over 24 hours dropped to 3.5%, bringing the overall **Total delay rate to 21%**
- In January, delays over 12 hours reduced to 4.08%, and delays over 24 hours dropped to 4.08%, bringing the overall **Total delay rate to 8.16%**
  The SPC shows a sustained reduction December with January remaining low and stable, providing reassurance that improvements are being maintained.



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 31st January 2026.**

	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total
Total number undergoing Induction of Labour	45	95	43	30	163	49	60	485
Total Delayed	18	0	2	2	48	4	9	83
% of Total	40.00%	0.00%	4.65%	6.67%	29.45%	8.16%	15.00%	17.11%

- There has been a **27.3%** increase in the number of women undergoing IOL from **381** in December to **485** in January.
- There has been a **31.7%** increase in the total number of delays from **63 (16.5%)** in December to **83 (17.1%)** in January.
- The percentage of delays is highest at COC at **40.0%**, compared with **0%** at LWH.

5. Trajectories/objectives agreed

Action Plan

Outpatient induction accounted for 18% of activity. Review has identified that 10 women who were clinically suitable for outpatient induction did not proceed on that pathway. This has been identified as the current priority. A focused review is underway to understand variation in practice and to strengthen the outpatient process in collaboration with the Nest/Lunar team, with the aim of maximising appropriate utilisation and reducing avoidable inpatient demand. In addition, work is progressing on the development and implementation of a SOP for the management of low-risk women who decline post-dates induction of labour. This will provide clearer guidance on suitability, outpatient processes and pathway standardisation.

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 • 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. 18/02 – Arrowe have consistently performed below standard for their delays therefore decision made to not visit.	01/02/2026	
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	01/03/2026	
Implement midwifery administration of second Propess (if prescribed by ST3+).	Amelia Crowther	Implemented on 1st December 2025	30/11/2025	
IOL patient information video plans in place for multilingual voiceovers to support accessibility and informed consent	Amelia Crowther/Meg Ellams	Video complete, awaiting final sign off from comms, and then can commence voiceovers in various languages. 18/02 – Video complete, review ongoing into the most used languages and to obtain staff to complete the voiceovers	31/03/2025	
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	
Development and implementation of a SOP) for the management of low-risk women who decline post-dates induction of labour	Despina Georgiou	18/02 – To also include the outpatient process and suitability of patients for outpatient and how this process looks.	31/03/2025	

Joint Oversight Support with LMNS 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.

6. Monitoring/reporting routes

MNSI Position and Reports Received

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.

Current position

Four cases in progress

Three cases in progress - One case complete and closed for January

Referred April 2025 MI-041711 (HIE/NND) in progress – Draft report delayed until COD from PM
Referred September 2025 MI-047285 (Shoulder Dystocia HIE) Draft report received 22/01/26
Referred September 2025 MI-047288 (Pool birth HIE) in progress

7. Timelines

Updates on other workstreams

Qtr 3 Postnatal Readmissions

Quarter 3 saw 14 readmissions in total. Of the 14 readmissions, 4 were avoidable, and 10 were unavoidable.

Both October and November had 6 admissions, and December received only 2 re-admissions. Reasons for admission included Wound Concerns (4 – 28.57%), Hypertension (2 – 14.28%), Pyelonephritis (1 – 7.14%), Mastitis (1 – 7.14%), Perineal Infection (1 – 7.14%), Secondary PPH (1 – 7.14%), Pain (2 – 14.28%), Cardiac (1 – 7.14%) and Blood Patch (1 – 7.14%).
Of the 4 Avoidable readmissions, the reasons for re-admission were related to Mastitis (1), Hypertension (1) and wound infections (2).

1 Case of wound infection was deemed avoidable due to returning with Healthcare Acquired Infection. Upon review of the care provided, the patient underwent multiple invasive procedures, and it could not be ruled out that the infection was acquired during clinical care. Wound after care was found to be in line with guidance. Maternity teams were informed in safety briefings to be vigilant in using ANTT and hand hygiene, and to be aware of healthcare-acquired infections.

The 2nd Case of wound infection was deemed avoidable because a wound swab was not actioned for 3 days, during which a positive culture grew. The patient had complained of various ailments throughout postnatal re-admission, but did not appear to have been reviewed holistically to query infection. The patient subsequently returned unwell with a wound infection requiring a sepsis screen.

1 Case of hypertension was deemed avoidable as the patient had been diagnosed with pre-eclampsia but was managed postnatally as pregnancy-induced hypertension. This was due to the use of interchangeable language rather than remaining with the correct diagnosis. This led to a patient's medication being stopped earlier than the hypertension guideline suggests, which resulted in admission to control elevated blood pressure.

1 Case of mastitis was deemed unavoidable as adequate feeding support was not provided before discharge directly from the Birth Suite. The patient was mixed feeding but received no breastfeeding support, which resulted in mastitis. This would have been avoided by completing both the formula and breastfeeding feeding reviews.

Overall, Quarter 3 showed a slight reduction, with 15 Postnatal readmissions in the previous Quarter. This Quarter, 2 cases of wound infection involved the same patient, who returned for planned surgical intervention. This would result in 13 unplanned postnatal readmissions.

Although both quarters had 4 unavoidable readmissions, this quarter resulted in a slight decrease. Although Wound infection was the leading theme this quarter, there were no themes across the 3 wounds infections, with all admissions presenting under different circumstances.

Maternity Care Bundle

The Maternal Care Bundle (MCB) was launched in January 2026 outlining best practice standards across five areas of clinical care. The MCB sets out responsibilities for both Trusts and commissioners. The aim of the MCB is to reduce maternal mortality and morbidity and reduce inequalities in theses adverse outcomes.

The five elements are:

Element 1: Venous thromboembolism
Element 2: Pre-hospital and acute care
Element 3: Epilepsy in pregnancy
Element 4: Maternal mental health
Element 5: Obstetric Haemorrhage

The associate clinical lead (O&G) and assurance and improvement manager have reviewed WHH's position against the interventions. The initial benchmarking exercise has identified WHH already has significant compliance with the MCB. NHSE will be launching an implementation tool in Q4 for trusts to track their progress. The MCB implementation tool will be reviewed on an ad-hoc basis by NHSE. There will be no formal submission deadlines as there is for SBL and MPOP. Upon release of the implementation tool, formal benchmarking will be completed. Quarterly update will be provided to QSACiC through the maternity and neonatal safety overview paper.

Complaints

4 complaints were received relating to care in the maternity and neonatal services in January 2026

ID	Specialty	Description	Complaint Received in the Trust
25981	Maternity	Complainant as multiple concerns regarding his wife's labour and the care provided.	In Progress
26041	Maternity	Patient unhappy with level of care provided, conflicting information, pre-eclampsia and gestational diabetes miscommunication, lack of help with feeding	In Progress
26096	Maternity	Complainant has multiple concerns relating to the coordination of her care during and after her labour and treatment she received after suffering post=partum haemorrhage	In Progress
26048	Maternity	Patient had been administered an expired vaccine during pregnancy	In Progress

8. Assurance committee (if relevant)

Coroner Regulation 28 Enquiries

No Regulation 28 enquiries have been received.

9. Recommendations

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

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/04/012iv**			
Subject:	**Quarter 3 2025/26 Transitional Care (TC) Report**			
Date of meeting:	1 April 2026			
Action required:	**To note**			
Author(s):	Erica Wiles – Neonatal Matron			
Executive director sponsor:	Ali Kennah, Chief Nurse			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
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. Achieving positive outcomes with regard to Transitional Care will have a positive impact on this group.			
Executive summary:	The paper provides an overview of babies who required Transitional Care (TC) in the period October to December 2025. An audit of babies who received TC within Q3 2025-26 has been undertaken and results of this will be described within this paper along with any identified learning. Following the CQC inspection of Maternity Services at WHH in September 2023, a full review of the current Transitional Care (TC) Model has taken place. A multidisciplinary (MDT) Working Group was created with			

<table>
<tr><td></td><td colspan="3">representatives from both Maternity and Neonatal Services.

The Q3 Transitional Care audit has identified the following:
71 babies who met the broad admission criteria for TC in Q3.
52 babies received IV antibiotics on the postnatal ward – these babies were cared for by the maternity team; the Neonatal team administered the IV antibiotics.
Three babies received TC from birth.
Three babies received step-down TC.
Five babies received TC care via the PEEP for 30 pathway.
Eight babies did not receive TC.
The audit has identified learning, action to resolve have been added to the TC action plan.
The action plan is monitored via Women’s & Children’s Governance (WCH) and the Neonatal Oversight Meeting.</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 of Directors is asked to note the contents of the report.</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">QSACiC/26/03/39iv</td></tr>
<tr><td>Date of meeting</td><td colspan="2">10 March 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring</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>Freedom of information exemptions applied:
(if relevant)</td><td colspan="3">None</td></tr>
</table>

1. Background/context

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

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

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

Following the CQC inspection of Maternity Services at WHH in September 2023, a review of the current transitional care model has taken place, from this a working group was created and a robust action plan developed. Alongside this, an audit of babies who received TC within Q3 2025/26 has been undertaken and results of this will be described within this paper.

2. Key elements

2.1 WHH Transitional Care Position

The findings of this report have been collated from a review of all babies who met the criteria for TC during the Q3 reporting period from 1st October to 31st December.

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

WHH Transitional Care Criteria

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

Any baby requiring one or more of the following:

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

2.2 Summary of Babies who met the Transitional Care Criteria

During Q3, 49 babies met the criteria for TC. An audit of these cases has identified the following:

Received Transitional care from birth	3
Appropriately received NNU care and stepped down to TC when well enough	3
Allocated to PEEP for 30 pathway	5
Did not received TC	8
Receiving IV antibiotics on the postnatal ward	52

Quarter 2 Transitional Care (TC) Activity Summary

- A total of **71 babies** met the criteria for Transitional Care (TC) in Q2.
- Of these **eight** babies did not receive TC care
    - **Two babies** were potential candidates for TC at birth; however, due to high patient acuity and staff sickness on the Neonatal Unit (NNU), TC staffing was not possible.
    - **Four babies** were suitable for step-down to TC however their mother had been discharged home once medically fit.
    - **One baby met criteria however due to safeguarding TC could not be facilitated**
    - **One baby was suitable for step-down TC however this was not facilitated due to maternal mental health.**

The remaining babies who met TC criteria received TC care. Babies who were receiving Intravenous antibiotics received care from the maternity team and neonatal team.

Neonatal transitional care is discussed during WHH ATAIN review group, in Q3 4 term admissions have been highlighted as avoidable should TC care have been initiated.

2.3 Implementation of Transitional Care Shift on Neonatal Unit Roster

In **July 2025**, a dedicated **Transitional Care (TC) shift** was incorporated into the neonatal unit's staffing roster. This shift enables the consistent allocation of a

specialised TC nurse for each shift. During Q3, there was **two occasions** when TC could not be facilitated due to staffing pressures. This occurred because an acute increase in acuity required the TC nurse to be redeployed to the neonatal unit.

The neonatal unit will continue to allocate the TC shift and will facilitate ongoing auditing of staffing compliance by tracking instances when the shift is cancelled or covered by external staff from the NHS Professionals (NHSP) bank. This monitoring will support the identification of staffing gaps and help evaluate the impact on transitional care quality and patient outcomes.

TC staffing model

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

There have been staffing challenges within the Neonatal team in Q3 due to high maternity leave however the allocation of a TC nurse on the neonatal unit roster has had a positive impact on the consistency of delivering the TC service.

Given the positive impact of the dedicated TC nurse allocation, alternative models are now being considered and will be included in the overarching Neonatal Transitional Care staffing paper.

2.4 Quality improvement project

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

2.5 Good Practice from the Q3 2025/26 audit:

- Excellent neonatal care for babies, thus ensuring safety of babies who have been separated from their mothers.
- Sharing of audit outcomes across the MDT with both Midwifery and Neonatal Teams to ensure learning is communicated.
- Significant improvements in relation to the timely step down of these babies to TC
- PEEP for 30 pathway continues to reduce term admissions.

2.6 Recommendations:

- Risk assessment to be implemented when unable to facilitate TC.
- Utilise TC to reduce term admissions.

- Staffing – Continue to ensure neonatal staff are allocated to TC babies. TC shift added to roster to allow allocation and audit when shift sent to NHSP or staff member required on NNU.
- To continue TC education with Neonatal and maternity teams following ratification of updated guideline.
- TC review group to continue to review and discuss cases and monitor actions/progress against the action plan.
- Collaborative project with Neonatal and maternity teams for the midwifery team to become 2nd checkers for neonatal IV antibiotics.

2.7 Outstanding actions from action plan

- Ongoing TC audit which will be reported through this committee.
- Maternity estates project to commence early 2026.

3. Monitoring/reporting routes

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

4. Assurance committee (if relevant)

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

Within MIS year 7, there remains the requirement for a formal QI project to ensure a sustainable transitional care model. WHH has an ongoing piece of work which will be reviewed and refreshed to ensure it meets all requirements of the new guidance and to reflect learning from recent quarterly reviews of the WHH transitional care offer.

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

5. Recommendations

The Trust Board of Directors members are requested to note the contents of this report.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/04/012v**			
Subject:	**CQC Maternity Survey Results 2025**			
Date of meeting:	1 April 2026			
Action required:	**To note**			
Author(s):	Helen Wall – Assurance & Improvement Manager			
Executive director sponsor:	Ali Kennah, Chief Nurse			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
		✓		
	Further Information / Comments:			

Executive summary:	This paper provides and overview of the CQC maternity results for 2024. The information provides the committee with an analysis of the responses of people who have given birth at the Trust between January and February 2025.
	
	Following the significant improvement in 2024, the Trust is 'about the same' as other Trusts for 57/58 questions.
	
	• Regional comparison; somewhat worse than expected:
	  • Section 1 Antenatal Care; question B14. Thinking about your antenatal care, were you treated with respect and dignity?
	• Trust comparison; slight decrease compared to 2024 results:
	  • Section 1 Antenatal care question B14. Thinking about your antenatal care, were you treated with respect and dignity?			

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

Section 2 Labour and Birth; C21. Thinking about your care during labour and birth, were you treated with kindness and compassion?
Section 3 Care in the ward after birth; question D7. Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth?

An action plan has been developed to help drive improvements which will be monitored through Women's Health Governance.
</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 of Directors is asked to note the contents of the report.</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">QSACiC/26/03/39v</td></tr>
<tr><td>Date of meeting</td><td colspan="2">10 March 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2"></td></tr>
<tr><td>Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring</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>Freedom of information exemptions applied:
(if relevant)</td><td colspan="3">None</td></tr>
</table>

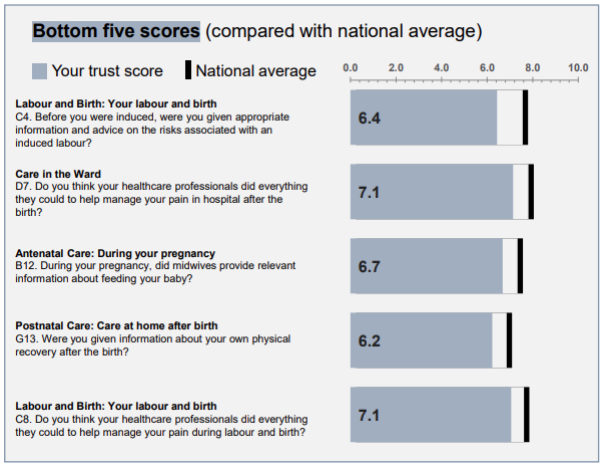
1. Background/context

The CQC maternity survey takes place annually for women and people over the age of 16 who had a live birth in February 2025 are eligible to take part and asks a sample who gave birth about their experiences of antenatal care, labour and birth and postnatal care. The sample for the Maternity Survey is selected from all maternity service users aged 16 and over at the time of delivery who had a live birth between 1 February and 28 February 2025. (Note: the survey is sent to 300 people, as our number of births for February fell below this number, surveys were also sent to some women who gave birth in January 2025.) This paper provides an overview of the results of the CQC Maternity Survey 2025.

2. Key elements

2.1 2025 Results

123 patients responded to the survey with a response rate of 41.28% for 2025 compared to a 2024 response rate of 44%. Responses were received from women which were representative of the ethnicities of women giving birth at WHH. Results identify the Trust was somewhat worse than most trusts for 1 question and were about the same as most trusts for 57 questions.



Our bottom five scores, compared with the national average, are '**about the same**' compared the national average and do not demonstrate any particular outliers.

Our lowest scores

Bottom scoring 5 questions 2025	2025 score	2024 score
After your baby was born, did you have the opportunity to ask questions about your labour and birth?	5.9	6.1

If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?	6.1	6.7
Were you given information about your own physical recovery after the birth?	6.2	6.9
On the day you left hospital, was your discharge delayed for any reason?	6.3	6.1
Thinking about the last time you attended triage in person, how did you feel about the length of time you waited before you were seen by a midwife?	6.3	New question

Our top scores

Top scoring 5 questions 2025	2025 score	2024 score
If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	9.4	9.6
Did a midwife ask you about your mental health?	9.4	9.6
Thinking about your antenatal care, were you spoken to in a way you could understand?	9.2	9.2
During your labour, were you ever sent home when you were worried about yourself or your baby?	9.2	9.4
Were you given enough support for your mental health during your pregnancy?	9.1	8.9

2025 data compared to 2024 data

Patient survey section	2025 Response Score	2024 Response Score	Comparison
Antenatal Care - The start of your care during pregnancy	7.4	8.0	About the same
Antenatal Care - Antenatal check ups	8.2	8.6	About the same
Antenatal Care - During your pregnancy	8.4	8.7	About the same
Labour and Birth - Your labour and birth	8.1	8.5	About the same
Labour and Birth - Staff caring for you	8.4	8.7	About the same
Care in the ward after birth	7.4	8.0	About the same
Postnatal Care - Feeding your baby	8.3	8.2	About the same
Postnatal Care - Care at home after birth	7.7	7.9	About the same
Triage: Assessment and Evaluation	7.9	New area 2025	About the same
Complaints	6.7	6.8	About the same

Comparisons

- Regionally within bottom 5 lowest scores for 'During your pregnancy' section. These are all '**about the same**' as the national average.
- Regional comparison; somewhat worse than expected:
    - Section 1 Antenatal Care; question B14. Thinking about your antenatal care, were you treated with respect and dignity?
- Trust comparison; slight decrease compared to 2024 results:
    - Section 1 Antenatal care question B14. Thinking about your antenatal care, were you treated with respect and dignity?
    - Section 2 Labour and Birth; C21. Thinking about your care during labour and birth, were you treated with kindness and compassion?
    - Section 3 Care in the ward after birth; question D7. Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth?

3. Actions required/responsible officer

Discussion and next steps

Our 2024 survey data was a significant improvement from 2023. We are pleased to have mostly maintained our position in line with the region for 2025. However we are striving for further improvement in women's experiences of maternity services at WHH.

The maternity SLT have reviewed the survey responses and an action plan has been developed to drive improvement. Since the survey took place, WHH has worked with the MNVP leads to develop a feedback form to help drive improvements in people's care. The form was implemented in June 2025 and has been a useful tool to gather patient experience and make timely improvements to the maternity service. The form is readily available for people to access in all patient areas via a QR code. In relation to our lowest scores, significant work has taken place to drive improvement in these areas, which is evidenced in our action plan.

An action plan has been developed in response to the results of the survey.

Appendix 1: CQC Maternity Survey Results 2025 Action Plan

4. Monitoring/reporting routes

The action plan will be monitored by the Maternity SLT through Women's Health Governance. Any concerns will be escalated to Women's and Children's CBU Governance. The action plan has also been presented to Patient Experience.

5. Assurance committee (if relevant)

The action plan will be monitored by the Maternity SLT through Women's Health Governance. Any concerns will be escalated to Women's and Children's CBU Governance. The action plan has also been presented to Patient Experience.

6. Recommendations

The Trust Board of Directors members are requested to note the contents this report.

North Cheshire and Mersey
NHS Foundation Trust

NHS Staff Survey 2025

Trust Board – 1 April 2026

Home
Community
Hospital

Overview

What this deep dive covers:

- Participation / response rates (WHH: 39%; BCH: 52.5%)
- High-level results across all **9 People Promise elements**
- Protected characteristics insight (race, disability, sexual orientation)
- Key organisational risks (advocacy, morale, psychological safety, staffing, workload)
- Next steps and proposed priority actions for assurance

The survey provides robust intelligence and highlights clear, consistent themes across both legacy organisations:

- **Shared challenges** focus on staff voice, morale, workload and fairness
- **Shared strengths** include compassion, inclusion, teamwork and managerial support

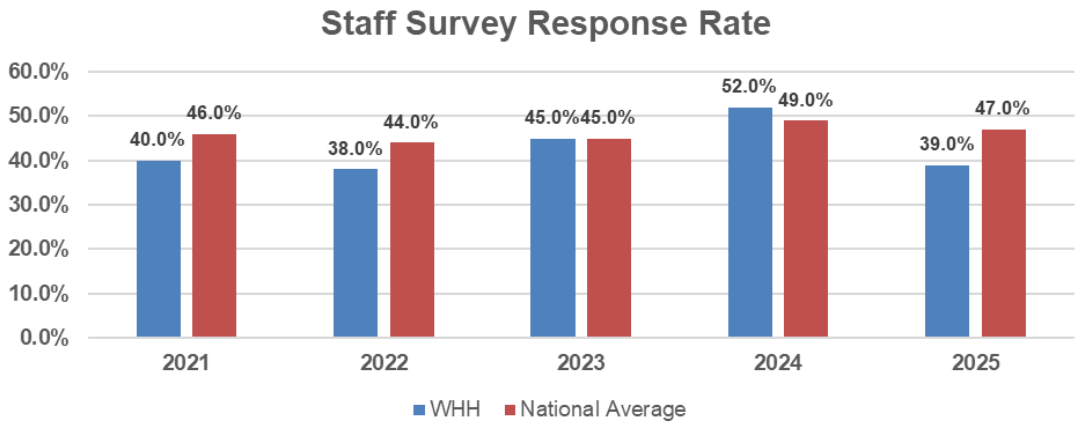
At an organisational level as part of the Medium-Term Planning Framework there is a requirement to undertake an analysis to support a minimum of three organisational actions which must be reported to the Board. This cannot be completed until a full analysis of the free text comments is completed (due to be released to each Trust in March 2026)

Response rates

Warrington and Halton Teaching Hospitals

A total of **1812 staff members** completed the 2025 survey, which equates to **39%** of the eligible workforce. This is a 13% decline in comparison to the 2024 survey

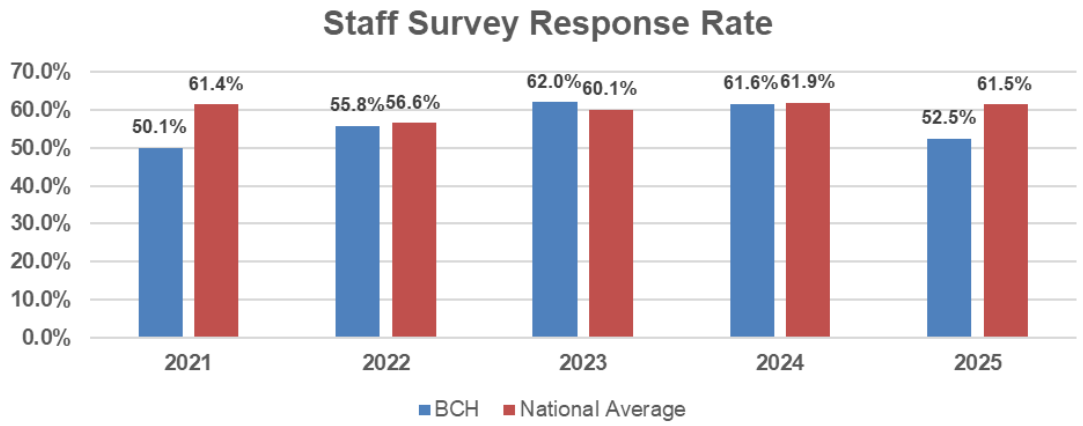
The results also show that the Trust performed 8% below than the national average response rate of 47%



Bridgewater Community Healthcare

A total of **821 staff members** completed the 2025 survey, which equates to **52.5%** of the eligible workforce. This is a 9% decline in comparison to the 2024 survey

The results also show that the Trust performed 9% below than the national average response rate of 61.5%



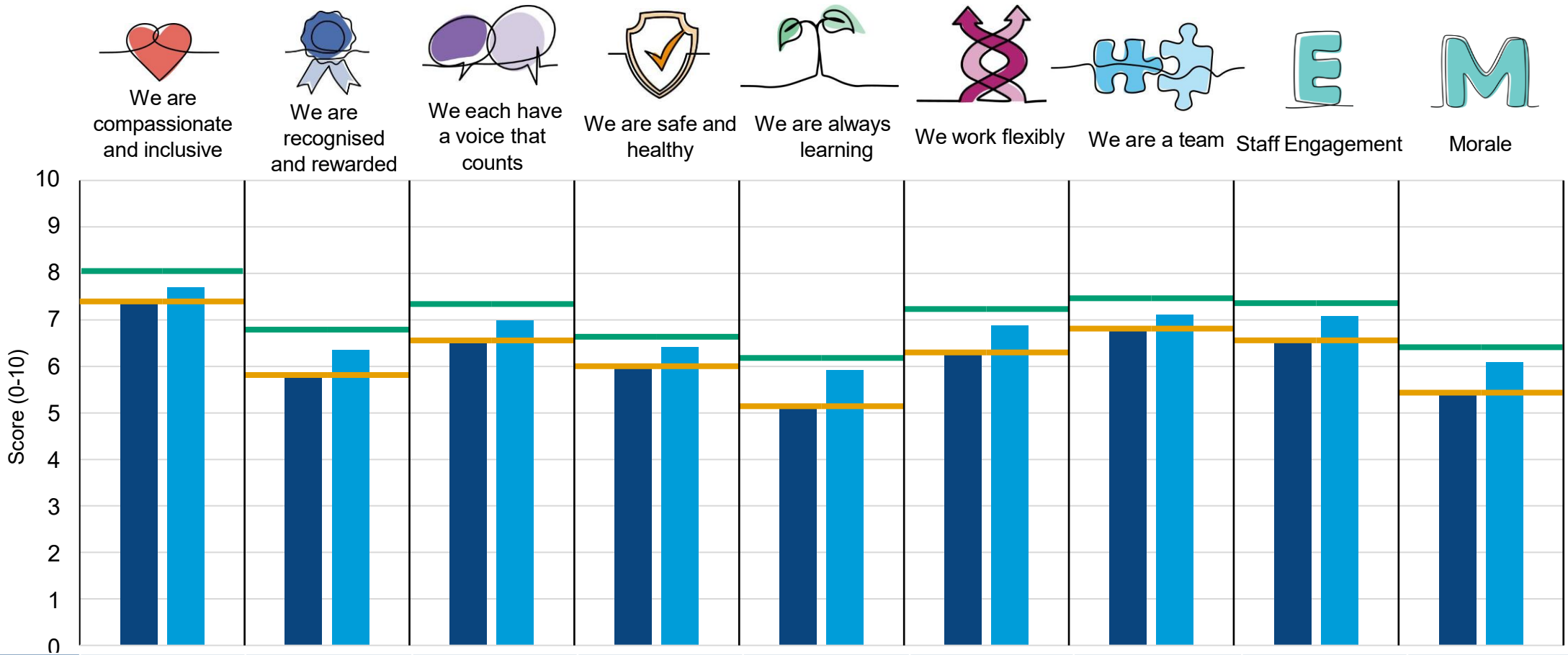
People Promise elements and themes: Warrington and Halton Teaching Hospitals NHS Foundation Trust Benchmark

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
WHH	7.31	5.96	6.63	6.11	5.62	6.32	6.85	6.64	5.86
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	1810	1808	1792	1796	1741	1797	1806	1807	1811

People Promise elements and themes: Bridgewater Community Healthcare NHS Foundation Trust Benchmark

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
BCH	7.41	5.82	6.56	6.00	5.14	6.30	6.81	6.56	5.44
Best result	8.05	6.79	7.34	6.64	6.18	7.23	7.47	7.36	6.41
Average result	7.70	6.36	6.98	6.41	5.92	6.89	7.12	7.09	6.09
Worst result	7.40	5.82	6.56	6.00	5.14	6.30	6.81	6.56	5.44
Responses	818	817	817	818	789	812	818	819	819

People Promise and Themes

High-level analysis following the release of the results (12 March 2026)

• Home • Community • Hospital

Caring for you

We are compassionate and inclusive

High-level analysis and results

Findings

- WHH scores above sector on compassionate leadership (+0.13), inclusion (+0.11) and diversity (+0.16).
- BCH saw declines across all compassion/inclusion areas (–0.38 People Promise score).
- Both Trusts report reduced feelings of fairness and diminished trust in organisational decision making.

Protected characteristics

- **Race**: BME staff much more likely to experience discrimination, harassment and lower psychological safety.
- **Disability**: Disabled staff score lower on inclusion, feel less valued and report more exhaustion.
- **Sexual orientation**: LGB+ staff report better scores on discrimination but lower engagement and morale.

Assurance implications

- Cultural strengths at team level are evident, but organisational inclusion is fragile.
- Increased discrimination reporting from BME and disabled staff indicates systemic issues requiring targeted action.

Preliminary actions

- Strengthen anti racist and anti discriminatory practice.
- Improve reasonable adjustments and disability confidence.
- Board oversight of equality gaps through WRES and WDES alignment.

We are recognised and rewarded

High-level analysis and results

Findings

- Recognition and reward remain the lowest scoring domain for BCH (–0.59) and WHH.
- Pay satisfaction remains significantly below benchmark.
- Staff perceptions of being valued have deteriorated in both organisations.

Protected characteristics

- **Disabled and LGB+** staff feel less valued by the organisation.
- **BME** staff scored higher on appraisal helpfulness, showing opportunity for targeted leadership.

Assurance implications

- Lack of recognition is strongly associated with morale decline and turnover risk.

Preliminary actions

- Relaunch recognition scheme (Trust wide “You Made a Difference”).
- Equip managers with everyday recognition tools.
- Integrate recognition into leadership capability programme.

We each have a voice that counts

High-level analysis and results

Findings

- Significant decline in psychological safety, especially at WHH (–0.30 to –0.69 in speaking up areas).
- BCH results show reduced involvement in decisions and lowered confidence concerns will be acted upon.

Protected characteristics

- **BME** staff feel less safe speaking up and less trust that concerns lead to action.
- **Disabled** staff report lower confidence in organisational responsiveness.

Assurance implications

- Organisational psychological safety represents a strategic risk and impacts retention and quality outcomes.

Preliminary actions

- Refresh Freedom To Speak Up pathways across the new organisation.
- Quarterly “You Said, We Did” publication.
- Leadership development focused on transparency and follow through.

We are safe and healthy

High-level analysis and results

Findings

- Declines across both Trusts in wellbeing, stress indicators, MSK absence and burnout.
- WHH experienced improvement in burnout indicators, although still below sector norm.

Protected characteristics

- **Disabled** staff report higher levels of exhaustion, presenteeism, stress and unsafe workloads.
- **BME** staff more likely to face harassment, abuse and discrimination.

Assurance implications

- Clear link between unsafe workloads, psychological safety and increased turnover intent.

Preliminary actions

- Strengthen Health and Wellbeing offer (financial, psychological, MSK support).
- Violence reduction and “See it. Report it. Stop it.” campaign rollout.
- Embed learning from incident reporting into team briefs.

We are always learning

High-level analysis and results

Findings

- BCH shows the largest decline here (–0.63).
- WHH: access to development (–0.26), appraisal effectiveness (–0.16).
- Development is highlighted as a major concern in free text themes.

Protected characteristics

- **Disabled** staff score lowest across this domain.
- **BME** staff report more benefit from appraisals than white staff.

Assurance implications

- Weakness in learning and development threatens long term workforce capability.

Preliminary actions

- Improve appraisal quality through structured QA and manager training.
- Publish career pathways.
- Enhance access to education through digital learning catalogue.

We work flexibly

High-level analysis and results

Findings

- WHH: “We work flexibly” did not significantly change from 2024.
- BCH: significant decline (–0.61).
- Operational pressures reducing real flexibility across services.

Protected characteristics

- **Disabled** staff experience far lower flexibility.
- **LGB+** staff score lower on flexible working and support for work life balance.

Assurance implications

- Flexibility is essential for retention, especially in hard to recruit areas.

Preliminary actions

- Refresh flexible working policy and manager guidance.
- Share internal case studies where flexible models improved performance.

We are a team

High-level analysis and results

Findings

- WHH “We are a team” stable year on year; BCH declines across teamwork indicators.
- Both Trusts experience more strained team relationships and weakened collaboration.

Protected characteristics

- **Disabled** staff feel less valued and respected by colleagues.
- **BME** staff feel less personal attachment to teams and less cohesion.

Assurance implications

- Need to rebuild team level stability post integration and through workforce redesign.

Preliminary actions

- Identify model teams and scale best practice.
- Embed team based development and reflection sessions.
- Strengthen cross site networking.

Initial Organisational Priorities

Aligned to the Medium-Term Planning Framework

• Home • Community • Hospital

Caring for you

Organisational priorities

Initial overview (to be confirmed post release of the free-text comments report, expected by the end of March 2026)

Rebuild Advocacy and Organisational Trust
- Launch a high visibility “You Said, We Did” programme
- Strengthen patient-first narrative
- Increase executive presence in clinical areas

Strengthen Psychological Safety and Speaking Up
- Refresh Freedom to Speak Up pathways in line with integration
- Leadership training focused on transparency and follow-through, built and embedded within the new Leadership and Management Framework
- Publish quarterly anonymised “actions taken” summaries

Address Violence and Bullying Behaviour
- Launch the “See it. Report it. Stop it.” campaign across both Trusts
- Refresh data analysis and reporting to align protected characteristic data into incident reporting mechanisms
- Implement Active Bystander training and skill base across all services

Reenergise Recognition and Reward
- Relaunch recognition scheme
- Equip leaders with recognition tools
- Embed everyday recognition behaviours

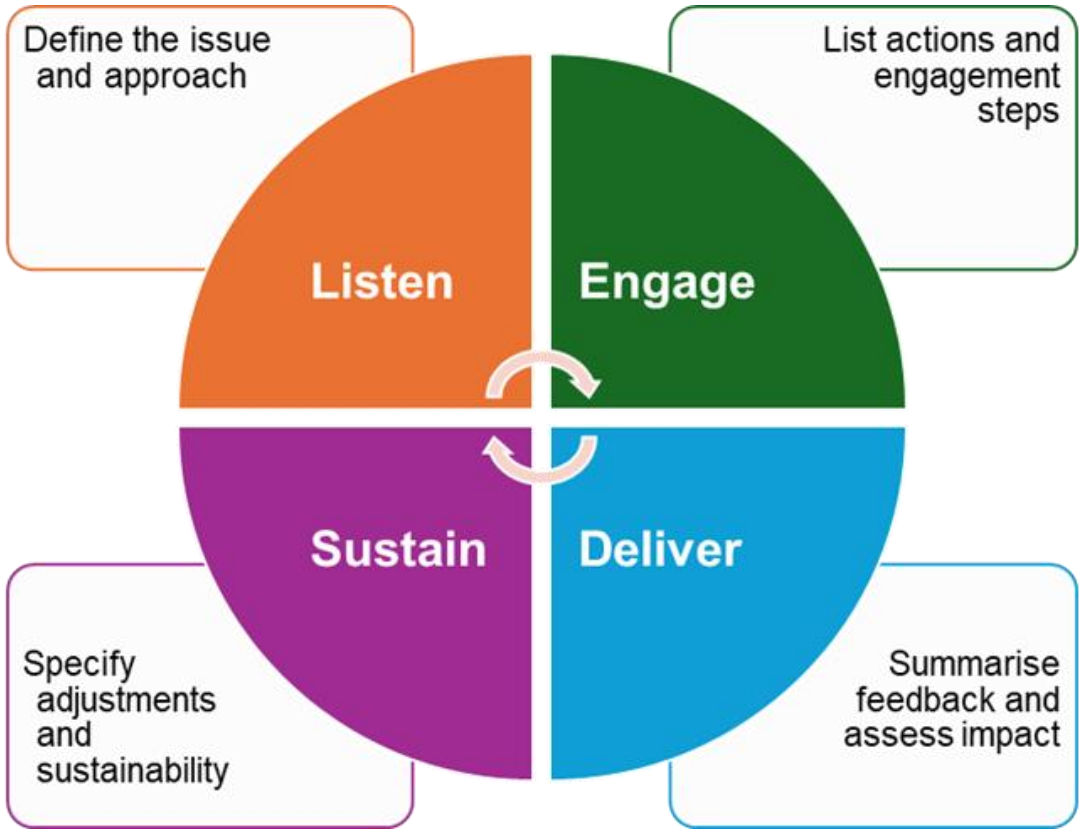
Strengthen Learning and Development
- Improve appraisal quality through management capability
- Develop clear career pathways
- Enhance access to training (digital catalogue first approach)

Leverage Team Strengths
- Identify and scale model teams in line with workforce design principles
- Promote cross-team collaboration through a quality, people and sustainability lens, balanced against performance indicators through the Culture Plan
- Maintain investment in diversity and inclusion programmes and enhance the maturity of staff networks and peer groups in local areas

Listen, engage, deliver, sustain (LEDS) cycle

New tool to support localised change and improvements

- **Clear delivery framework in place:** Managers to use the LEDS cycle (Listen, Engage, Deliver, Sustain) to turn staff survey feedback into action.
- **Action planning is structured and owned:** Teams identify a priority issue, set a clear aim, define success measures and assign responsibilities and timelines.
- **Delivery is measured and evidenced:** Impact is checked through pulse feedback/check-ins and outcome measures (e.g., satisfaction, uptake), with learning captured.
- **Accountability and sustainability built in:** Managers close the loop by reporting back to staff, adjusting what doesn't work and embedding successful changes into routine practice.
- **Consistency of approach:** A simple manager template and practical tips (visibility, co-design, keep it focused, repeat cycle) support reliable delivery across teams.



Next steps

Following the release of the survey results on 12 March 2026

- Complete a full review of all results and benchmark against other NHS Trusts in the region and national
- Launch the communications plan to support awareness and action
- Develop and finalise organisational priorities in line with the Medium-Term Planning Framework (following the release of the free-text comments report)
- Develop localised action plans with Care Groups and divisions to support real-time improvements utilising the LEDS cycle
- Monitor staff survey compliance through the People Performance Committee
- Align results against the Culture Plan from April 2026 onwards
- Meet with Staff Network leadership teams to support protected characteristic improvement plans
- Reset People Promise programmes of work for 2026/27 following the release of the results, initial focus areas include: Compassionate Cultures / Bullying and Harassment / Flexible Working

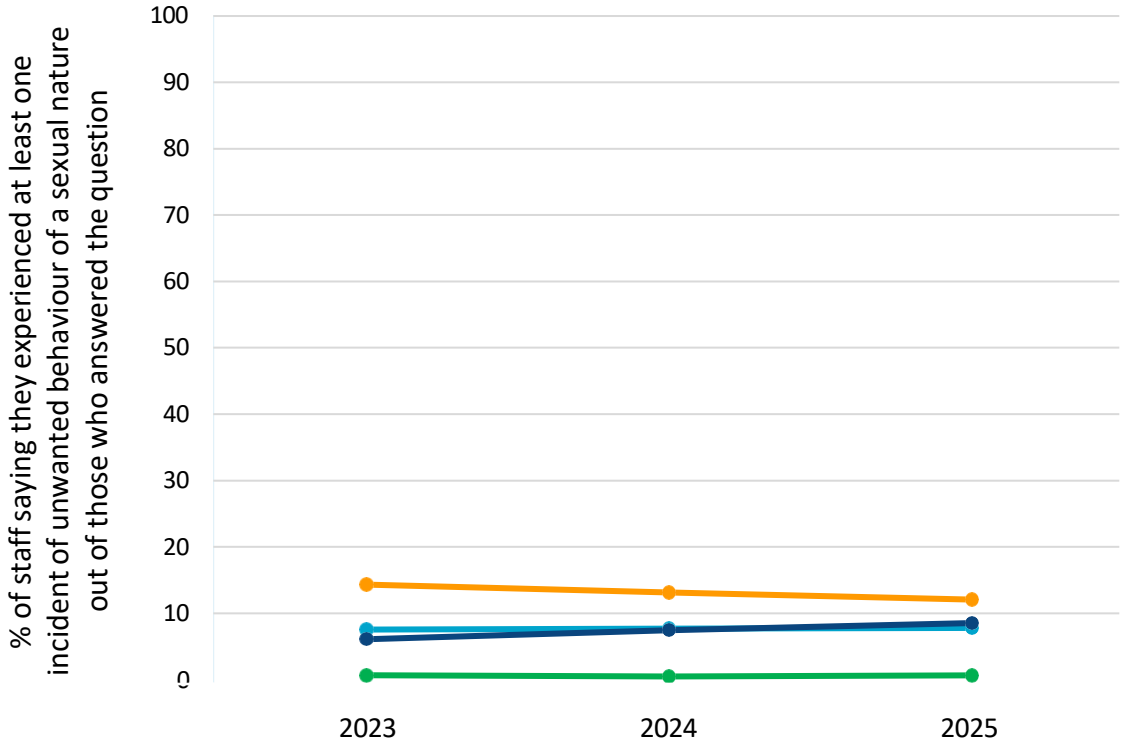
Appendix 1 – Sexual Safety

• Home • Community • Hospital

Caring for you

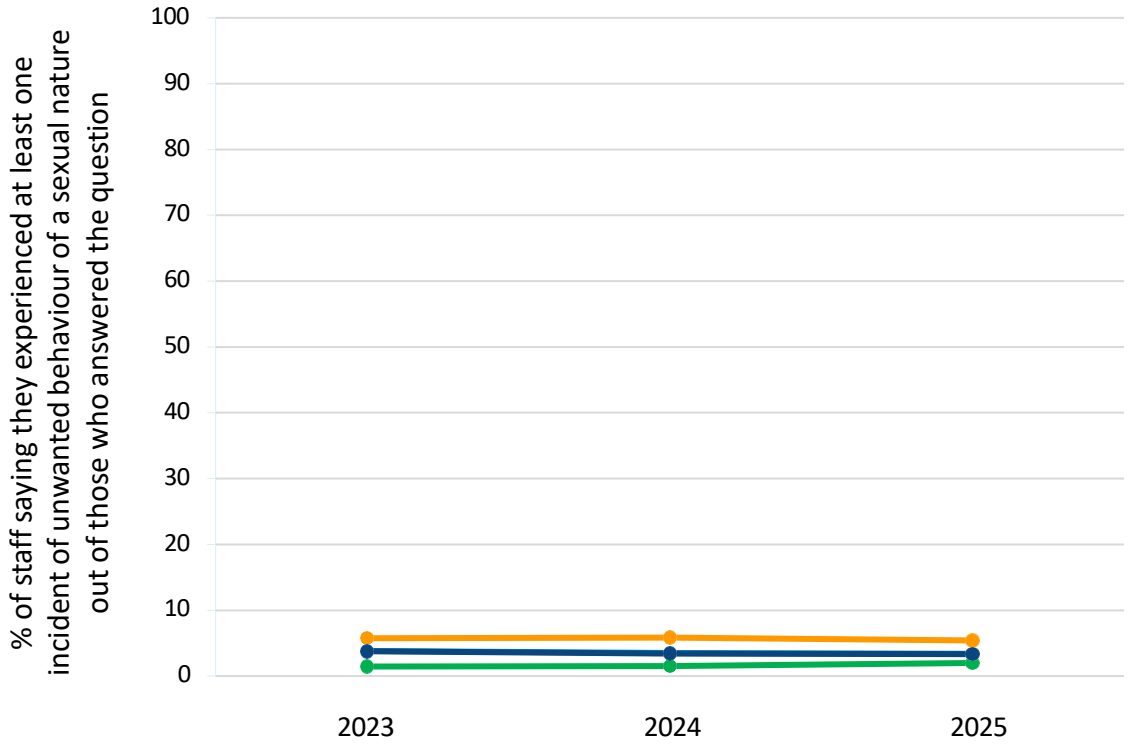
WHH: Sexual safety in the workplace

Q17a In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? From patients / service users, their relatives or other members of the public



	2023	2024	2025
Your org	6.36%	7.73%	8.80%
Best result	0.94%	0.76%	0.92%
Average result	7.82%	7.97%	8.07%
Worst result	14.59%	13.40%	12.33%
Responses	2043	2398	1806

Q17b In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? From staff / colleagues

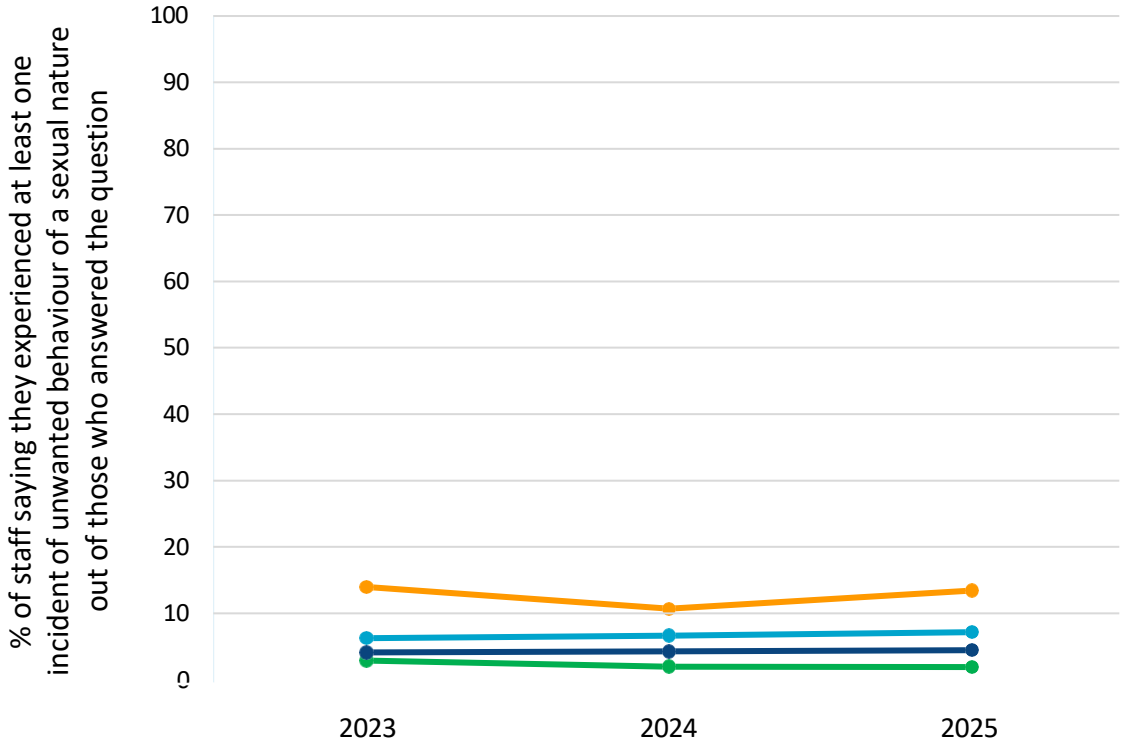


	2023	2024	2025
Your org	3.77%	3.40%	3.33%
Best result	1.45%	1.53%	1.99%
Average result	3.82%	3.53%	3.39%
Worst result	5.74%	5.85%	5.41%
Responses	2040	2390	1803

*These questions do not contribute towards any People Promise element score, theme score or sub-score

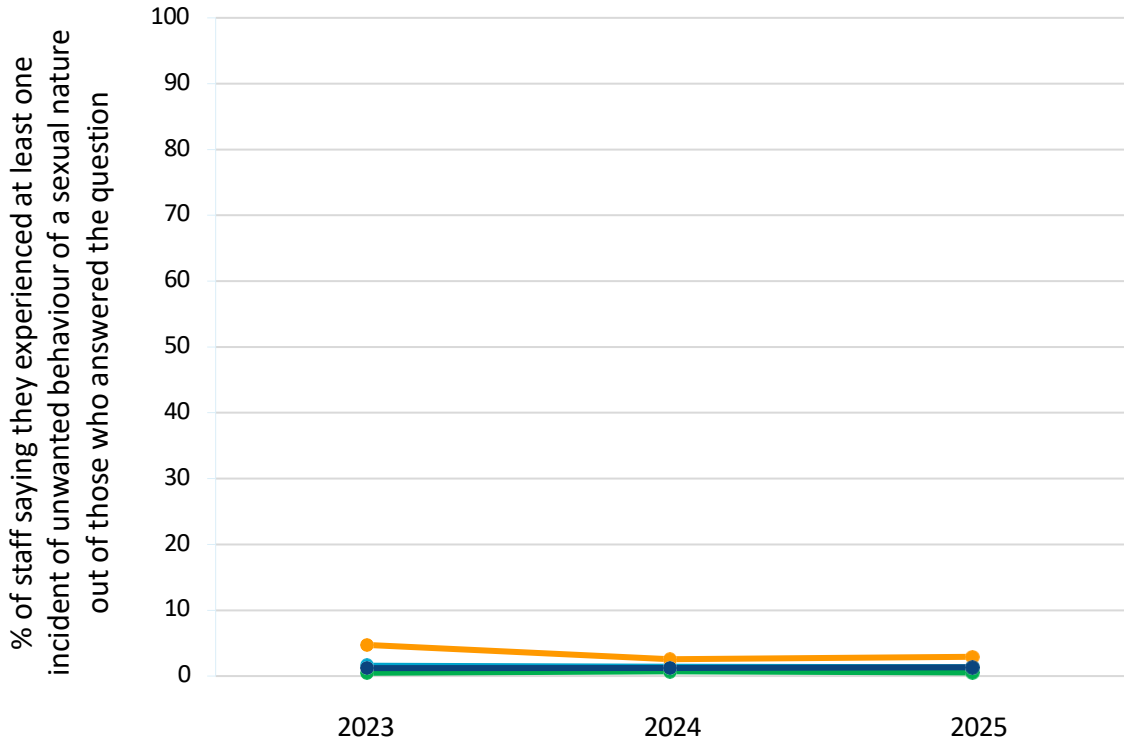
BCH: Sexual safety in the workplace

Q17a In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? From patients / service users, their relatives or other members of the public



	2023	2024	2025
Your org	4.38%	4.55%	4.71%
Best result	3.15%	2.22%	2.17%
Average result	6.52%	6.88%	7.43%
Worst result	14.24%	10.96%	13.68%
Responses	960	1007	812

Q17b In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? From staff / colleagues



	2023	2024	2025
Your org	1.21%	1.25%	1.33%
Best result	0.50%	0.72%	0.53%
Average result	1.58%	1.43%	1.34%
Worst result	4.73%	2.56%	2.92%
Responses	960	1005	814

*These questions do not contribute towards any People Promise element score, theme score or sub-score

What the data tells us

Sexual safety in the workplace

WHH (acute comparison):

- **Patient/public incidents:** 8.80% in 2025, up from 7.73% (2024) and 6.36% (2023). 2025 is above the sector average (8.07%) and well above the best Trust (0.92%)
- **Staff/colleague incidents**: 3.33% in 2025, improving from 3.40% (2024) and 3.77% (2023), slightly better than the sector average (3.39%); with significant differences compared to the best Trust (1.99%)

Implications:

- Patient/public sexual safety remains the key risk signal (rising trend and above average)
- Colleague-to-colleague results are stable/slightly improving and at/better than average

BCH (community comparison):

- **Patient/public incidents**: 4.71% in 2025, a steady rise from 4.55% (2024) and 4.38% (2023), notably better than the sector average (7.43%); with significant differences compared to the best Trust (2.17%)
- **Staff/colleague incidents**: 1.33% in 2025, a small rise from 1.25% (2024) and 1.21% (2023), marginally better than the sector average (1.34%) with significant differences compared to the best Trust (0.53%)

Implications:

- Stronger position than average for patient/public incidents (though gradual rise needs containing)
- Low levels for colleague-to-colleague, close to best-in-class

Appendix 2 – People Promise and Themes Warrington and Halton Teaching Hospitals

• Home • Community • Hospital

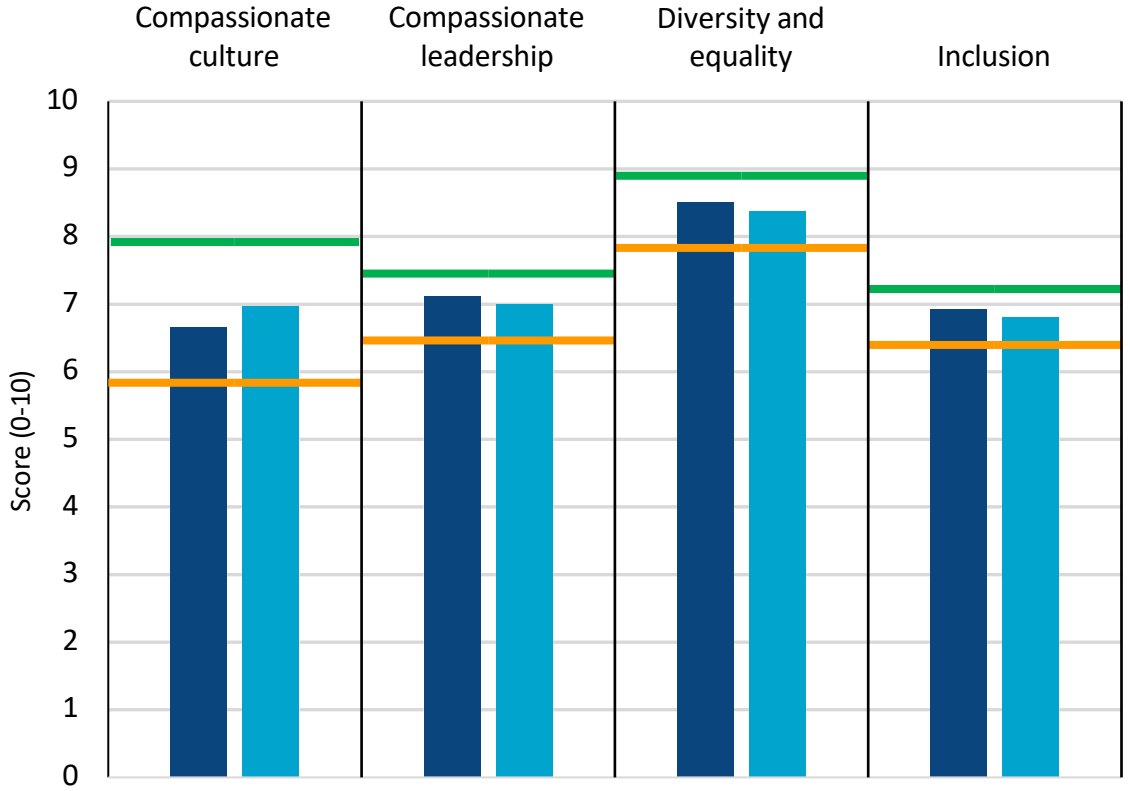
Caring for you

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre

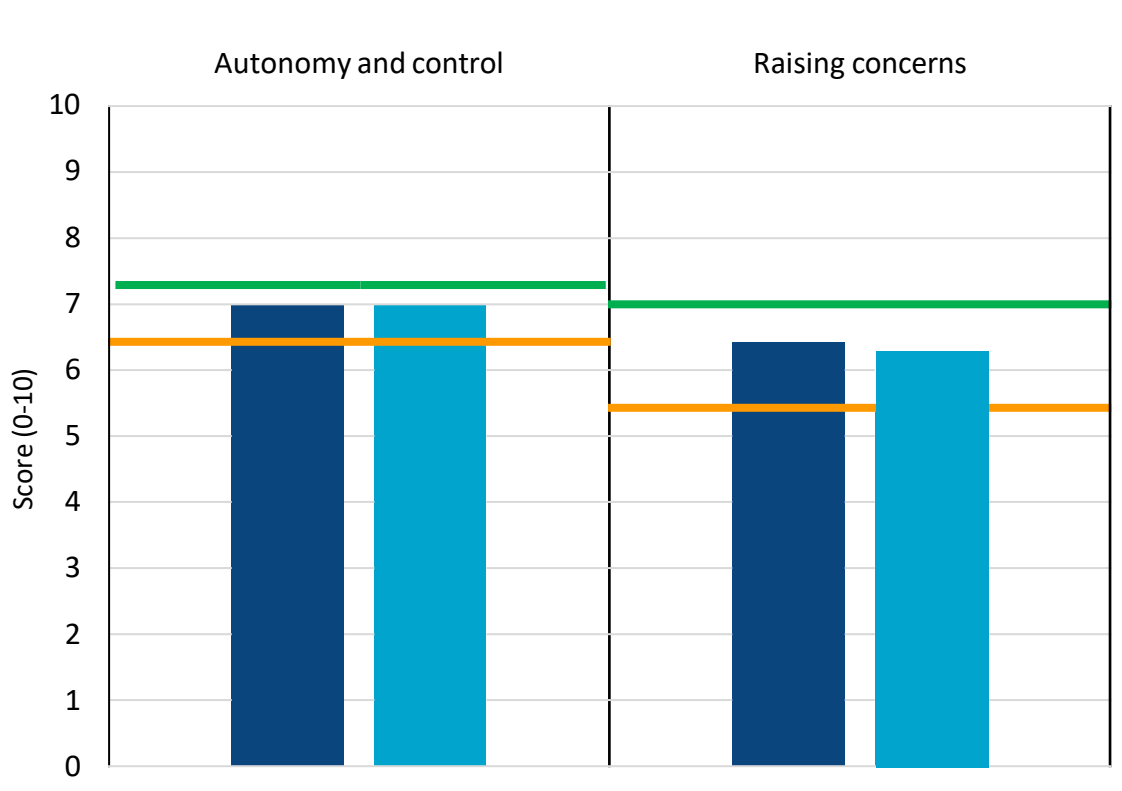
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Your org	6.67	7.12	8.51	6.93
Best result	7.92	7.45	8.90	7.22
Average result	6.97	6.99	8.37	6.80
Worst result	5.84	6.46	7.83	6.40
Responses	1805	1810	1803	1801

Promise element 3: We each have a voice that counts



	Autonomy and control	Raising concerns
Your org	6.99	6.28
Best result	7.31	7.02
Average result	6.92	6.30
Worst result	6.43	5.43
Responses	1806	1798

Note: People Promise element 2 'We are recognised and rewarded' does not have any sub-scores. Overall trend score data for this element is reported on slide 21.

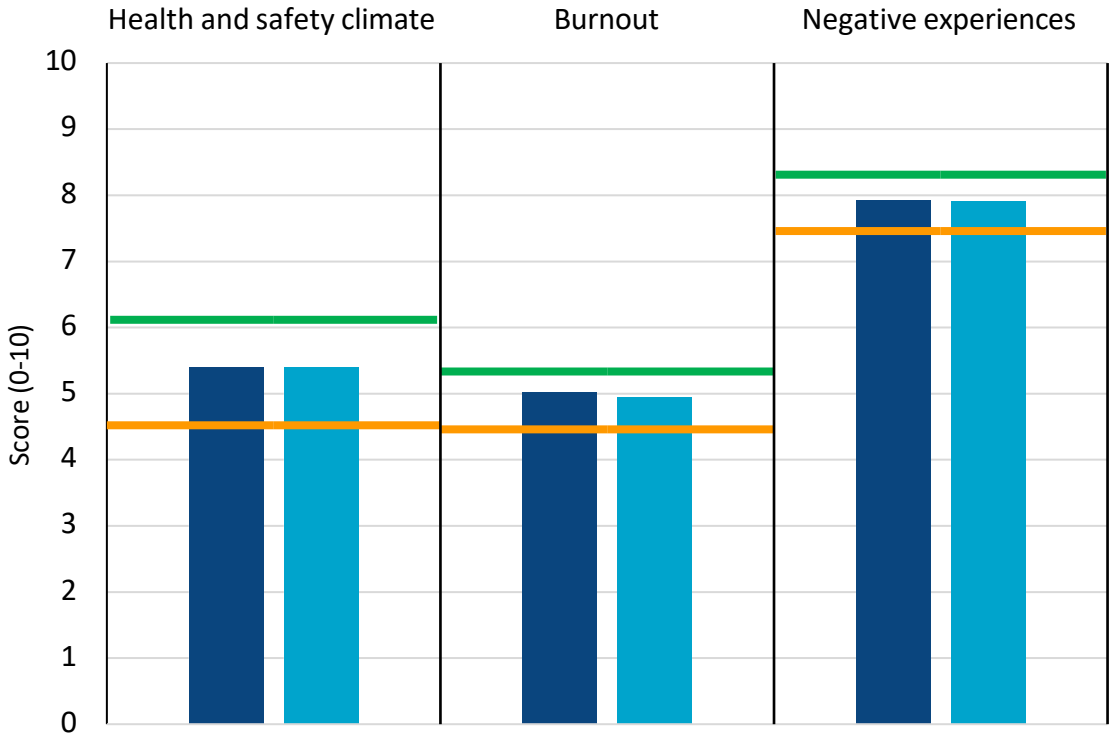
People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre

NHS

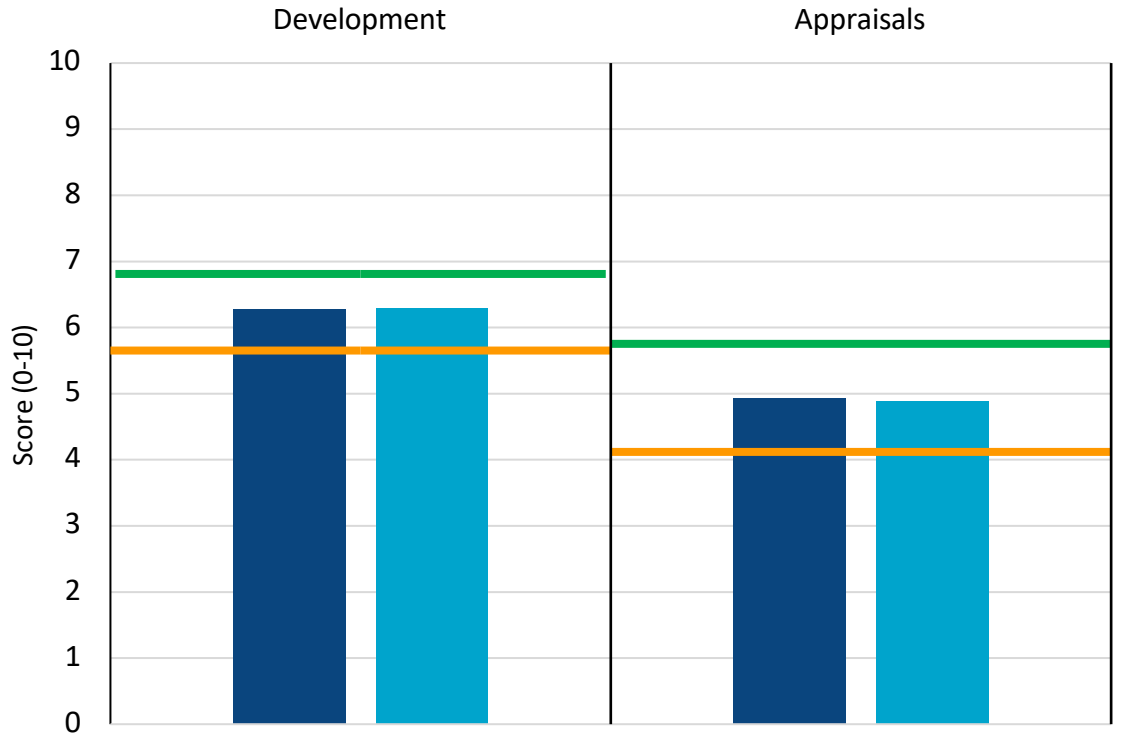
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 4: We are safe and healthy



	Health and safety climate	Burnout	Negative experiences
Your org	5.41	5.02	7.93
Best result	6.12	5.33	8.31
Average result	5.39	4.94	7.90
Worst result	4.52	4.46	7.46
Responses	1806	1812	1802

Promise element 5: We are always learning



	Development	Appraisals
Your org	6.28	4.93
Best result	6.81	5.75
Average result	6.29	4.89
Worst result	5.65	4.12
Responses	1808	1742

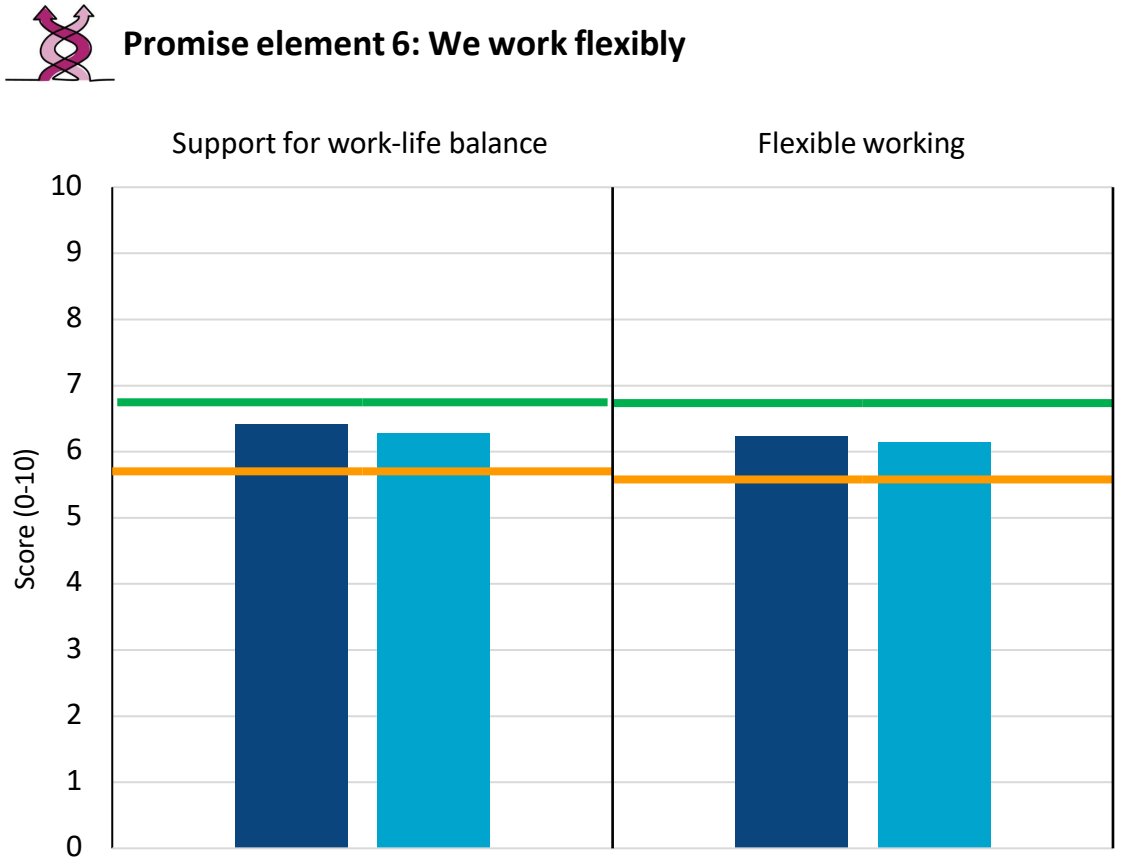
People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre

NHS

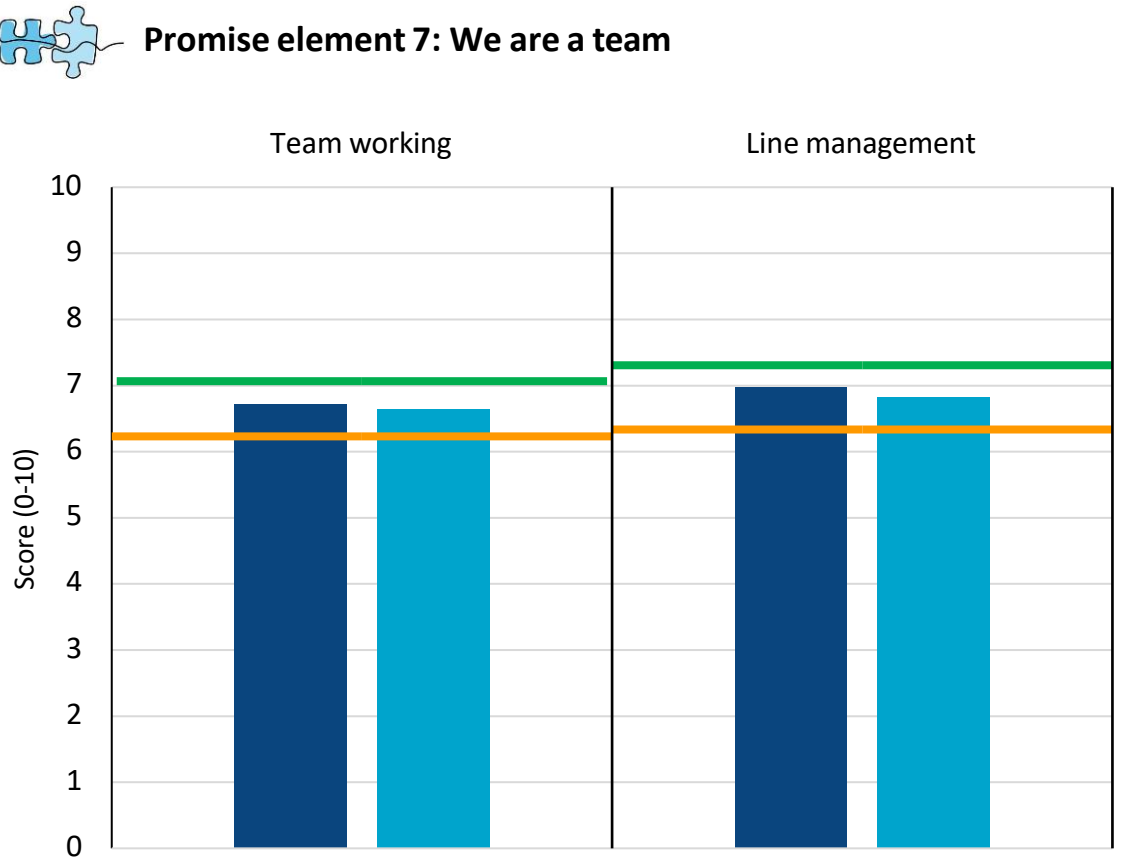
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 6: We work flexibly



	Support for work-life balance	Flexible working
Your org	6.41	6.23
Best result	6.75	6.73
Average result	6.28	6.15
Worst result	5.70	5.58
Responses	1809	1800

Promise element 7: We are a team



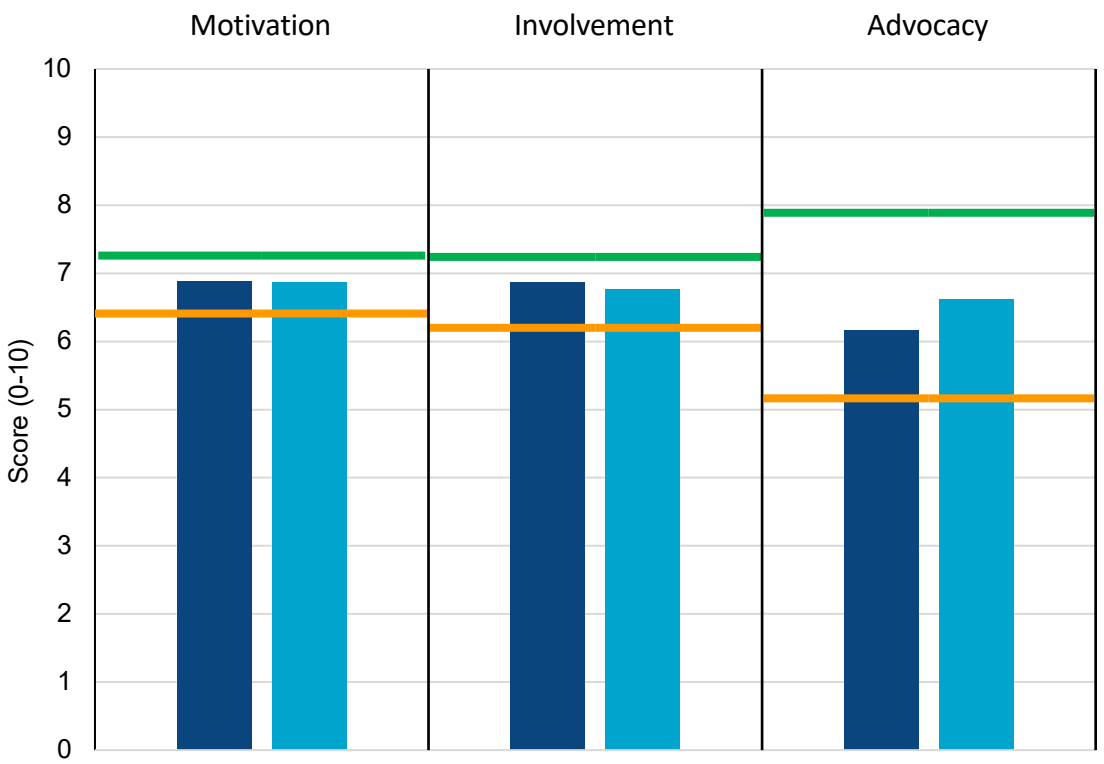
	Team working	Line management
Your org	6.72	6.98
Best result	7.07	7.31
Average result	6.64	6.82
Worst result	6.23	6.34
Responses	1807	1810

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre NHS

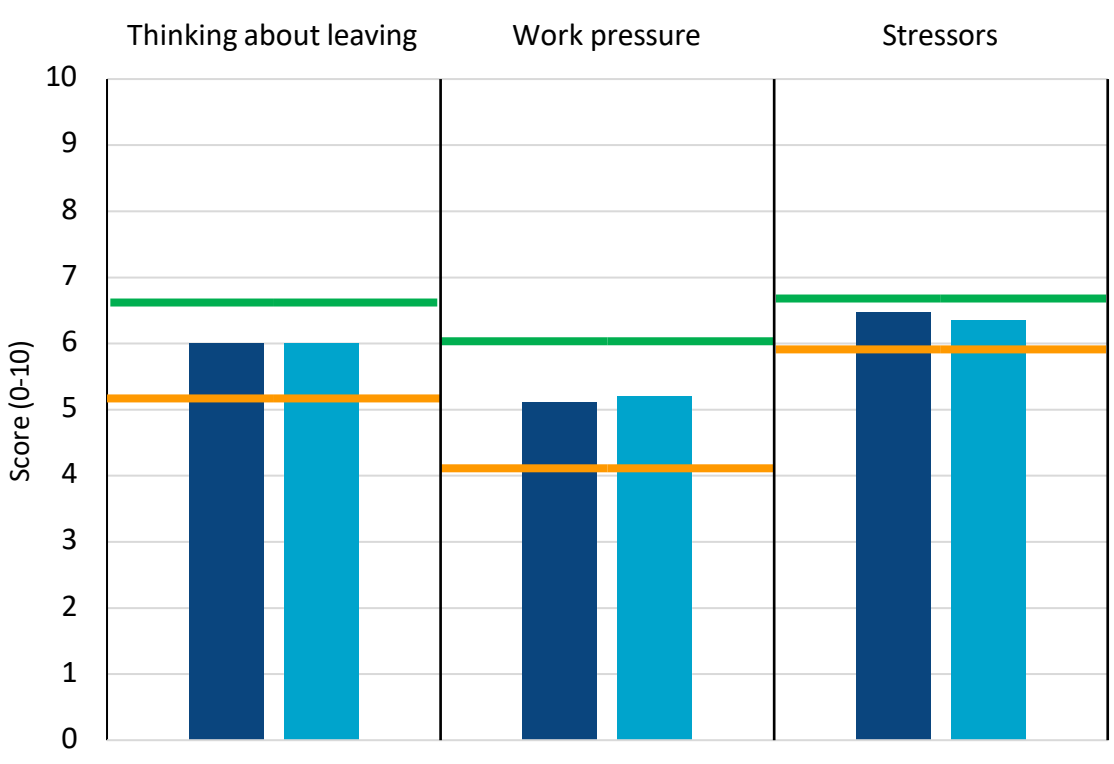
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff engagement



	Motivation	Involvement	Advocacy
Your org	6.88	6.87	6.17
Best result	7.26	7.24	7.89
Average result	6.87	6.77	6.63
Worst result	6.41	6.20	5.17
Responses	1783	1806	1806

Theme: Morale



	Thinking about leaving	Work pressure	Stressors
Your org	6.00	5.12	6.47
Best result	6.62	6.03	6.68
Average result	6.00	5.20	6.35
Worst result	5.17	4.11	5.91
Responses	1807	1806	1810

Appendix 3 – People Promise and Themes Bridgewater Community Healthcare

• Home • Community • Hospital

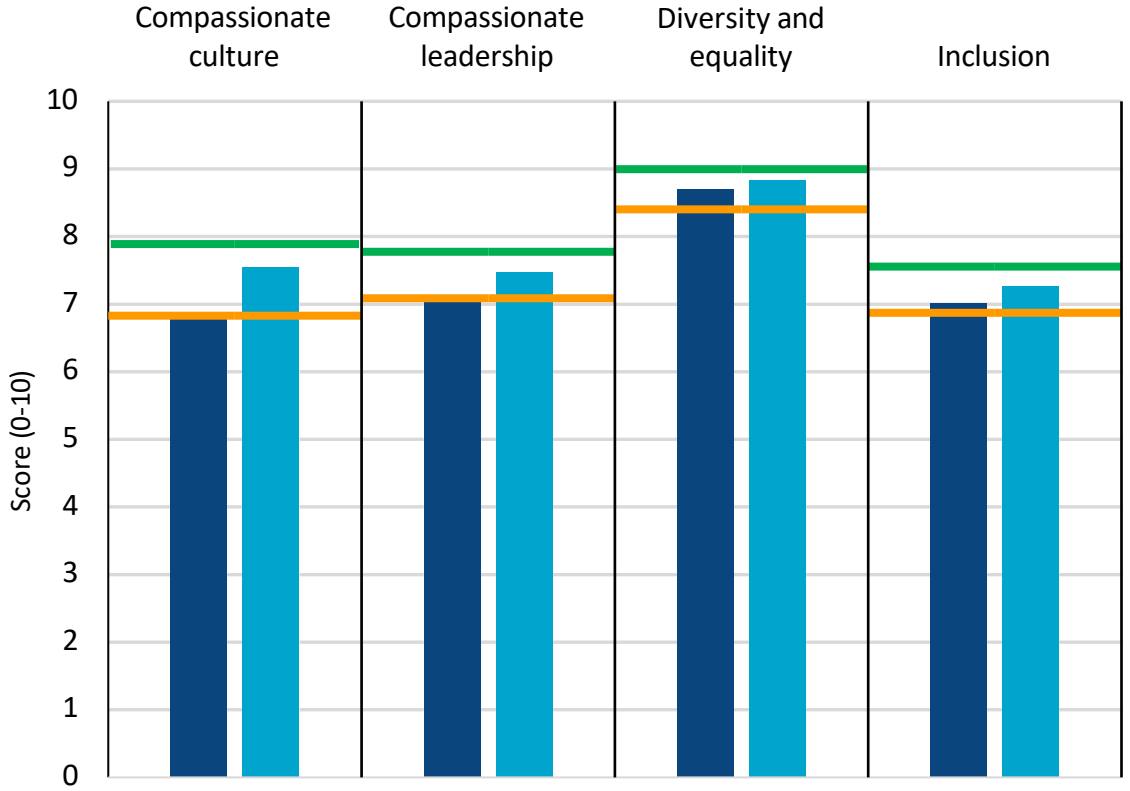
Caring for you

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre

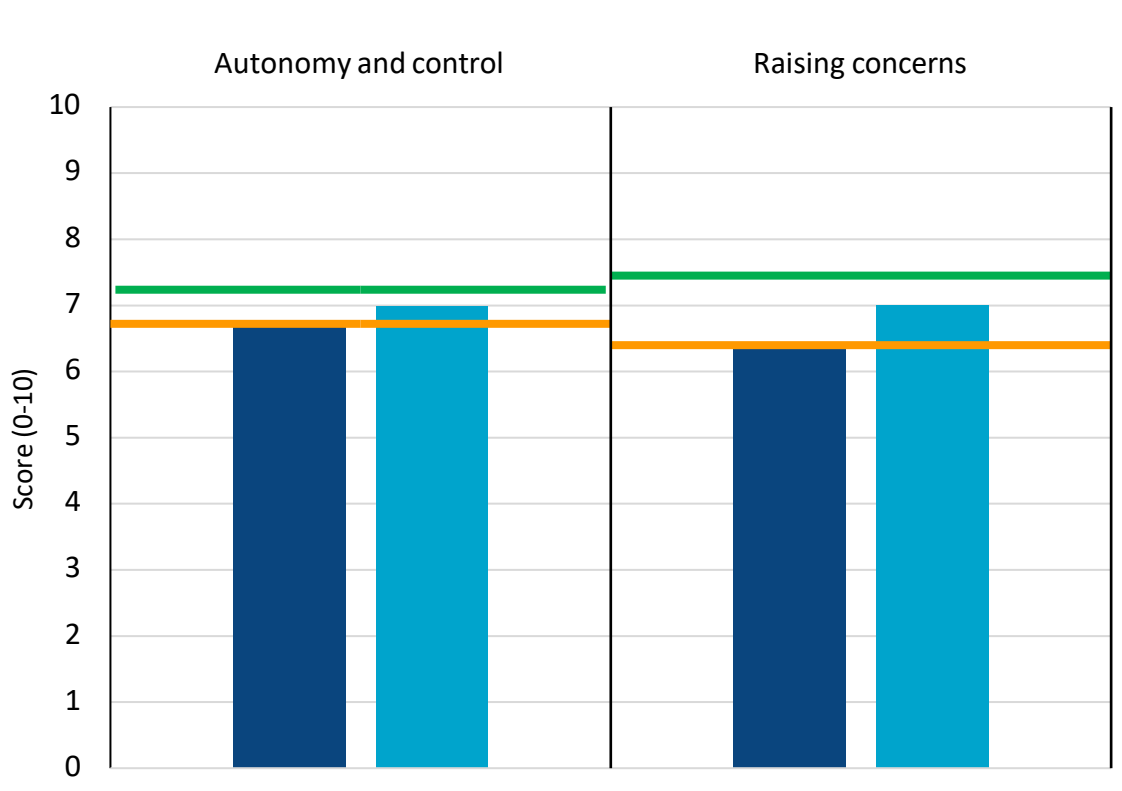
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Your org	6.83	7.09	8.70	7.02
Best result	7.89	7.77	9.00	7.56
Average result	7.55	7.47	8.83	7.26
Worst result	6.83	7.09	8.40	6.87
Responses	819	818	813	813

Promise element 3: We each have a voice that counts



	Autonomy and control	Raising concerns
Your org	6.72	6.40
Best result	7.24	7.45
Average result	6.99	7.01
Worst result	6.72	6.40
Responses	819	818

Note: People Promise element 2 'We are recognised and rewarded' does not have any sub-scores. Overall trend score data for this element is reported on slide 21.

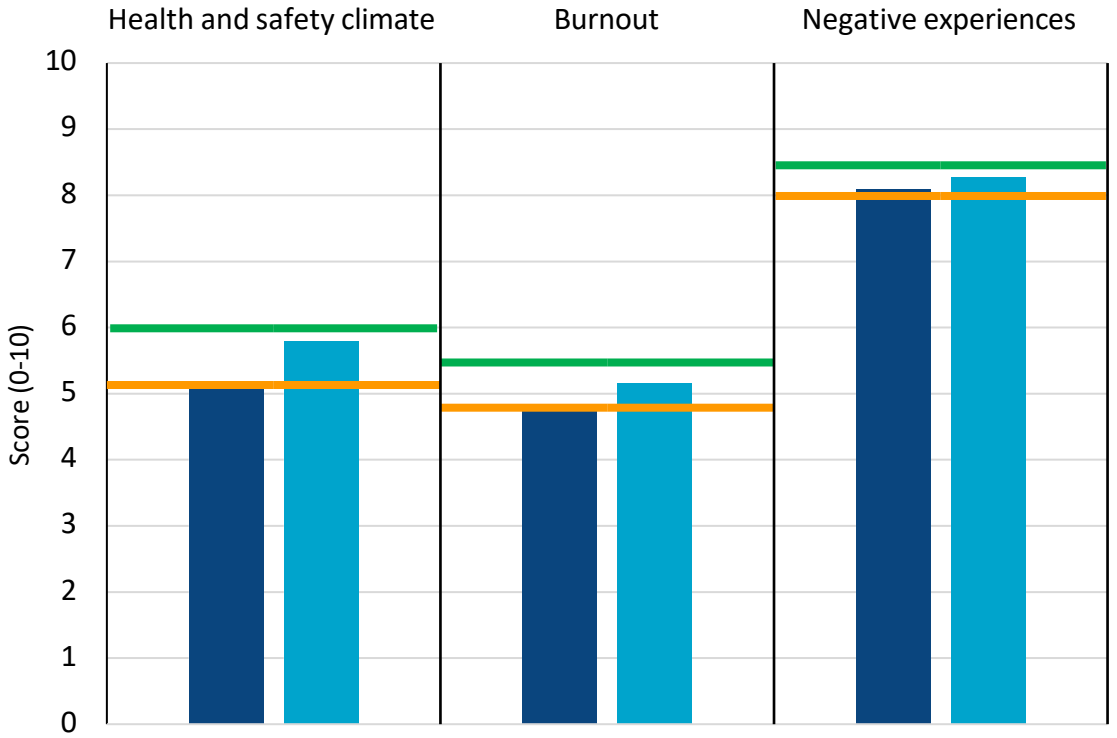
People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre

NHS

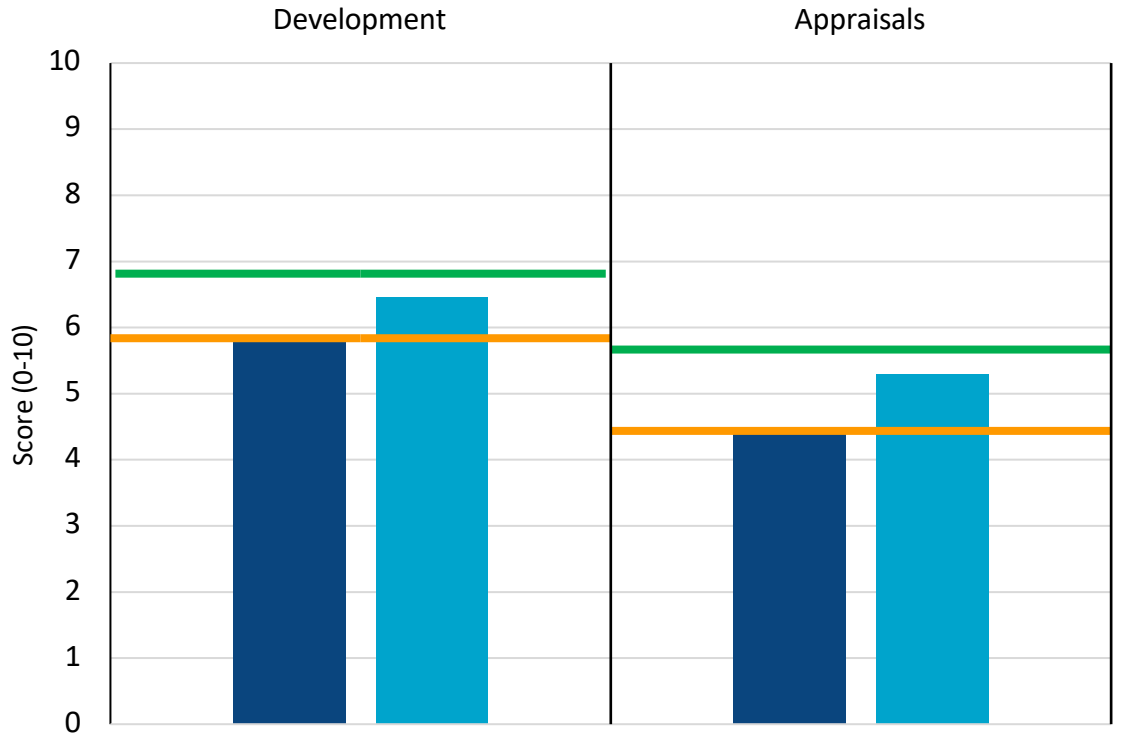
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 4: We are safe and healthy



	Health and safety climate	Burnout	Negative experiences
Your org	5.13	4.79	8.09
Best result	5.99	5.47	8.45
Average result	5.79	5.16	8.27
Worst result	5.13	4.79	7.99
Responses	819	819	820

Promise element 5: We are always learning



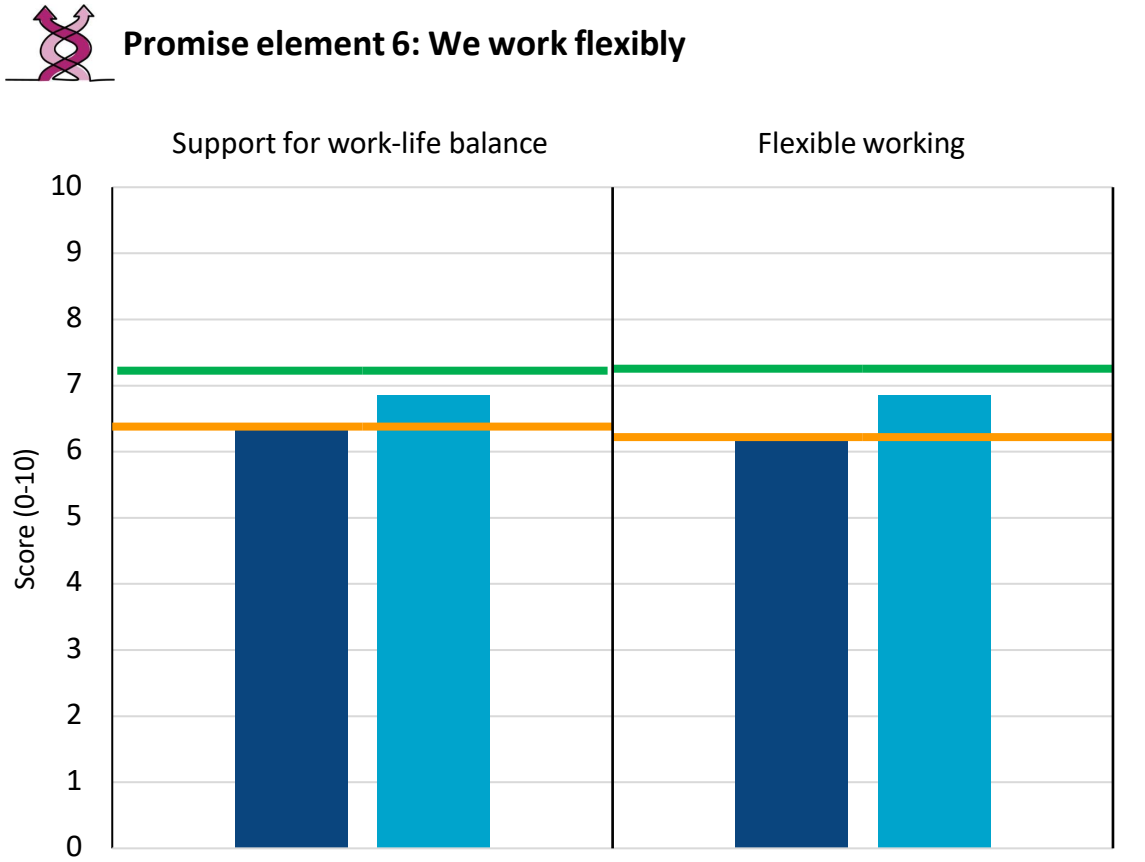
	Development	Appraisals
Your org	5.84	4.44
Best result	6.81	5.67
Average result	6.46	5.30
Worst result	5.84	4.44
Responses	819	790

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre

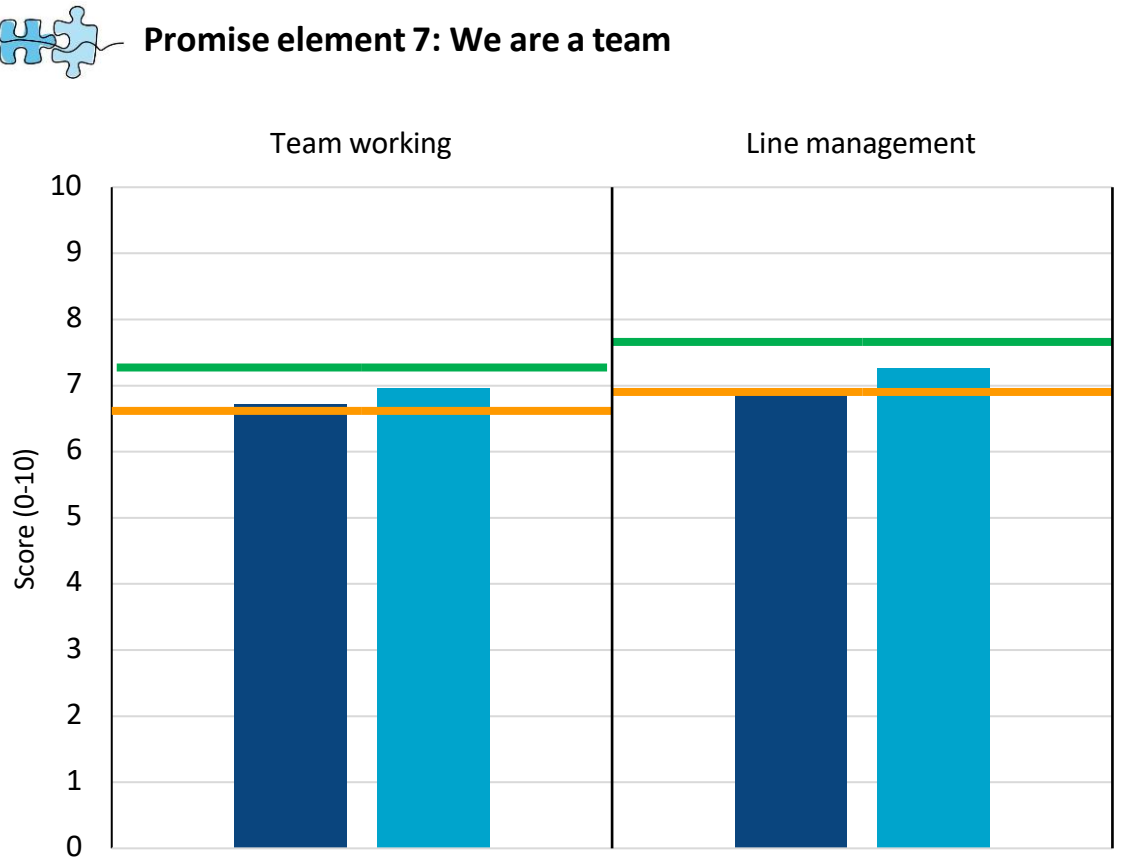
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 6: We work flexibly



	Support for work-life balance	Flexible working
Your org	6.38	6.22
Best result	7.23	7.26
Average result	6.86	6.86
Worst result	6.38	6.22
Responses	819	812

Promise element 7: We are a team



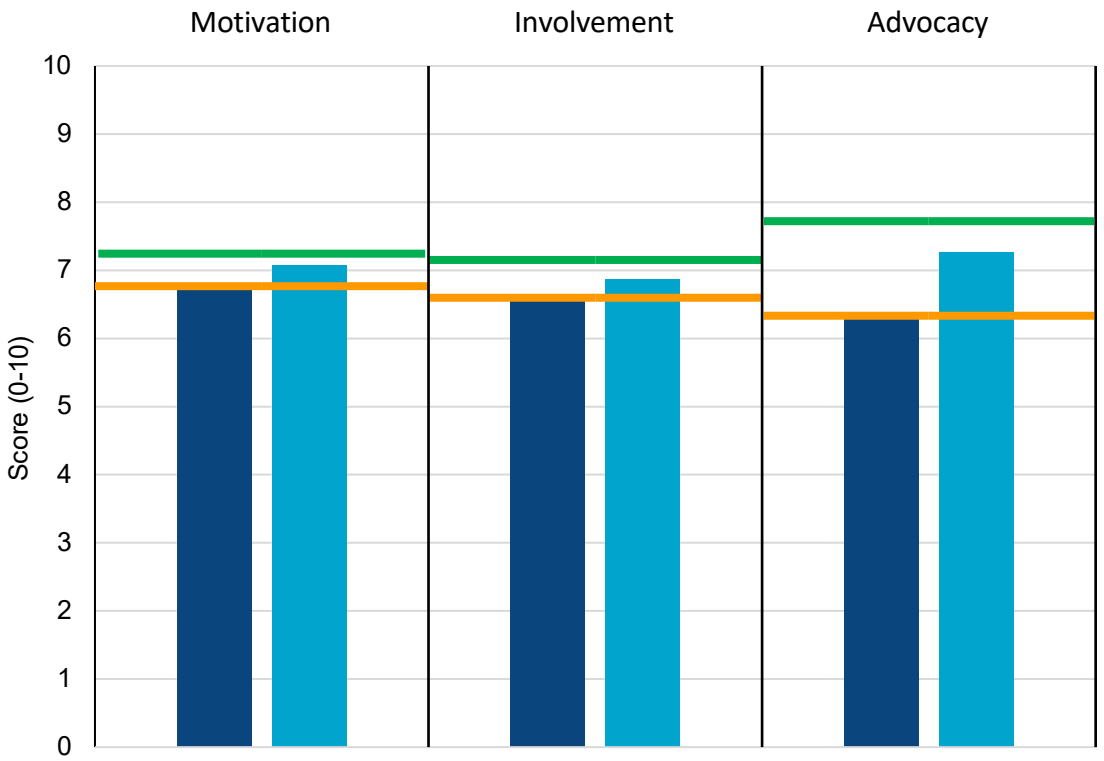
	Team working	Line management
Your org	6.72	6.90
Best result	7.27	7.66
Average result	6.95	7.27
Worst result	6.62	6.90
Responses	818	818

People Promise elements, themes and sub-scores: Sub-score overview

Survey Coordination Centre NHS

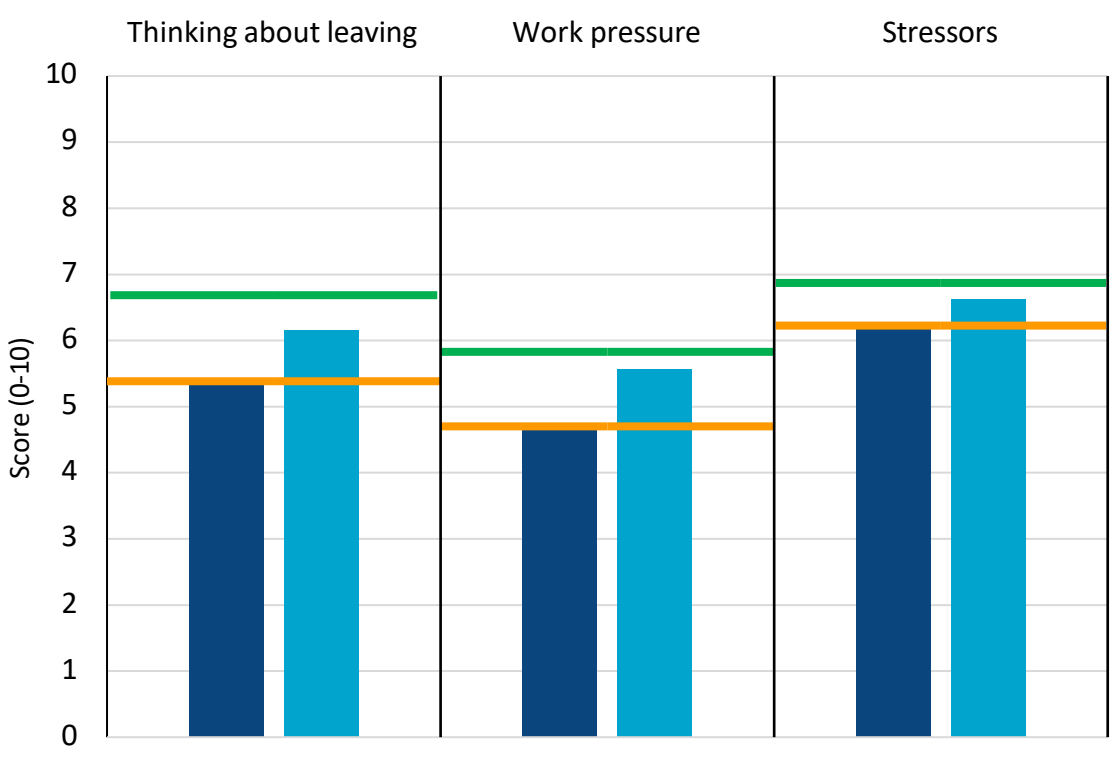
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff engagement



	Motivation	Involvement	Advocacy
Your org	6.77	6.60	6.33
Best result	7.24	7.15	7.72
Average result	7.08	6.87	7.26
Worst result	6.77	6.60	6.33
Responses	814	819	819

Theme: Morale



	Thinking about leaving	Work pressure	Stressors
Your org	5.38	4.70	6.23
Best result	6.69	5.83	6.87
Average result	6.16	5.57	6.62
Worst result	5.38	4.70	6.23
Responses	817	818	818

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/04/014**			
Subject:	Bi-monthly Strategic Projects Highlight Report (January and February 2026)			
Date of meeting:	1st April 2026			
Action required:	**To note**			
Author(s):	Megan Wainwright, Strategy Project and Tem Support Officer			
Executive director sponsor:	Lucy Gardner, Chief Strategy & Partnership Officer			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience 2. PEOPLE - We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future with staff developing, growing and thriving. 3. SUSTAINABILITY - We will work in partnership with others to achieve social and economic wellbeing in our communities and improve equity in health outcomes			
Link to risks on the board assurance framework:	Choose an item.			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
Executive summary:	• At the end of February, WHH and BCH received feedback on the recent NHS England review of the full business case for the Better Care Together integration programme. The feedback was positive and the NHSE 'Amber' rating means that the integration programme is able to continue as planned to a scheduled acquisition date of 1 April 2026. On this date, both organisations will formally come together as one, to become North Cheshire and Mersey NHS Foundation Trust. In the meantime, the focus of both partner organisations is on delivery of a safe and successful 'day one' for the new			

	integrated Trust with significant work taking place across all core workstreams.
	• The Runcorn Health and Education Hub is due open services from June 2026.
	• The Living Well Warrington digital platform has been shortlisted in two categories for the upcoming HSJ Digital awards 2026. The team will present to the judging panel in March and the awards ceremony is in May.
	• The Living Well Hub in Warrington welcomed its 50,000th visitor in February and continues to attract interest from around the country with recent site visits including teams from Bradford and Rotherham.
	• The Trust has developed 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 has been approved by Board and submitted.		

Purpose: (please select as appropriate)	**Approval**	**To note** ✓	**Decision**
Recommendation:	The Trust Board is asked to note this report for information.		
Previously considered by:	**Committee**	Not Applicable	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome		
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***None***		
Freedom of information status (foia):	Release Document in Full		
Freedom of information exemptions applied: ***(if relevant)***	None		

Strategic projects update
January- February 2026

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	Strategy Development	Carl Mackie/ Carolyne Ward	

Key messages

- At the end of February, WHH and BCH received feedback on the recent NHS England review of the full business case for the Better Care Together integration programme. The feedback was positive and the NHSE ‘Amber’ rating means that the integration programme is able to continue as planned to a scheduled acquisition date of 1 April 2026. On this date, both organisations will formally come together as one, to become North Cheshire and Mersey NHS Foundation Trust. In the meantime, the focus of both partner organisations is on delivery of a safe and successful ‘day one’ for the new integrated Trust with significant work taking place across all core workstreams.
- The Runcorn Health and Education Hub is due open services from June 2026.
- The Living Well Warrington digital platform has been shortlisted in two categories for the upcoming HSJ Digital awards 2026. The team will present to the judging panel in March and the awards ceremony is in May.
- The Living Well Hub in Warrington welcomed its 50,000th visitor in February and continues to attract interest from around the country with recent site visits including teams from Bradford and Rotherham.
- 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 has been approved by Board and submitted.

Stakeholder and engagement overview

Key stakeholder engagement in period	Job title, organisation	Topic/Nature of engagement
Mark Holloway	Associate Director of National Estates Delivery, NHSE England North West	Development of strategic estates plans
Alex Kirkpatrick	Deputy DoF, NHSE NW	Integration
Su Foster	Estates Delivery Lead, Cheshire and Merseyside	Development of strategic estates plans
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 neighbourhood health in Warrington
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 Rotherham Local Authority and Voluntary Sector	Various individuals including Chief Operating Officer for GP Federation, Head of Planning, Public Health consultants etc.	Site visit to Living Well Hub
Team from Dept of Health and Social Care	Various individuals from the research and policy development team from DHSC	Living Well in Warrington, including site visit to the Living Well Hub and engagement with adult social care teams from Warrington Borough Council
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	Professional support and advice to the Better Care Together integration programme
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
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
Dora Westbrook	Dept for Work & Pensions, Workplace Transformation Lead	Delivery of DWP services at Living Well Hub Warrington
Richard Rout	Chief Executive, Halton Borough Council	Strategic Estates and Integration
Sally Yeoman	CEO, Halton and St Helen's Voluntary Action	Runcorn Town Board
Kathy McMullin	Healthwatch Community Outreach lead, Healthwatch Halton	Runcorn health and education hub
Jude Adams	Cheshire and Merseyside ICB	UTC
Derek Twigg MP	MP	Strategic estates and integration
Mary Murphy	Principal and CEO Riverside and Crompton Colleges	Runcorn health and education hub
Halton & St Helens VCSFE Forum	VCSFE sector organisations across Halton and St Helens	Runcorn health and education hub

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:

- 'Amber' approval rating received from NHS England regional team following review of full business case. On track to complete transaction and integrate the two partner organisations wef 1 April 2026.
- Day one mobilisation meetings taking place weekly to focus attention of all workstreams on delivery of safe and successful day one.

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
Formal approval of the transaction by the Secretary of State for Health and Social Care	20 March 2026
Completion of formal transaction and establishment of new integrated organisation – North Cheshire and Mersey NHSFT	1 April 2026
Commencement of phase two of the integration programme – focus shifts towards integration of clinical services	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

- Build complete and internet fibre cable installed.
- CQC application undergoing final review and submission.
- Branding finalised and toolkit completed.

Runcorn town deal- part 2

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Quality	People	Sustainability
Patient Safety	**Looking after our people** ✓	**Working in partnership**✓
Clinical effectiveness ✓	**Innovating the way we work** ✓	**Working responsibly** ✓
Patient experience ✓	**Growing our workforce for the future** ✓	**Sustainable estate and digitally enabled** ✓
Research, development and innovation	Belonging in WHH	**Financial sustainability** ✓

Milestone	Date
General manager recruitment	March 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

- Further development of UTC business case in line with NHS England expectations
- Site tour of Warrington Hospital with Regional Delivery Director NHS England, making the case for further investment on acute site(s)

New hospitals and strategic estates planning- part 2

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality	People	Sustainability
Patient Safety ✓	**Looking after our people ✓**	**Working in partnership ✓**
Clinical effectiveness ✓	**Innovating the way we work ✓**	**Working responsibly ✓**
Patient experience ✓	**Growing our workforce for the future ✓**	**Sustainable estate and digitally enabled ✓**
Research, development and innovation ✓	Belonging in WHH	**Financial sustainability ✓**

Milestone	Date
Delivery of updated strategic estates masterplan	December 2026
Notification of UTC Bid outcome	TBC

Contact details
Carl Mackie
Halton Health New Town and Strategy Manager
carlmackie@nhs.net

Strategy Development

Project Overview

- Development and subsequent delivery of overall WHH Trust strategy.
- Creation of a clinical strategy in alignment with a strategic estates development plan
- Support to the development, delivery and governance of enabling strategies, clinical strategies, and strategic priorities.

What does this mean for NCM?

- The development of the integrated organisational strategy and clinical strategy will describe our shared vision for the future
- They will outline the Trust's journey across the next 5 years, outlining how we will deliver safe, high-quality, evidence-based care for our patients across Halton, Warrington and Greater Manchester

Progress since last report

- Development of proposed plan to produce the organisational strategy and clinical strategy

Strategy Development - 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
Programme of staff engagement commences	June 2026
Clinical Strategy Engagement Sessions Underway	August 2026
New Organisational Strategy and Clinical Strategy published	March 2027

Contact details
Carolyne Ward
Strategic Project Manager
carolyne.ward@nhs.net

Carl Mackie
Halton Healthy New Town and Strategy Manager
carlmackie@nhs.net

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/04/015**			
Subject:	**Communications and Engagement Update (bimonthly) January to February 2026**			
Date of meeting:	1 April 2026			
Action required:	To note			
Author(s):	Alison Aspinall, Head of Communications and Engagement			
Executive director sponsor:	Kate Henry, Director of Communications & Engagement			
Link to strategic aim:	1. QUALITY - We will always put our patients first, delivering safe, compassionate, inclusive and effective care and an excellent patient experience. 2. PEOPLE - We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future with staff developing, growing and thriving. 3. SUSTAINABILITY - We will work in partnership with others to achieve social and economic wellbeing in our communities and improve equity in health outcomes.			
Link to risks on the board assurance framework:	BAF 1: Quality of Care & Patient Safety BAF 4: Embedded Health Equity BAF 9: Partnership, Integration & System Working			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
		✓		✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
		✓		
	Further Information / Comments:			
Executive summary:	This report updates on communications and engagement activity during January and February 2026*. 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:			

<table>
<tr><td></td><td colspan="3">Communications Activity: The Communications and Engagement Team managed 13 job requests, issued 4 media releases and published 8 stories across various Trust websites during January and February 2026
Campaigns: Key campaigns supported included National Apprenticeship Week (9 to 15 February)
Patient and Public Participation Group (PPRG): Meeting held on 15 January, to present and discuss the infant feeding clinical pathway and new behavioural framework for North Cheshire and Mersey NHS FT
Community engagement: Promotion of the annual Experts by Experience Newsletter gained positive feedback
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 in 2026

* Please note this reporting period covers the work of the WHH Communications and Engagement Team. Future reports will encompass acute and community communications and engagement work for NCM</td></tr>
<tr><td>Purpose: (please select as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>Recommendation:</td><td colspan="3">The Trust Board is asked to note the contents of this update on Communications and Engagement activity during the period.</td></tr>
<tr><td rowspan="4">Previously considered by:</td><td>Committee</td><td colspan="2">EMT</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">EMT/26/138i</td></tr>
<tr><td>Date of meeting</td><td colspan="2">24 March 2026</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">To note</td></tr>
<tr><td>Next steps:</td><td colspan="3">None</td></tr>
<tr><td>Freedom of information status (foia):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>Freedom of information exemptions applied:</td><td colspan="3">None</td></tr>
</table>

North Cheshire and Mersey
NHS Foundation Trust

Trust Board meeting

Communications and engagement update Bi-monthly report (January to February 2026)

1 April 2026

Home Community Hospital

Our role within NCM

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 **13** communications 'job requests' for design, film, photography and communications campaign support
- issued **4** Trust media releases (plus **1** WHH Charity media release)
- published **8** stories across our main Trust website, charity website and breast screening services website
- prepared / issued **9** media statements and responses
- handled **19** enquiries from local, regional and national print and broadcast media

* Please note this reporting period covers the work of the WHH Communications and Engagement Team. Future reports will encompass acute and community communications and engagement work for NCM

January / February activity and achievements overview

- Supported BCH colleagues with the launch of their Drive Ability and North West Community Dental Service microsites
- Supported the annual National Apprenticeship Week campaign (9 to 15 February) with the Apprenticeship Team activities and news
- Promoted the annual Experts by Experience newsletter, celebrating contributions of 194 EbyE volunteers across 26 projects
- Shared information with the public and staff about building improvements works within maternity services
- Supported involvement of staff, EbyEs and partners in our 2026-27 joint quality priorities survey
- Welcomed our chair designate and associate non-executive director Andy Carter
- Promoted a midwifery open day at The Nest, to encourage awareness of roles within midwifery and Team Lunar
- Developed a media handling approach for a high profile inquest with reputational impact

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

Media

Media releases issued during this period included:

Meet the NHS champions shortlisted for annual Thank You Awards
Read the release

You can do so much more with the NHS App than you realise
Read the release

Living Well community website shortlisted at national digital healthcare awards
Read the release

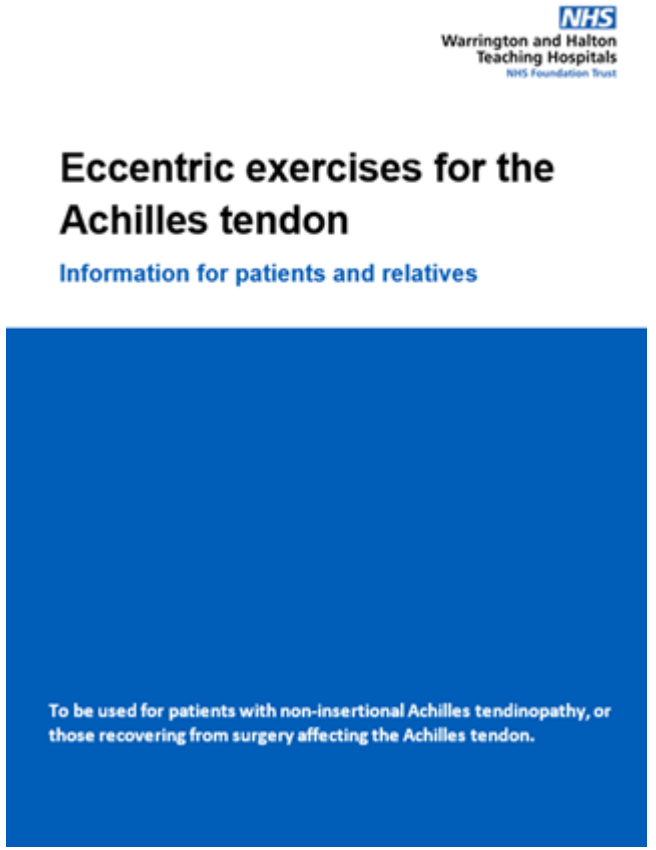
Warrington and Halton Teaching Hospitals receive national funding to reduce carbon emissions
Read the release

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 **3** new leaflets through the PINFO process
- reviewed and edited **21** existing leaflets to ensure content remains clinically appropriate and reflects WHH style guidelines
- identified a total of **177** expired leaflets
- archived **1** leaflet
- continued work on development of a process and policy for North Cheshire and Mersey
- appointed Midlands and Lancashire CSU to develop a PINFO database to introduce automation for aspects of chasing and reporting.



Key campaigns / highlights

• Home • Community • Hospital

Caring for you

Better Care Together (BCT) – update

Microsite and engagement activity

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

- January: 2,409 visits
- February: 1,900 visits
- The most viewed pages after the homepage: Resources
- Total site visits: 30,088

Site updates for this period include:

- News updates – summary of Full Business Case and new branding and service name launched for North West Community Dental Service
- Clinical integration toolkit available to download, joint policy templates available, additional Organisational Development support resources added and updated FAQs

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

- January: 239 staff comprising 53% WHH (127) and 47% BCH (112)
- February: 203 staff comprising 55% WHH (112) and 45% BCH (91)

Patient and Public Participation Group (PPRG) update

15 January 2026

The focus of the meeting was the infant feeding clinical pathway and the future behavioural framework

Infant feeding

The group discussed existing support for families, including antenatal education, tongue-tie identification / treatment, digital resources, diagnosis of cow's milk protein allergy and staff training.
The group explored preferences for infant feeding support, suggesting focus should be given to:

- trusted access to information from professionals and online
- use of welcoming and inclusive language within resources
- expansion of tongue-tie diagnostic training
- peer support and parental awareness / education
- supporting digitally excluded families and addressing wider equality needs within communities

Behavioural Framework

Participants supported the proposed behavioural framework approach for North Cheshire and Mersey NHS Foundation, based on four new values (kind, open, fair and one team).

Warrington and Halton Hospitals Charity





Website activity

- January: 1,404 (1,194 active)
- February: 1,384 (1,113 active)

The most viewed page was the Supporters' Club

Newsletters

- Two newsletters published: January 2026 and February 2026

News

Items published in this period included:

- Local biker's fundraising supports children at Warrington Hospital
- Pulmonary Rehabilitation Team step up for 36 mile challenge

Working with People and Communities Strategy January to February 2026

• Home • Community • Hospital

Caring for you

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	• 35 Experts by Experience recruited during 2025-26 (4 during January to February). • 220 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	• 25 EbyE projects delivered in 2025-26 (plus 4 extended projects – health literacy, site map updates, WELL Runcorn and WHH/BCH integration). • 52 EbyEs participating in January and February 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 Q2 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 / inclusion groups. • Better Care Together integration activity is supported with Bridgewater colleagues. • Continued to support 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. Easy Read version of supplementary information distributed with patient letters is ready for 1 April.	• 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 20th place in the NHS sector rankings (February 2026).	• Ongoing
3. Accessible content creation	• New accessible policy and standard operating procedure (SOP) templates have been launched to both WHH and BCH. • Accessible meeting templates also now created for NCM ready for 1 April • NCM AIS policy is now approved ready for 1 April.	• Ongoing
5. Patient information	• Revised NCM Patient Information Policy developed and going through the approval and ratification process ready for 1 April.	• Ongoing
7. Signage / wayfinding	• Delivered via Wayfinding and First Impressions Task and Finish Group. Estates are progressing updated maps and wayfinding signage 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 in partnership with Bridgewater Community Healthcare for 2026-27.	• 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. The community event undertaken in this period was: ✓ Outreach with governors (Birchwood Shopping Centre)	• 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 where appropriate.	• 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. • Ongoing cross-promotion of WHH volunteering opportunities within the volunteer programme and EbyE membership via emails, networking and online resources.	• 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 through campaigns and stands in support of National Apprenticeship Week (February 2026). • Promoted a midwifery open day on 24 January in The Nest, to raise awareness of midwifery roles. • 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. • Use WHH locations or partner venues for community engagement activity.	• 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. • Celebrated news stories and raised awareness of the 30 for 30 fundraising challenge to celebrate 30 years of WHH charity in 2026.	• Ongoing

Upcoming engagement events

• Home • Community • Hospital

Caring for you

Events timetable

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.
6 September 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.

North Cheshire and Mersey
NHS Foundation Trust

Trust Board

Agenda reference:	**BM/26/04/016**			
Subject:	**Committee Terms of Reference**			
Date of meeting:	1 April 2026			
Action required:	**Approval**			
Author(s):	John Culshaw, Company Secretary			
Executive director sponsor:	Nikhil Khashu, Chief Executive			
Link to strategic aim:	All			
Link to risks on the board assurance framework:	All			
Equality considerations: (please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
				✓
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
Executive summary:	Following the acquisition of Bridgewater Community Healthcare NHS Foundation Trust, the Board is required to approve a revised governance framework that reflects the establishment of North Cheshire and Mersey NHS Foundation Trust as a single statutory organisation. The attached Terms of Reference establish the following Committees as formal Committees of the Board, replacing the previous Committees in Common arrangements that operated during the transition period: • Quality and Safety Assurance Committee • Strategic People Committee • Finance, Sustainability and Performance Committee The proposed Terms of Reference reflect the move from aligned but sovereign decision making to clear, unified accountability, with direct delegated authority from the Trust Board. They provide consistent oversight across acute, community and dental services and align with the Trust's revised operating and leadership model from April 2026.			

	Each set of Terms of Reference has been reviewed and supported by the relevant Committee in Common and is now presented to the Trust Board for approval.		
Purpose: (please select as appropriate)	**Approval** ✓	**To note**	**Decision**
Recommendation:	The Trust Board is asked to review and approve the Committee Terms of Reference		
Previously considered by:	**Committee**	Quality, Safety & Assurance Committee in Common; Strategic People Committee in Common, Finance, Sustainability & Performance Committee in Common	
	Agenda Ref.	QSACiC/26/03/44; SPCiC/26/03/241; FSPCiC/26/03/234	
	Date of meeting	10.03.26; 18.03.26; 23.03.26	
	Summary of Outcome	Supported	
Next steps: state whether this report needs to be referred to at another meeting or requires additional monitoring	***None***		
Freedom of information status (foia):	Release Document in Full		
Freedom of information exemptions applied: ***(if relevant)***	None		

1. Background/context

Following completion of the acquisition, the Committees in Common model is no longer required. While appropriate during the integration phase, that model relied on parallel decision making by two sovereign Boards.

The proposed Terms of Reference establish single Committees of the Board**,** with unified authority, simplified membership and quorum arrangements, and clear accountability to the Trust Board. This strengthens assurance, reduces duplication and provides a coherent governance framework for the enlarged organisation.

2. Key elements

Quality and Safety Assurance Committee (Appendix 1)

The revised Terms of Reference for the Quality and Safety Assurance Committee reflect the transition from a Committee in Common arrangement to a single statutory Committee of the Board. Key changes include:

- establishment of a single Committee with delegated authority from the Trust Board, replacing parallel decision making by two sovereign Boards
- extension of the Committee's remit to provide assurance across the entire integrated organisation, including acute, community and dental services
- updated membership aligned to the new executive and operational leadership structure
- simplified quorum arrangements, while maintaining appropriate clinical and executive representation
- strengthened and clarified responsibilities in relation to patient safety, quality governance, regulatory compliance and escalation into the Board Assurance Framework
- rationalisation of reporting and assurance routes

Strategic People Committee (Appendix 2)

The revised Terms of Reference for the Strategic People Committee establish the Committee as a single formal Committee of the Board, replacing the Strategic People Committee in Common. Key changes include:

- removal of the Committee in Common model and establishment of one statutory Committee with clear authority from the Trust Board
- revised membership reflecting the unified leadership structure and removal of mirrored WHH and BCH roles
- simplified quorum requirements while ensuring appropriate executive and Non-Executive Director input
- strengthened responsibilities in relation to workforce performance, culture, leadership, staff experience, education and equality, diversity and inclusion

- clearer accountability for people-related risks and assurance reporting into the Board Assurance Framework

Finance, Sustainability and Performance Committee (Appendix 3)

The revised Terms of Reference for the Finance, Performance and Sustainability Committee replace the former Committee in Common with a single Committee of the Board responsible for integrated oversight of finance and performance. Key changes include:

- establishment of a single Committee with delegated authority from the Trust Board, replacing aligned but sovereign decision making
- expanded remit to oversee finance, operational performance, productivity, estates, digital and sustainability across the whole Trust
- consolidation of oversight across acute, community and dental services, supported by a single integrated performance framework
- updated membership aligned to the new executive structure, removing duplication associated with the dual-Trust model
- strengthened responsibilities for delivery of the financial plan, financial recovery, cost improvement programmes and productivity
- integration of oversight of enforcement undertakings and clear escalation routes to the Trust Board
- rationalisation of reporting groups and assurance mechanisms to support clearer triangulation of finance, workforce and activity

3. Recommendations

The Trust Board is asked to review and approve the Committee Terms of Reference

North Cheshire and Mersey
NHS Foundation Trust

Terms of Reference
Quality and Safety Assurance Committee

1. Purpose

The Quality and Safety Assurance Committee (the *Committee*) is established as a formal Committee of the Board of Directors of North Cheshire and Mersey NHS Foundation Trust (*the Trust*).

The purpose of the Committee is to provide oversight, scrutiny and assurance to the Board on all aspects of the quality and safety of care across the Trust's acute and community services. This includes assurance over clinical effectiveness, patient safety, patient experience, regulatory compliance, quality governance, and organisational learning.

The Committee supports the Board in ensuring that high-quality, safe, effective and compassionate care is delivered consistently across all Care Groups, including the integrated Community Services Care Group established following the acquisition of Bridgewater Community Healthcare NHS Foundation Trust.

2. Authority

The Committee is authorised by the Board to:

- Investigate any activity within its remit.
- Seek any information it requires from any employee, who is directed to cooperate with any request made by the Committee.
- Obtain external professional advice as necessary, in line with the Trust's Scheme of Delegation.
- Require attendance from relevant executives, clinical leaders or senior managers where assurance is required.

The Committee has no executive powers other than those specifically delegated by the Board.

Date:
Approved:
Review date:

3. Membership

3.1 Core Members

- Two Non-Executive Directors, *one of whom shall chair the Committee* and *one of whom shall be the Maternity Board Safety Champion*.
- Chief Nurse
- Executive Medical Director
- Chief Operating Officer
- Chief Finance Officer
- Chief People Officer
- Director of Strategy and Partnerships
- Director of Communications & Engagement
- Company Secretary
- Deputy Chief Nurse & Director of Clinical Governance
- Deputy Medical Director
- Chief Pharmacist
- Director of Midwifery & Associate Chief Nurse / Maternity Safety Champion Lead
- Associate Medical Director for Patient Safety
- Associate Director of Quality

3.2 Attendees (as required by agenda item)

- Chief Executive
- Associate Chief Nurse – Planned Care
- Associate Chief Nurse – Unplanned Care
- Associate Chief Nurse – Community Services
- Associate Medical Director – Patient Safety
- Associate Medical Director – Clinical Effectiveness
- Associate Director of Infection Prevention & Control / Associate DIPC
- Senior Information Risk Owner (SIRO)
- Head of Therapies / AHP Lead
- Director of Safeguarding
- Representatives from any Care Group where issues are being discussed

3.3 Observers

- A Governor representative (non-voting)
- Others by agreement of the Chair

4. Quorum

The Committee shall be quorate with **seven members**, including at least:

- One Non-Executive Director
- One of: Chief Nurse, Executive Medical Director or Chief Operating Officer
- One additional Executive Director

Deputies may attend with the agreement of the Chair, provided they have appropriate seniority and authority.

Participation by secure audio or video link constitutes presence for the purposes of quorum.

5. Frequency of meetings

The Committee will meet **monthly**. Additional meetings may be convened at the request of the Committee Chair or the Board.

6. Duties and Responsibilities

6.1 Quality Governance, Strategic Oversight and Assurance

- Monitor delivery of the Trust's Quality Strategy and associated objectives.
- Oversee quality-related enabling strategies including Clinical Effectiveness, Patient Experience, Quality Improvement and Risk Management.
- Ensure governance and reporting structures support safe, effective and consistent care across all Care Groups, including community services.

6.2 Patient Safety

- Obtain assurance on the effectiveness of incident reporting, investigation and learning systems.
- Review Serious Incident investigations and associated improvement actions.

- Monitor delivery of national patient safety priorities and compliance with statutory duties.
- Oversee mortality and harm review processes, including implementation of learning.

6.3 Clinical Effectiveness

- Approve and oversee delivery of the Trust's clinical audit programme.
- Ensure compliance with NICE guidance and external accreditation standards.
- Receive assurance on research governance and clinical improvement work.

6.4 Patient Experience

- Scrutinise intelligence from complaints, compliments, surveys, patient engagement activities and equality considerations.
- Ensure patient and service-user voice informs service improvement.

6.5 Workforce-Related Quality and Safety

- Obtain assurance on staff safety, safeguarding, training compliance, wellbeing and cultural indicators that impact quality of care.
- Ensure workforce-related risks to quality are monitored and escalated appropriately.

6.6 Infection Prevention and Control

- Receive regular assurance on IPC performance, risks and compliance.
- Oversee actions to reduce avoidable infections and meet national standards.

6.7 Learning, Policy and Action Planning

- Ensure robust frameworks exist for policy management, organisational learning and action planning.
- Monitor delivery of improvement actions arising from investigations, audit and inspection findings.

6.8 Risk Management

- Review quality-related risks within the Board Assurance Framework (BAF) and Corporate Risk Register.
- Ensure appropriate escalation, mitigation and monitoring arrangements are in place.

6.9 Regulatory Compliance

- Obtain assurance of ongoing compliance with CQC fundamental standards and other statutory obligations.

- Oversee preparation of the annual Quality Account prior to submission to the Audit Committee and Board.

6.10 Sub-Committees and Reporting Groups

The following groups will report directly to the Committee:

- Patient Safety and Clinical Effectiveness Sub-Committee
- Patient Experience and Inclusion Sub-Committee
- Health and Safety Sub-Committee
- Infection Prevention and Control Sub-Committee
- Adult & Children's Safeguarding Committee
- Medicines Governance Group
- Information Governance and Corporate Records Group
- Quality Compliance Oversight Group
- Palliative and End-of-Life Care Group

Additional groups may be added or revised subject to Board approval.

7. Reporting

The Committee Chair shall provide a written assurance report to the Board following each meeting.

Minutes will be formally recorded and submitted to the Board for information.

An annual report on the Committee's work will be presented to the Board, demonstrating compliance with its duties.

8. Attendance

Core members are expected to attend at least 75% of meetings over a rolling 12-month period.

Deputies should be appropriately briefed and of sufficient seniority to contribute fully.

In-person attendance is preferred, but secure audio/video attendance is acceptable and counts as full participation.

Attendance will be monitored by the Corporate Governance Team and reported annually to the Board

9. Administrative Arrangements

The Committee will be supported by the Corporate Governance Team.

- Papers will be circulated at least five working days before the meeting. Papers received after the deadline will be accepted only with the Chair's approval and must be identified as late papers.
- Papers must clearly identify purpose (note/discuss/approve), key issues, implications (including regulatory and risk), and recommendations.
- No papers will be tabled at the meeting without prior approval of the Chair.
- An action log will be maintained and overdue actions escalated to the Chair and, where necessary, the Board.
- A Cycle of Business will be maintained.

10. Review and effectiveness

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

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

Terms of reference revision tracker

Name of committee:	Quality and Safety Assurance Committee
Version:	V1
Implementation date:	April 2026
Review date:	March 2027
Approved by:	TBC
Approval date:	TBC

Revisions			
Date	**Section**	**Reason on change**	**Approved**

Terms of reference obsolete		
Date	**Reason**	**Approved by:**

North Cheshire and Mersey
NHS Foundation Trust

Terms of Reference
Strategic People Committee

1. Purpose

The Strategic People Committee (the Committee) is established as a formal Committee of the Board of Directors of North Cheshire and Mersey NHS Foundation Trust (the Trust).

The purpose of the Committee is to provide strategic oversight, scrutiny and assurance to the Board on all aspects of the Trust's workforce, organisational development, culture, education, inclusion, leadership and staff experience. This includes assurance over the effectiveness of workforce planning, the wellbeing and development of colleagues, the delivery of the People and Workforce EDI Strategy, and the systems and processes that support a positive, safe and inclusive working environment.

The Committee supports the Board in ensuring that the Trust is a great place to work, where colleagues feel valued, engaged and able to thrive. It ensures that the Trust attracts, retains and develops a capable and compassionate workforce; that there are robust governance arrangements for equality, diversity and inclusion, wellbeing, leadership and organisational development.

2. Authority

The Committee is authorised by the Board to:

- Investigate any activity within its remit.
- Seek any information it requires from any employee, who is directed to cooperate with any request made by the Committee.
- Obtain external professional advice as necessary, in line with the Trust's Scheme of Delegation.
- Require attendance from relevant executives, clinical leaders or senior managers where assurance is required.

The Committee has no executive powers other than those specifically delegated by the Board.

Date:
Approved:
Review date:

3. Membership

3.1 Core Members

- Two Non-Executive Directors, (*one of whom shall chair the Committee*)
- Chief People Officer
- Deputy Chief People Officer
- Deputy Director of People and OD
- Chief Nurse
- Executive Medical Director
- Chief Operating Officer
- Chief Finance Officer
- Director of Strategy and Partnerships
- Director of Communications & Engagement
- Company Secretary
- Associate Chief People Officer: Strategic Workforce Development & Culture

3.2 Attendees (as required by agenda item)

- Associate Chief People Officer
- Guardian of Safe Working
- Freedom to Speak Up Guardian
- Health & Wellbeing Guardian
- Director of Medical Education / Education Governance Leads
- Representatives from Care Groups / Divisions where relevant workforce items are being discussed

3.3 Observers

- A Governor representative
- Others by agreement of the Chair

4. Quorum

The Committee shall be quorate with four members, including at least:

- One Non-Executive Director

- One of: Chief People Officer, Chief Nurse, Executive Medical Director or Chief Operating Officer
- One additional Executive Director

Deputies may attend with the agreement of the Chair, provided they have appropriate seniority and authority.

Participation by secure audio or video link constitutes presence for the purposes of quorum.

5. Frequency of meetings

The Committee will meet monthly. Additional meetings may be convened at the request of the Committee Chair or the Board.

6. Duties and Responsibilities

6.1 Strategic People Planning and Workforce Assurance

- Oversee the Trust's People Strategy and its enabling programmes.
- Scrutinise plans for workforce redesign and sustainability.
- Receive and review workforce plans, including supply, recruitment, retention, succession and talent development.
- Ensure alignment with national workforce policy and the NHS People Promise.

6.2 Workforce Performance, Culture and Leadership

- Monitor key workforce indicators including turnover, sickness, temporary staffing, vacancies, safe staffing and rostering.
- Oversee delivery of the Trust's culture and leadership plans.
- Scrutinise the creation and embedding of a just, restorative and learning culture.
- Review staff engagement, FTSU themes, leadership development programmes and culture-related risks.

6.3 Equality, Diversity and Inclusion

- Oversee the Workforce Equality, Diversity and Inclusion Strategy.
- Ensure statutory and regulatory obligations are met (WRES, WDES, Gender Pay Gap, EDS, public sector equality duty).

- Promote inclusive employment practices, fair access to development and equitable experience.

6.4 Staff Wellbeing and Experience

- Review health and wellbeing programmes and their impact.
- Receive staffing-related risks (safe staffing, maternity staffing, Guardian of Safe Working reports).
- Monitor actions linked to staff experience, morale and retention.

6.5 Education Governance and Organisational Development

- Oversee education governance for medical and non-medical staff.
- Provide assurance that training, appraisal, revalidation and learning systems are effective.
- Receive reports on leadership, OD, workforce development and organisational learning.

6.6 Workforce Risk, Policy and Compliance

- Review all people-related risks within the BAF and Corporate Risk Register.
- Monitor themes from employment relations cases, tribunals, subject access requests and complex workforce issues.
- Oversee annual review and approval of workforce policies and ensure timely consultation processes.

6.7 Subcommittees and Reporting Groups

The following groups report directly to the Strategic People Committee:

- People Delivery Sub-Committee
- Workforce Experience, Diversity & Inclusion Improvement Plan Sub-Committee
- Any other groups as determined by the Committee and approved by the Board

Subcommittees will submit Chair's Log.

7. Reporting

The Committee Chair shall provide a written assurance report to the Board following each meeting.

An annual report on the Committee's work will be presented to the Board, demonstrating compliance with its duties.

8. Attendance

Core members are expected to attend at least 75% of meetings over a rolling 12-month period.

Deputies should be appropriately briefed and of sufficient seniority to contribute fully.

In-person attendance is preferred, but secure audio/video attendance is acceptable and counts as full participation.

Attendance will be monitored by the Corporate Governance Team and reported annually to the Board

9. Administrative Arrangements

The Committee will be supported by the Corporate Governance Team.

- Papers will be circulated at least five working days before the meeting. Papers received after the deadline will be accepted only with the Chair's approval and must be identified as late papers.
- Papers must clearly identify purpose (information/ assurance/ approval), key issues, implications (including regulatory and risk), and recommendations.
- No papers will be tabled at the meeting without prior approval of the Chair.
- An action log will be maintained and overdue actions escalated to the Chair and, where necessary, the Board.
- A Cycle of Business will be maintained.

10. Review and effectiveness

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

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

Terms of reference revision tracker

Name of committee:	Strategic People Committee
Version:	V1
Implementation date:	April 2026
Review date:	March 2027
Approved by:	TBC
Approval date:	TBC

Revisions			
Date	**Section**	**Reason on change**	**Approved**

Terms of reference obsolete		
Date	**Reason**	**Approved by:**

North Cheshire and Mersey
NHS Foundation Trust

Terms of Reference
Finance, Sustainability and Performance Committee

1. Purpose

The Finance, Sustainability and Performance Committee (the Committee) is established as a formal Committee of the Board of Directors of North Cheshire and Mersey NHS Foundation Trust (the Trust). The Committee provides strategic oversight, scrutiny and assurance on all aspects of finance, operational performance, productivity and sustainability across the Trust's acute and community services.

The Committee supports the Board in ensuring:

- Delivery of the Trust's financial plan and mandated deficit trajectory.
- Effective oversight of financial governance, performance recovery, productivity and sustainability.
- Transparent and triangulated reporting across finance, operations, workforce and quality.
- Full compliance with NHS regulatory requirements, including enforcement undertakings.

2. Authority

The Committee is authorised by the Board to:

- Investigate any activity within its remit.
- Seek any information it requires from any employee, who is directed to cooperate with any request made by the Committee.
- Obtain external professional advice as necessary, in line with the Trust's Scheme of Delegation.
- Require attendance from relevant executives, clinical leaders or senior managers where assurance is required.

The Committee has no executive powers other than those specifically delegated by the Board.

3. Membership

Date:
Approved:
Review date:

3.1 Core Members

- Two Non-Executive Directors (one to chair the Committee).
- Chief Finance Officer.
- Chief Operating Officer.
- Executive Medical Director.
- Chief Nurse.
- Chief People Officer.
- Director of Strategy and Partnerships.
- Director of Communications & Engagement.
- Deputy Chief Finance Officer.
- Company Secretary.
- Associate Director of Estates & Facilities.
- Chief Information Officer.

3.2 Attendees (as required by agenda item)

- Chief Executive.
- Divisional/ Care Group Directors.
- Associate Directors for Finance, Performance, Digital or Estates.
- Representatives from Care Groups / Divisions where relevant items are being discussed

3.3 Observers

- A Governor representative
- Others by agreement of the Chair

4. Quorum

The Committee will be quorate with five members, including:

- At least one Non-Executive Director; and
- At least two Executive Directors (from Finance, COO, Medical Director or Chief Nurse).

Deputies may attend with the agreement of the Chair, provided they have appropriate seniority and authority.

Participation by secure audio or video link constitutes presence for the purposes of quorum.

5. Frequency of meetings

The Committee will meet monthly. Additional meetings may be convened at the request of the Committee Chair or the Board.

6. Duties and Responsibilities

6.1 Financial Planning and Performance

The Committee will:

- Oversee delivery of the Trust's financial plan, including run-rate improvement and achievement of the mandated deficit trajectory.
- Scrutinise the Cost Improvement Programme (CIP), including recurrent delivery, convergence with divisional plans, risk mitigation and assurance on sustainability.
- Monitor all financial governance systems including financial control, cashflow, budget management and adherence to national funding conditions.
- Review monthly financial performance, highlighting variances, associated risks and required actions.

6.2 Integrated Performance Oversight

The Committee will:

- Receive and review the Integrated Performance Report (IPR), ensuring triangulation across finance, operations, workforce and productivity.
- Scrutinise operational recovery plans (including UEC, flow and elective), assessing their financial impact and contribution to sustainability.
- Monitor key operational metrics necessary for delivery of the Trust's objectives.

6.3 Strategy, Sustainability and Long-Term Planning

The Committee will:

- Oversee the medium and long-term financial model and its alignment with Trust strategy.
- Review major investments, business cases and proposals for capital expenditure.
- Oversee estates and digital strategies, ensuring alignment with financial capacity and sustainability ambitions.

- Receive updates on productivity, transformation and efficiency programmes, including GIRFT and workforce productivity.

6.4 Risk Management and Internal Control

- Monitor risks relating to finance, performance and sustainability within the Board Assurance Framework (BAF) and Corporate Risk Register.
- Obtain assurance that mitigation actions are effective and escalate any concerns where risk tolerance is breached.
- Seek assurance on compliance with regulatory requirements including NHS Provider Licence conditions.

6.5 Enforcement Undertakings

The Committee will:

- Monitor compliance with enforcement undertakings, including commitments under section 106.
- Immediately escalate to the Board if:
    - undertakings are at risk,
    - the financial plan is at risk, or
    - performance deterioration compromises sustainability.

6.6 Reporting Groups

The following groups will report directly to the Committee:

- Capital Planning Group.
- Financial Resources Group.
- Digital Strategy Group.
- Medical Staffing Review Group.
- GIRFT/Clinical Productivity Group.
- Improvement & Productivity Group.
- Estates and Facilities Groups (as applicable).

7. Reporting

The Committee Chair shall provide a written assurance report to the Board following each meeting.

An annual report on the Committee's work will be presented to the Board, demonstrating compliance with its duties.

8. Attendance

Core members are expected to attend at least 75% of meetings over a rolling 12-month period.

Deputies should be appropriately briefed and of sufficient seniority to contribute fully.

In-person attendance is preferred, but secure audio/video attendance is acceptable and counts as full participation.

Attendance will be monitored by the Corporate Governance Team and reported annually to the Board

9. Administrative Arrangements

The Committee will be supported by the Corporate Governance Team.

- Papers will be circulated at least five working days before the meeting. Papers received after the deadline will be accepted only with the Chair's approval and must be identified as late papers.
- Papers must clearly identify purpose (information/ assurance/ approval), key issues, implications (including regulatory and risk), and recommendations.
- No papers will be tabled at the meeting without prior approval of the Chair.
- An action log will be maintained and overdue actions escalated to the Chair and, where necessary, the Board.
- A Cycle of Business will be maintained.

10. Review and effectiveness

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

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

Terms of reference revision tracker

Name of committee:	Finance, Sustainability and Performance Committee
Version:	V1
Implementation date:	April 2026
Review date:	March 2027
Approved by:	TBC
Approval date:	TBC

Revisions			
Date	**Section**	**Reason on change**	**Approved**

Terms of reference obsolete		
Date	**Reason**	**Approved by:**